DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2WOF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00740

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245275**

2.STATE VENDOR OR MEDICAID NO.
(L2) **964043600**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDENBROOK OF EDINA**
(L4) **6200 XERXES AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/30/2017**

6. DATE OF SURVEY **08/15/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date:
Eva Loch, Unit Supervisor — 08/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 08/31/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/18/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245275
August 31, 2018

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Richfield, MN 55423

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 17, 2018 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
August 13, 2018

Ms. Kelly Ellis, Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Richfield, MN 55423

RE: Project Number S5275028

Dear Ms.. Ellis:

On June 21, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 7, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

However, compliance with the health deficiencies issued pursuant to the June 7, 2018 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 7, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 7, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 7, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Edenbrook Of Edina is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation

Programs for two years effective September 7, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program

Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered

August 31, 2018

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Richfield, MN 55423

RE: Project Number S5275028

Dear Administrator:

On August 13, 2018, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 7, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on June 7, 2018, and lack of verification of substantial compliance with the health deficiencies at the time of our August 13, 2018 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 15, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 17, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 7, 2018, as of July 17, 2018.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of August 13, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 7, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 7, 2018, is to be rescinded. They will also notify the State

Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 7, 2018, is to be rescinded.

In our letter of August 13, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 7, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 17, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2WOF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00740

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245275**

2.STATE VENDOR OR MEDICAID NO.
(L2) **964043600**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDENBROOK OF EDINA**
(L4) **6200 XERXES AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/30/2017**

6. DATE OF SURVEY **06/07/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Dawn Chiabotti, HFE NE II 07/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 07/17/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
05/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 21, 2018

Ms. Kelly Ellis, Administrator
Edenbrook of Edina
6200 Xerxes Avenue South
Richfield, MN 55423

RE: Project Number S5275028

Dear Ms. Ellis:

On June 7, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the

attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 17, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 17, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 7, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING _____ B. WING _____	06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF EDINA	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/4/2018 through 6/7/2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		7/17/18

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

Electronically Signed | 06/29/2018

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 3 of 9 residents (R4, R8 and R11) reviewed for dining. Findings include: On 6/4/18, at 5:51 p.m. dining services were observed in the three north dining area where nine residents were being supervised and/or assisted with dining. R11 sat at a rectangular table with three other residents seated on each side of the table. R11 sat next to R4 who was positioned at the end of the table without a	F 550	DON educated staff in the dining room about sitting when providing assistance with feeding. All staff were educated on a dignified dining experience. IDT assessed needs of residents and made some alterations to seating in the 3 north dining room. Manager on Duty rotations were set up to monitor dining rooms. Completed July 17, 2018. Dining room managers will compete random audits weekly for the next 90	

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F 550	Continued From page 2 resident sitting across from her. R8 sat at a table with two other residents. On 6/4/18, at 6:03 p.m. the nursing assistant (NA)-B approached R11, stood next to her with her back to R4 and proceeded to feed and offer beverages to R11 while standing for ten minutes. R4 was isolated during this time and did not converse with staff or other residents. At 6:13 p.m. NA-B left the table and returned at 6:14 p.m. to assist R11 with her dessert. NA-B again stood to assist R11 with her back to R4 and occasionally would lean over with her elbow on the table while feeding R11. R4 was isolated and not engaged in any conversations from 5:51 p.m. to 6:30 p.m. On 6/4/18, at 6:13 p.m. the registered nurse (RN)-B approached R8 and fed her while standing. RN-B left R8's table after giving her five spoons of the meal and approached R11's table. RN-B assisted R11 while standing next to her with her back to R4, fed her two spoons of her desert, and then returned to R8's table to assist. R11's quarterly Minimum Data Set (MDS) assessment dated 3/16/18, identified R11 needed supervision with eating and her cognition was severely impaired. R4's admission MDS dated 3/1/18, identified R4 needed setup help and was independent with eating, and her cognition was severely impaired. R8's quarterly MDS dated 3/11/18, identified R8 needed setup help and supervision with eating, and her cognition was severely impaired. On 6/4/18, at 6:17 p.m. RN-B acknowledged she	F 550	days. The results of these audits will be shared with the facilities QAPI committee for input on the increase, decrease, or discontinuance of the audits based on the findings. Correction will be monitored by Director of Social Services/ or designee.	

