STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center	935 Kenwood Avenue Duluth, MN 55811

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the medical provider was updated in a timely manner about worsening edema which needed additional nursing interventions to manage for 1 of 3 residents (R1) reviewed who had heart failure. R1 developed edema in their legs which caused the nurses to place Tubigrips (a compression-style device) on them, however, the medical provider was not immediately updated about this.Findings include: R1's hospital Discharge summary, dated [DATE], identified R1 had been treated for an acute condition of acute blood loss anemia, along with multiple other medical conditions including high blood pressure, chronic heart failure, atrial fibrillation (irregular heartbeat), and diabetes mellitus. R1 was discharged with a Foley catheter in place to the care center for short-term rehabilitation. R1's medications were listed which identified he consumed torsemide (a diuretic medication) 20 milligrams (mg) twice daily. R1's next appointment was scheduled for 5/8/26 with the provider. The section labeled, Condition on Discharge, identified his vital signs which included a weight of 212.1 pounds (lbs), and a physical exam identified, Mild pitting edema in BLE [both legs]. R1's progress notes, dated 5/4/26 to 5/9/26, identified the following information: On 5/4/26, R1 was admitted to the care center from the hospital. R1 was alert and oriented and recorded with, HRIR [heart rate, irregular], trace edema BLE, +PP [pedal pulses] . R1's lung sounds were clear, but he had shortness of breath at rest.On 5/7/26, R1 remained at the care center following hospitalization for anemia and heart failure. The note recorded, Edema: Yes, with more dictation reading, 2-3 + to BLE. R1 did not have any obvious weight gain or loss, and the nurse wrote a nursing order for Tubigrips, and to elevate his affected extremities. The note was authored by registered nurse (RN)-C. On 5/8/26, R1 continued to have edema present which was recorded, 2-3 + to BLE.R1's Search Vitals Results, dated 5/4/26 to 5/8/26, identified R1's recorded daily weights collected at the care center. These were: 5/4/26 - 198.8 lbs5/5/26 - 201.0 lbs 5/6/26 - 202.3 lbs 5/7/26 - 202.2 lbs 5/8/26 - 202.8 lbs R1's First Eldercare admission Regulatory Visit note, dated 5/8/26, identified R1 was seen by the medical provider. R1 was identified to have heart failure and R1 stated he is doing well today. R1 denied chest pain but acknowledged chronic shortness of breath ongoing. A physical exam was recorded which identified, Extremities: . swelling of his [BLE]. The note did not address whether the Tubigrips were present or not.R1's medical record lacked evidence that the medical provider was contacted on 5/7/26 about the increased edema despite the nursing staff deciding to implement a new treatment (i.e., the Tubigrips) to help reduce it and improve the condition. When interviewed on 5/27/26 at 12:46 p.m., licensed practical nurse (LPN)-A stated the care center often had patients with heart failure and the monitoring for each person depended on the specific physician orders they came with or had. LPN-A stated Tubigrips would sometimes be used to help control edema as they didn't require a physician order to use. LPN-A stated the typical threshold for notification to the medical provider about heart failure or potential fluid overload was not based on edema but rather on their weight being elevated over a certain threshold (i.e., 3 lbs in 24 hours/5 lbs in a week) adding this was a general rule. LPN-A stated residents with edema should be monitored at least daily for the edema but there was no specific order set to record the monitoring being (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. LPN-A stated if edema was concerning, or if the medical provider was updated about it, that information should be written in a progress note. On 5/27/26 at 1:07 p.m., a telephone call was made to RN-C. A return call was received at 3:30 p.m., and RN-C recalled R1 as having increased edema in his legs on 5/7/26. RN-C stated R1 often did not like to lay down and was often up in his wheelchair so they thought adding Tubigrips would be helpful for the increased swelling. RN-C was asked when to notify the provider about increased edema and responded, That is a good question. RN-C explained the prompt to notify the provider was typically done off their weight status and not specifically for just increased edema. RN-C stated any notification to the provider would have been documented in the progress notes and expressed they did not recall placing a note for the physician or calling them on 5/7/26. RN-C reiterated they just felt the edema was from him sitting often and thought, Let's see how these [Tubigrips] work the next day or so. RN-C stated if R1's weight had been more drastically elevated along with the edema; it would have prompted an immediate telephone call to the provider. On 5/27/26 at 1:41 p.m., nurse practitioner (NP)-A stated they worked for the service R1 had been under while at the care center, however, they had not personally seen him so could not answer specific questions about his care. NP-A stated R1 remained in the hospital and discussed the current standard-of-care for heart failure is to do a daily weight and place the patient on a low sodium diet. NP-A stated it would be appropriate to update the provider at the first sign of increased swelling or edema as that was an indication something is not right. On 5/27/26 at 2:36 p.m., the director of nursing (DON) and registered nurse unit manager (RN)-B were interviewed. DON stated all nurses were aware to complete a daily check of edema for a patient with heart failure but, in general, edema was not specifically tracked in the medical record. If a nurse noticed increased swelling in the legs, then the nurse should review the previous charting to determine if the edema was more or less than previous shifts. RN-B explained a Tubigrip was like a sleeve and were able to be placed with a simple nursing order. DON verified the application of Tubigrips would be considered a form of treatment and felt the nurses could update the provider even simply as placing a note in their folder for the next rounds if the physician was scheduled to be there soon. However, if they were needed to be used for several days in a row, then a telephone call to the provider would be appropriate. RN-B stated they felt immediate notification to the provider would only be considered for emergent items or updates. DON and RN-B verified there was nothing recorded in the medical record to demonstrate the medical provider was contacted on 5/7/26 when the edema was identified as worse and a new form of treatment was started by the nurse. RN-B stated they felt any increase of edema should be relayed to the provider and added going from a ?trace' to 2-3+ of edema in a few days period was on paper a significant increase. A facility Change in Condition, Resident Examination and Evaluation policy, dated 11/2025, identified a resident examination and evaluation would be completed upon admission, with a change in physical function, or with an acute change of condition. The policy added, When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is a need to alter treatment significantly, the licensed nursing associate consults with the attending provider and [will] notify the resident/resident representative. A procedure was listed which directed to contact the medical provider for abnormalities including changes in physical status from baseline and a need to alter treatment significantly. The notification was to be recorded in the medical record. However, the policy lacked any definitions on what was considered a need to alter treatment significantly or what the facility defined as ?immediately.'