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F 550	Continued From page 3 was standing while feeding R8 and R11 and should have been sitting next to any resident while feeding them. On 6/4/18, at 6:18 p.m. NA-B acknowledged she was standing while feeding R11 and her back was to R4. NA-B further stated she was trained during orientation to sit with residents while feeding them and she should not have stood while feeding R11. On 6/6/18, at 9:59 a.m. the assistant director of nursing (ADON) stated she was informed about staff who stood while feeding residents on 6/4/18. ADON stated she would expect staff to sit with residents while feeding them to promote dignity during meals and to not stand with their backs to other residents. On 6/7/18, at 11:08 a.m. the director of culinary services (DCS) stated he had heard about staff standing and feeding residents which could have appeared as staff would be looking down on residents and it would also not be a safe practice. DCS further stated it was a dignity issue and in-services were conducted to remind staff about the right way to feed residents. On 6/7/18, at 11:30 a.m. the director of nursing (DON) stated her expectation would be for all residents who required assistance with eating to be assisted while staff was seated next to them. She further stated the facility had a dining policy but it did not address how to feed residents. The facility's dignity and respect policy dated 2/3/17, indicated staff should promote "resident independence and dignity in dining."	F 550		
F 553	Right to Participate in Planning Care	F 553		6/8/18

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F 553 SS=D	Continued From page 4 CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide opportunity to participate in person centered care planning and	F 553	R23 has had diagnosis updated and was scheduled for psychiatry, vision, and dental appointments. A calendar has	

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F 553	Continued From page 5 failed to provide services requested by the resident and as identified by physician for 1 of 1 residents (R23) reviewed. Findings include: R23's annual Minimum Data Set (MDS) dated 10/14/17, indicated R23 was cognitively intact. R23's admission record printed on 6/7/18, indicated a medical diagnosis of bipolar disorder. During interview on 6/4/18, at 2:38 p.m. R23 stated she wanted the following medical appointments scheduled; psychiatry, vision and dental. R23 explained she requested these appointments be scheduled a few months ago but were the appointments had not been scheduled and nobody had followed up with her. R23 stated she did not have any specific problems with her vision or dental status and just wanted a routine exam. R23 explained she thought it had been about a year since she had seen a dentist and was unsure how long it had been since she had last had her vision evaluated. R23 stated she wanted to see a psychiatrist to have her medications evaluated. R23 explained she had bipolar disorder and had seen a psychiatrist in the past. R23's psychology visit notes were reviewed: - The note dated 3/9/18, indicated R23 wanted to see a dentist and an eye doctor; - The note dated 3/16/18, indicated R23 was still waiting to have a dental and vision appointment made, and once made "it would be helpful to let her know so she is not worrying."; - The note dated 3/23/18, indicated R23 wanted to see a psychiatrist to have her medications evaluated;	F 553	been made for so R23 knows when the appointments are. Social Worker was educated to be reading ACP notes. HUC were educated on communicating appointments to residents. Completed on June 8, 2018. A committee was started to be auditing/reviewing and addressing ACP notes and recommendations. Will include social worker, nurse, and administrator/designee. This committee will meet weekly. A note of committee review will be placed in resident□s medical record. Correction will be monitored by Director of Social Services/ or designee.	

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F 553	Continued From page 6	F 553		

- The note dated 4/13/18, indicated two psychiatry clinic options per R23's request;
- The note dated 5/18/18, indicated again that it would be helpful for staff to write down when R23's eye doctor and psychiatry appointments are.

R23's physician orders dated 3/7/18, indicated to schedule an appointment with dentist and eye doctor at the facility.
R23's medication administration record for June 2018, indicated R23 was taking Zyprexa (an antipsychotic medication) 10 milligrams daily for bipolar disorder. R23's care plan dated 6/4/18, indicated psychosocial well-being as a concern and interventions indicated to provide resident with opportunities to participate in care.

On 6/6/18, at 8:58 a.m. social worker (SW)-A stated she was unaware of the psychology recommendations that indicated R23 wanted vision, dental and psychiatry appointments scheduled. SW-A stated the health unit coordinator (HUC) did appointment scheduling for residents. SW-A also stated she communicated with R23 if there were any updates and during care conferences which would be documented in R23's chart. SW-A was unable to identify when R23 had her last care conference.

On 6/06/18, at 12:39 p.m. HUC-B stated she scheduled medical appointments for residents, and was not aware of any requests by R23 for dental, vision, and psychiatrist appointments. HUC-B verified R23 had no appointments scheduled for dental, vision or psychiatry.

On 6/7/18, at 9:34 a.m. the director of nursing (DON) stated the proper procedure for setting up

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F 553	Continued From page 7 a psychiatry appointment should have been to obtain a physician's order before scheduling. The DON explained the facility has dental and vision services onsite and did not know why R23 had not been scheduled for these appointments as requested. The DON stated it was a resident right to be able to choose their providers and participate in their planning their cares. The DON stated SW-A was responsible for reviewing the psychology visit notes then communicating the recommendations to the appropriate departments. The facility's Care Planning Policy and Procedure revised on 10/27/17, indicated "The resident, the resident's family and /or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan." A policy regarding scheduling vision and dental appointments was requested but none provided.	F 553		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		7/2/18

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F 578	Continued From page 8 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed identify the preference for Health Care Directives for 1 of 1 residents (R4) reviewed for advanced directives. Findings include: The Admission Record printed on 6/6/18, indicated R4 was admitted 2/22/18, with diagnoses including Alzheimer's disease and dementia, R4's primary language was Spanish,	F 578	Social worker immediately conducted a facility audit of advance directives. R4 family was called to discuss wishes of Full Code. The facility completed a review of all residents to ensure the profile in PCC and the POLST matched their wishes and care plan. Education was completed with licensed nursing staff and IDT on POLST, updating PCC, and care plan to match the	

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F 578	Continued From page 9 and was admitted from home. The Admission record for Advance Directive was left blank. The admission minimum data set (MDS) assessment dated 3/1/18, indicated R4's cognition was severely impaired. Review of admission documentation in both the hard copy and electronic medical record (EMR) on 6/5/18, at 9:24 a.m. revealed there was no evidence of R4's health care directive or resuscitation status, and no record if the facility staff informed the resident or representative of their rights to establish one. On 6/6/18, at 10:03 a.m. the assistant director of nursing (ADON) verified R4's advanced directives were missing from both hard copy and electronic medical record and stated all residents should have them completed so that staff could identify their wishes in an emergency. On 6/6/18, at 10:10 a.m. the director of nursing (DON) stated she was told R4 did not have advanced directives in either her paper chart or EMR and staff would not know R4's resuscitation status without them. DON further stated the facility staff "missed that when R4 was admitted to the facility", and they would have to audit all the facility's records to ensure the advanced directives were in place. The facility's Code Status Designation policy and procedure dated 7/28/15, and revised 6/5/18, indicated "1. Upon admission, the Social Worker, or designee, will review the resident Advanced Directive and initiate action to ensure code status order. 2. The code status order will be signed by the physician. 3. Each facility will have a method for identifying resident code status."	F 578	resident□s wishes. Completed on 7/2/18. The Director of Nursing/designee will audit random residents weekly to assure the POLST, PCC, and the care plan match the resident□s wishes. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. Correction will be monitored by Director of Nursing/ or designee.	

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F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		7/5/18

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F 584	Continued From page 11 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a homelike environment for 3 of 3 resident rooms (R159, R152, R4) reviewed for environmental concerns. Findings include: On 6/4/18, at 4:09 p.m. R159 was observed in her room, sitting on the edge of her bed. R159 stated that she did not understand how she could have been admitted to a location that did not even have a bulletin board or anything on the walls and said "No calendar, no bulletin, no pictures, nothing". R159 had a television mounted on the wall opposite of her bed, and a round wall clock was on her bedside table. There were no wall hangings, pictures or personal items in the room. During the tour of the first floor on 6/4/18, at 6 p.m., it was noted that not any of the resident rooms had wall hangings to personalize the space. The hallways, front lobby, front reception desk area, and common areas were void of wall decorations, pictures, posters, or bulletin boards. On 6/5/18, at 9:18 a.m. R152, who was sitting up in her bed having raisin bran cereal for breakfast, stated "there is not a picture on the wall or anything" and that "this is like living in a jail cell." R152 had a television and a round clock mounted on the wall opposite of her bed with no wall hanging, pictures or personal items in the room. On 6/5/18, at 9:24 a.m. R4's room was observed to have a bed, nightstand and dresser in the room	F 584	R159 was offered by 2 staff members to put artwork up on the wall. Resident refused. R 152 supplies removed immediately, and placed back into appropriate storage. R4 had the bulletin board put up on the wall. Staff was educated about leaving nursing supplies out in resident rooms. Artwork for the facility was ordered on June 27, 2018 set to arrive on July 3, 2018. Activity staff educated to put activity calendars up on wall for residents. Social worker educated to communicate and document discussions with families during first care conference to encourage residents to bring personal items from home to help residents feel more comfortable in rooms. Completed on July 5, 2018. Director of Nursing/designee will compete random room audits weekly for the next 90 days. The results of these audits will be shared with the facilities QAPI committee for input on the increase, decrease, or discontinuance of the audits based on the findings.	

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F 584	Continued From page 12	F 584		

with no personal items or pictures in the area. There was a small fake flower display on the nightstand with a 2/3 empty roll of toilet paper in front of it. There was a bucket containing wound care supplies on her dresser with no other items present. There was a bulletin board on the floor next to the dresser and hanging hooks exposed on the wall next to the dresser. Review of R4's admission minimum data set (MDS) assessment dated 3/1/18, identified R4's cognition was severely impaired.

On 6/5/18, at 3:29 p.m. the environmental director (ED) stated 3rd floor had not been renovated and did not know when or if it was scheduled to be. ED further stated there were no personal items in the room except maybe the fake flowers, there were no pictures on the wall and the bulletin board was on the floor.

On 6/6/18, at 10:39 a.m. the director of nursing (DON) toured R4's room and stated there was a toilet paper roll, a bottle of incontinence cleanser and a piece of used incontinent brief in front of fake flowers on R4's nightstand. She also stated there was a box of wound dressings on R4's dresser and there were no personal items displayed in R4's room. The DON stated her expectation would be for the facility's residents to have a home like environment and there should not be incontinence and wound care items left out in their rooms.

In an interview with the director of nursing on 6/7/18 at 8:38 a.m., she stated that the first floor opened to accept patients following a remodel on 4/13/18. In an interview with the administrator on 6/5/18, in the a.m.(unknown exact time) she stated the chief operating officer was taking care

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F 584	Continued From page 13 of getting wall hangings and it should have been part of the remodel project, but she did not know if anything had been ordered or was to be delivered.	F 584		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and	F 660		6/9/18

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treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and

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F 660	Continued From page 15 to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide effective discharge planning process to facilitate finding alternative placement in a timely manner and to avoid unnecessary delays in the resident's discharge from the facility for 1 of 1 residents reviewed (R23) for discharge planning. Findings include: During interview on 6/4/18, at 2:38 p.m. R23 stated she was done with therapy and was waiting to discharge to an assisted living facility (ALF). R23 stated originally she was going to discharge in April but now did not know when that will happen and she did not receive updates on the status of her discharge planning. R23 stated she had to ask for updates from the social worker (SW)-A and SW-A would say that she was working on it but would not say specifically what was going on. R23 stated she had to move her belongings out of her apartment a few months ago and that a relative was paying for a storage unit for her while R23 was waiting for an assisted living facility. R23 stated she felt she was burdening her family member. R23's annual Minimum Data Set (MDS) dated 10/14/17, indicated R23 was cognitively intact. R23's care plan revised on 10/16/17, noted R23 was at the facility for short term, interdisciplinary team determined that it was not safe for resident to return home, and social worker to work with resident to explore ALF options. Interventions indicated assist in evaluating options for	F 660	R23 was updated on current status of discharge plan. R23 care plan was updated of current discharge plan. Social worker educated on updating residents on their discharge plan and to document in medical record that conversation had taken place. Completed on July 9, 2018. The social worker will discuss discharge plans at care conferences and the tracking of the care conferences in stand up. Discharge plan will be updated in resident care plan. Administrator/designee will compete random chart audits weekly for the next 90 days. The results of these audits will be shared with the facilities QAPI committee for input on the increase, decrease, or discontinuance of the audits based on the findings. Correction will be monitored by Administrator/ or designee.	

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discharge, discuss with family and resident discharge options. However the care plan did not identify what the plan was for R23's discharge.

R23's psychologist visit note dated 4/13/18, indicated R23 had bipolar disorder with mild anxious distress. The note revealed R23 had turned down an ALF due to being worried about not being able to bring her furniture with her. The note further indicated R23 did not seem to have good insight into her discharge options, and recommended staff explain to R23 what her options were and to document the conversation. R23's psychologist visit note dated 5/18/18, noted R23 was at risk for entering a depressive episode due to not sleeping well from stress related to finding an ALF.

On 6/6/18, at 8:58 a.m. SW-A stated the plan was for R23 to discharge to an ALF, however SW-A had been unable to find placement for her. SW-A explained placement was difficult for R23 due to her insurance. SW-A stated she needed additional assistance in finding placement for R23, who was eligible for a caseworker through her insurance, but SW-A had not yet attempted to contact the caseworker or located the caseworker contact information. SW-A stated she communicated with R23 if there were any updates and also during care conferences which would be documented in R23's chart. SW-A was unable to identify when R23 had her last care conference.

On 6/7/18, at 9:34 a.m. the director of nursing (DON) stated R23 had been in the hospital a few times since original admission in July of 2017, and had not resumed her previous physical strength. The DON stated she was unsure if R23

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F 660	Continued From page 17 would meet the criteria for an ALF due to her current level of care needs. The DON explained that discharge planning should start upon admission including bringing on additional caseworkers. The facility's Care Planning Policy and Procedure revised on 10/27/17, indicated the purpose was "To ensure that each resident receives care individualized to him or herself and that goals and approaches for care are communicated to all parities including caregivers, the resident and the representative." which included also discharge plans.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident	F 661		7/2/18

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F 661	Continued From page 18 representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a summary of the resident stay (recapitulation) for 1 of 1 (R50) residents reviewed for closed record review. Findings include: A review of R50 closed medical record indicated the R50 was admitted with a diagnosis of enterococcus due to clostridium difficile (C-Diff), glaucoma, dependence to renal dialysis and sleep apnea. R50 discharged from the facility on 4/19/2018, with her son. Review of the medical record revealed there was no evidence of the recapitulation of resident's stay document. During an interview on 6/6/18, at 9:03 a.m. the health unit coordinator (HUC)-A reviewed the electronic record and could not locate the document. HUC-A said the recapitulation should have been completed by staff members at the time of R50 discharge. During interview on 06/06/18, at 11:03 a.m. the director of nursing (DON) stated, "Unfortunately, we are unable to find any discharge summary or information related to this patient (R50) in the record." During an interview on 06/07/18, at 10:59 a.m. the DON stated it was the policy of the facility to	F 661	R50 had already discharged from facility. No correction available. Education to nursing staff to complete discharge recaps. Facility to implement discharge meetings to plan for residents before they discharge from the facility to discuss discharge needs. Completed on July 2, 2018. Director of Nursing/Designee will compete random discharge audits weekly for the next 90 days. The results of these audits will be shared with the facilities QAPI committee for input on the increase, decrease, or discontinuance of the audits based on the findings. Correction will be monitored by Director of Nursing/ or designee.	

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F 661	Continued From page 19 do a recapitulation of the resident stay at the time of discharge. DON stated they used the electronic medical record and complete the discharge summary under the assessments. She further explained that more than one staff person had a role in the process. The Policy and Procedure titled "Discharging a Resident" dated 7/28/15,"4. Assess the resident's condition at time of discharge and document in the medical record. 5. Provide personal care prior to transferring to discharge location.", "8. Document in the medical record any additional information related to the discharge, discharge instructions and disposition of medications." and "10. Record the discharge summary within 30 days of discharge from the facility and close the medical record for storage " .	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide eyewear for 1 of 1 visually impaired resident (R29) who required staff's assistance with activities of daily living (ADL) cares. Findings include: R29's admission Minimum Data Set (MDS) assessment dated 5/2/18, indicated R29 required extensive assistance with activities of daily living,	F 677	R29 care plan reviewed/updated and care plan is being followed. Care plans have been reviewed to ensure plans of care are up to date to reflect the need of glasses or hearing aids. The Policy and Procedure for Care Planning remains current. The DON/designee will educate the IDT team on ensuring plans of care are updated as resident changes occur. Completed on July 2, 2018.	7/2/18

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F 677	Continued From page 20 had severely impaired cognition, and had adequate vision with corrective lenses such as contacts, glasses or magnifying glass. The Care Area Assessment for vision did not trigger. During an interview on 6/4/18, at 3:31 p.m. family member (FM)-F stated she had concerns that R29 was not wearing his glasses regularly. FM-F stated R29 was often placed in front of the television (TV) and he was supposed to wear bifocals. FM-F stated he would be unable to adequately see the TV without the bifocals on. During observation on 6/4/18, at 5:53 p.m. R29 was in the dining room for supper and he was not wearing glasses. At 12:36 p.m. R29 was up for lunch and was not wearing glasses. During an interview on 6/6/18, at 11:11 a.m. the nursing assistant (NA)-C explained she knew how to care for the residents by logging onto the computer where she saw the residents care plans. A review of the electronic health record (EHR) on 6/7/18, revealed R29's visual impairment, need to wear glasses and R29 needing staff's assistance to put glasses on was not care planned. On 6/6/18 at 11:43 a.m. the director of nursing (DON) was interviewed regarding the process for assessing resident's needs and developing the comprehensive plan of care. DON stated it was an interdisciplinary process that generally started with the MDS coordinator, and resident assessment. DON also stated that it would be her expectation that there would have been a care plan developed related to R29's vision.	F 677	The DON/designee will audit random care plans each week to ensure they are accurate. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. Correction will be monitored by Director of Nursing/ or designee.	

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F 677	Continued From page 21 During an interview on 6/7/18, at 12:47 p.m., the MDS coordinator acknowledged that there was no care plan in place for R29's visual impairment, and need to wear glasses. MDS coordinator stated that "was human error" and had a plan in place to ensure going forward all residents with visual impairment had care plans developed. A policy related to care planning related to provision of activities of daily living cares and services was requested but none received.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide compression therapy per physician orders for 1 of 1 residents (R23) reviewed for edema . Findings include: During interview on 6/4/18, at 2:48 p.m. R23 stated she was supposed to have ACE wraps placed to her legs daily. R23 explained the wraps were used to control swelling in her legs. R23 stated she thought her legs had become more swollen in the past few weeks because staff had	F 684	R23 orders were immediately corrected to reflect in the TAR. Resident had ace bandages applied. Nurse who put in order for compression was educated to ensure proper order entry. Education to nurses and HUCs about putting orders in so they populate on TAR. An audit was conducted physician orders to ensure that orders were populating to TAR. Residents with ace bandages, compression stockings, geri sleeves were identified to verify that the information was	6/8/18

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F 684	Continued From page 22 not been putting them on. R23 stated she had informed a physician about her concerns about the ACE wraps not being applied by staff and the physician told her that ace wraps were ordered and staff should be putting them on. During this interview R23 was observed with mild swelling in her lower legs, and was not wearing ace wraps. The ace wraps were observed rolled up on television stand in R23's room. R23's annual Minimum Data Set (MDS) dated 10/14/17, indicated R23 needed physical assistance from one personal for putting on and taking off all items of clothing including compression garments. The MDS further indicated R23 was cognitively intact. R23's psychologist visit note dated 3/16/18, indicated R23 was worried about the swelling in her legs because staff had not been wrapping them lately. Recommendations included staff talking to R23 about her concerns of swelling and leg wrapping. R23's physician orders dated 4/21/18, indicted ACE wraps (elastic bandages used to control swelling) should be applied to lower legs in the morning and taken off in the evening daily for swelling in lower legs. On 6/5/18, at 10:06 a.m. R23 stated ACE wraps were not placed on this morning, and R23's legs were observed without the ACE wraps. On 6/6/18, at 8:57 a.m. R23 was observed wheeling herself back from breakfast in her wheelchair with again no ACE wraps on. At 12:42 p.m. R23 was observed again with no ACE wraps on. On 6/6/18, at 1:46 p.m. registered nurse (RN)-A stated R23 had mild swelling in her legs. RN-A was not aware of any orders R23 had for ACE wraps to be applied and stated she had not	F 684	populating on the resident□s TAR. Completed on June 8, 2018. The DON/designee will audit random on orders each week to ensure they are accurate. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. Correction will be monitored by Director of Nursing/ or designee.	

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F 684	Continued From page 23 applied them today. RN-A stated she was not aware of there "ever being order" for R23 to have ACE wraps. R23's June 2018, treatment administration records (TAR) were reviewed, and it did not indicate any orders for ACE wrap application. On 6/7/18, at 9:34 a.m. the director of nursing (DON) stated her expectation if a resident had orders for ace wraps that order would be on the TAR and then the nurses would complete the task as ordered. An undated facility policy titled Application of ACE bandage was reviewed. It did not indicate the process for ACE wraps to be placed on the TAR or who had the responsibility to place the ACE wraps on a resident.	F 684		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide food that was palatable and at a temperature that was acceptable for 2 of 13 (R149, R27) residents on the first floor of the facility.	F 804	Dietary staff was educated to notify nursing staff before plating up room trays. R27 was offered to have food warmed up, but refused.	7/17/18

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F 804	Continued From page 24 Finding include: On 6/4/18, at 1:44 p.m. R149 stated the food was always cold when it came to her room and she did not want to eat it. R149 was in her room, sitting in a wheelchair with a plate of chicken and pasta on a tray in front of her. None of the food was eaten. On 6/6/18, at 8:58 a.m. R27 stopped the surveyor and complained about the food being cold. R27 stated the food was "ever warm enough" for him and the food was "cold all of the time" when it came to his room on the tray. During an observation of the tray service on 6/4/18, at approximately 5:15 p.m., a test tray was requested by the surveyor. Dietary aide (DA)-A put the plate and utensils on a tray and added it to the first floor cart. The food was observed plated and covered with a clear lid, ready to be delivered from the kitchen to the first floor. At 5:58 p.m. meal trays were started to be delivered to the residents on the first floor. At 6:15 p.m. the temperature of the food on a declined tray was taken by DA-A, who used a digital thermometer to test the food. The pork and beans (which were in a separate dish on the tray) was at 102.7 degrees Fahrenheit, the hot dog (which was under the lid) was at 90.6 degrees Fahrenheit, and the potato salad (which was also under the lid) was at 68.5 degrees Fahrenheit. During an interview on 6/6/18, at 9:12 a.m. the director of culinary services (DCS) stated that the food was set up and came out to the first floor on trays. The other wings had steam tables to keep the food warm when it left the kitchen. The food	F 804	Dietary Manager and staff were educated on proper food serving temperatures and plating up food too early. Dietary manager was educated on doing temperature audits. Nursing staff was educated to speak with dietary if there was complaints of cold food. Dietary staff were educated to be bringing steam cart out to the first floor and plate up trays for those wishing to eat in their room from the first floor dining room. Completed July 17, 2018. The Dietary Manager/designee will audit random food temperature each week to ensure they are accurate. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. Correction will be monitored by Dietary Manager/ or designee.	

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	245275	A. BUILDING _____ B. WING _____	06/07/2018

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F 804	Continued From page 25 was in the steam table and plated to be sent out on trays to the residents on first floor. DCS stated he would have let the staff know this was happening and made sure they were ready to get the food delivered to the residents prior to plating it. DCS also explained the only heating mechanism for keeping the food hot once it was plated was to put lids on and deliver them to the floor. DCS stated the temperature concerns were a combination of not having a heating mechanism and the time it took to set it up and trays passed. The facility's Hospitality and Dining Services policy and procedure dated 3/16/18, indicated "6. All foods will be covered if being carried a long distance before service. Hot foods will be kept hot (>140°F) and cold foods will be kept cold (<41°F) prior to service. Cooking of hot foods should be completed no more than 30 minutes prior to meal service".	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		7/17/18

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F 812	Continued From page 26 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain clean and sanitary equipment and environment in the kitchen to prevent the spread of food borne illness. This deficient practice had the potential to affect 58 of 59 residents residing at the facility and were served food from the kitchen. Findings include: On 6/4/18, at 12:07 p.m. during a tour of the kitchen the following sanitation problems were observed: - Hand soap was unavailable at the handwashing station. Next to the handwashing area the eyewash station had a black container filled with water from a leaking pipe. - There was dirt and debris, crumbs, empty creamer containers, used sugar packets, sticky spots on the floor throughout the entire kitchen area. - The stove had patches of rust, blackened and dried food particles. - The grill had bits of scrambled eggs along the side. - The can opener had an unknown gel like substance. - There was a bin of thickener left on the counter that was covered with a greasy film of dust. - The air conditioner vents were covered in black greasy dust and blowing on onions that were sitting on a shelf. - Cook-A in the kitchen was not wearing a hair or	F 812	Hand soap was placed in the dispenser. Maintenance received the neck for the sink and finished replacing to working order. Air Conditioner vent was cleaned. The refrigerator had all the contents discarded. Kitchen was completely deep cleaned. Cleaning schedules were implemented. Dietary staff was educated about cleaning schedules. The air conditioner was put on a schedule for cleaning. Staff were educated on hair nets and beard nets. Education provided to staff to report maintenance concerns and how to document them. Maintenance was educated to do monthly walk through each department with department manager to report concerns. Maintenance educated to do lock out tag out on items currently in repair or needing repair. Completed on July 17, 2018. The Dietary Manager/designee will audit cleaning each week to ensure logs are accurate to the work completed. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings.	

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F 812	Continued From page 27 beard net. The double door refrigerator on unit three had one door that would not stay shut. The director of culinary services (DCS)-C stated he was unsure when the problem had started but thought the seal had worked when he started in April 2018. The temperature on 6/4/18, at 12:40 p.m. was at 56 degrees Fahrenheit and contained shelled eggs dated 5/27/18, a sealed cardboard box of prepackaged scrambled eggs with indication to Keep Frozen and was dated 6/1/18. A cleaning schedule was requested and a blank copy was provided. On 6/7/18, at 10:52, the administrator confirmed that no cleaning schedule was in place. The facility's policies and procedures for kitchen sanitation and cleanliness was requested but none provided.	F 812	Correction will be monitored by Administrator/ or designee.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/9/18

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F 880	Continued From page 28 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 29 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to minimize the risk for spread of infection related to the cleansing and disinfection of the blood glucose meter (device used to test blood sugar levels) for 2 of 4 residents (R35, R36) observed to have blood glucose meter checks. Findings include: On 6/5/18, at 11:21 a.m. registered nurse (RN)-B was observed coming out of R35's room carrying a tray containing a glucometer and supplies used to test blood sugars. RN-B stated she had just completed blood sugar testing on R35 with the glucose meter (also called glucometer) in the tray and was now going to test R36's blood sugar. The tray was placed on the medication cart while RN-B retrieved R36's orders from the electronic medical record (EMR) and then was brought to R36's room. After testing R36's blood sugar with the glucometer RN-B placed the glucometer back into the tray and brought the tray to the medication cart. RN-B then placed the glucometer and supplies into the bottom drawer of the medication cart without cleaning or	F 880	(RN)-B was provided education related to appropriate cleaning of glucometers between residents, and after use. (RN)-B was also educated on appropriate cleaning for the glucometer supply tray. Facility nurses will be re-educated on the appropriate cleaning of glucometers and glucometer trays in relation to infection control. Completed on July 9, 2018. Director of Nursing/ designee will audit process of cleaning glucometers/ supply tray three times a week to ensure appropriate cleaning/ disinfecting of equipment is accurate. Audits will be three times a week, and random for the next 90 days. The results of the audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. Correction will be monitored by Director of Nursing/ or designee.	

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F 880	Continued From page 30 disinfecting it. On 6/6/18, at 11:31 a.m. RN-B stated the glucometer was a shared glucometer and she did not clean the glucometer between using it for testing blood sugars for R35 and R36. RN-B further stated she should have used the Clorox disinfectant wipes which were in the medication cart to clean the glucometer after each patient use and before placing it back into the tray, and into the medication cart. On 6/6/18, at 9:52 a.m. the assistant director of nursing (ADON) stated the residents in the facility used shared glucometers and they should have been cleaned after each use by using a Clorox wipe to keep the glucometer surface wet for one minute before placing it back into the tray. The ADON also stated she was aware of the incident where the glucometer was not cleaned between patient uses for R35 and R36 and the facility staff needed re-educated on the policies and procedures for cleaning glucometers. The facility's Cleaning and Disinfection of a Glucometer policy and procedure revised on 4/18/17, directed to have all glucometers that were shared among multiple residents to be thoroughly wiped with the disinfectant and allowed to air dry after every use and between each resident. The policy further directed staff to wipe all external surfaces using the bleach solution or commercially prepared environmental protection agency germicidal wipe and ensure the meter remained wet for one minute and allowed to air dry for an additional minute before using on the next resident.	F 880		
F 883	Influenza and Pneumococcal Immunizations	F 883		7/17/18

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F 883 SS=D	Continued From page 31 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883		

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F 883	Continued From page 32 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R23, R25) received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R23's Face Sheet printed on 6/7/18, indicated R23 was admitted to the facility on 10/7/17, was over the age of 65 and had diagnoses including chronic kidney disease stage 3, chronic obstructive pulmonary disease, chronic/acute respiratory failure and atrial fibrillation. R25's Face Sheet printed 6/7/18, indicated R25 was admitted to the facility on 2/24/17, was over the age of 65 and had diagnoses including heart failure and cerebral infarction. R23's and R25's medical records lacked	F 883	DON, ADON, and supervisor were all provided education related to obtaining consents for vaccines, and following recommendations per CDC regarding PPSV13 and PPSV23. Twin City Physicians and nurses will be re-educated about following through with obtaining consent for vaccines, and following the CDC recommendations for the administration of PPSV13 and PPSV23. R23 and R25 was reviewed by physician, and correction made per physicians orders. Completed by July 17, 2018. Director of Nursing/ designee will audit new admissions and orders three times a week to ensure appropriate administration of Immunizations is occurring per physician order. Staff have been granted access to MIIC to also verify immunizations of new admissions. Audits	

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F 883	Continued From page 33 documentation of pneumococcal polysaccharide vaccine (PPSV23) offered, education provided or evidence of consent or refusal of the vaccine. On 6/7/18, at 10:02 a.m. the director of nursing (DON) reviewed the immunization records for R23 and R25 and confirmed there was no documentation of PPSV23 offered or administered. DON confirmed both residents should have been offered and administered the PPSV23 if consent was obtained within a day or two of admission to the facility. The DON further stated the staff missed this and she would review all facility residents to ensure they had been offered pneumococcal vaccines as directed by the Center for Disease Control. The facility's Pneumococcal Vaccination policy and procedures revised on 3/20/18, indicated "All residents will be assessed for appropriateness of receiving the pneumococcal vaccine. residents who have been deemed as appropriate for receiving the pneumococcal vaccine and who consent to receiving the vaccine will be given the vaccine following the CDC guidelines for the administration of the PPSV23 and PCV13 [pneumococcal conjugate vaccine] as per recommendation on the CDC website." The policy further indicated consent forms to receive the vaccines would be signed upon admission by the resident or responsible party after reviewing the vaccine information statement, all immunizations transcribed into Point Click Care (the facility's electronic medical record program) under the immunization tab, and all consents for immunization scanned into Point Click Care.	F 883	will be three times a week, and random for the next 90 days. The results of the audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. Correction will be monitored by Director of Nursing/ or designee.	
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		7/17/18

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F 908	Continued From page 34 §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain kitchen equipment for cold food storage in a safe operating manner. This had the potential to affect 58 of 59 residents who ate food from the kitchen. Findings include: During a tour of the kitchen with the director of culinary services (DCS)-C on 6/4/18, at 12:07 p.m. one door on a double door refrigerator on unit three was observed open and would not seal. DCS-C stated the thermometer in the refrigerator read 50 degrees Fahrenheit. DCS-C was not sure but believed the seal was operational when he started his position in April 2018. The refrigerator contained ground coffee, apple juice, shelled eggs, one unopened box of 15 dozen eggs dated 5/27/18, a half open box of shelled eggs, and a sealed cardboard box of prepackaged scrambled eggs with indication to "keep frozen" on the box. The box had a date of 6/1/18 written on the top. The temperature of the refrigerator was observed again at 12:40 p.m. and was at 56 degrees Fahrenheit (F). None of the supplies had been removed from the refrigerator. At 3:46 p.m. the thermometer read 52 degrees and the supplies were still there. On 6/5/18 at 8:29 a.m. the thermometer of refrigerator was at 58 degrees Fahrenheit, and none of the supplies had been removed.	F 908	The refrigerator had all the contents discarded. Managers educated on the way in which to report broken items in their department to Maintenance. Education provided to staff to report maintenance concerns and how to document them. Maintenance was educated to do monthly walk through each department with department manager to report concerns. Maintenance educated to do lock out tag out on items currently in repair or needing repair. Dietary manager and staff educated on reporting broken items in the kitchen. Completed July 17, 2018. The maintenance director/designee will audit with monthly walkthroughs of the facility each week to identify needs. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. Correction will be monitored by Maintenance Director/ or designee.	

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F 908	Continued From page 35 During an interview on 6/5/18, at 8:32 a.m. the administrator stated she had been unaware of the broken seal on refrigerator on unit three until this morning and that environmental services were made aware of the problem and they would be repairing it. The administrator stated she was getting in touch with DCS-C to determine what should be done with the contents of the refrigerator. Review of refrigerator's temperature logs provided by the facility from 5/18/18 through 6/18/18, revealed the refrigerator temperatures were above 41 degrees F, as follows: 43 degrees F on 5/13/18, 43 degrees F on 5/17/18, 42 degrees F on 5/21/18, 43 degrees F on 5/22/18, 44 degrees F on 5/26/18, 42 degrees F on 5/29/18, 42 degrees F on 6/3/18, 52 degrees F 6/4/18, and 50 degrees F on 6/5/18. A policy related to equipment maintenance was requested but none received.	F 908		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F6275027

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EDENBROOK OF EDINA	**6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 11, 2018. At the time of this survey, Edenbrook was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.