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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7UNG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00454

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245560**

2.STATE VENDOR OR MEDICAID NO.
(L2) **767842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDGEBROOK CARE CENTER**
(L4) **505 TROSKY ROAD WEST**
(L5) **EDGERTON, MN** (L6) **56128**

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)

6. DATE OF SURVEY **09/10/2018** (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)
12/31

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

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
	56			
(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:
Holly Kranz, Unit Supervisor 9/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 9/11/2018 (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
06/01/1991
(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.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245560

September 11, 2018

Edgebrook Care Center
Attn: Administrator
505 Trosky Road West
Edgerton, MN 56128

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 August 29, 2018 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 11, 2018

Edgebrook Care Center
Attn: Administrator
505 Trosky Road West
Edgerton, MN 56128

RE: Project Number S5560027

Dear Administrator:

On July 31, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 20, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 10, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 10, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 20, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 29, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 20, 2018, effective August 29, 2018 and therefore remedies outlined in our letter to you dated July 31, 2018, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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: 7UNG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00454

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245560**

2.STATE VENDOR OR MEDICAID NO.
(L2) **767842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDGEBROOK CARE CENTER**
(L4) **505 TROSKY ROAD WEST**
(L5) **EDGERTON, MN** (L6) **56128**

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)

6. DATE OF SURVEY **07/20/2018** (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)
12/31

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (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
	56			
(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:
Susan Kalis, HFE NE II 08/06/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 08/08/2018 (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
06/01/1991
(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.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
July 31, 2018

Mr. Michael Redinger, Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

RE: Project Number S5560027

Dear Mr. Redinger:

On July 20, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

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 August 29, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 October 20, 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 January 20, 2019 (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 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

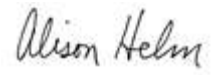
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Enclosure

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
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on July 17th, 18th, 19th, and 20th, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On July 17th, 18th, 19th, and 20th, 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		8/1/18

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

Electronically Signed | 08/01/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 656	Continued From page 1 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to address the use of an anticoagulant medication for a resident with significant bruising for 1 of 1 residents (R40) reviewed for unnecessary	F 656	Disclaimer: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 656	Continued From page 2 medications. Findings include: R40's, diagnosis listed on the admission record dated 7/18/18 included: type 2 diabetes, heart failure, chronic atria fibrillation, chronic obstructive pulmonary disease, chronic kidney disease, pain, major depressive disorder, and pain. R40's minimum data set (MDS) dated 6/20/18 revealed R40 received anticoagulation medication 7 days per week. R40 's medication administration record revealed he was receiving Warfarin (blood thinner) 5 milligrams (mg) orally every Sunday, Tuesday, and Thursday and 2.5 mg every Monday, Wednesday, Friday, and Saturday, for chronic atrial fibrillation. The resident was also on doxicycline (antibiotic) for a cellulitis infection of his lower extremities 6/28/18 - 7/3/18. (antibiotics increase the risk of bleeding when used with warfarin). R40's care plan last updated 7/11/18 did not identify anticoagulation use, or identify a high risk for bleeding or monitoring of bruises which R40 began to develop on 7/3/18. During a observation on 7/18/18 at 2:50 p.m., the entire back of both hands were covered with large dark burgundy color bruises, there were multiple large bruises as large as 3x5 centimeters noted on both forearms. R40's interdisciplinary progress notes revealed:	F 656	alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. R40□s care plan has been updated to reflect the use of anticoagulant medications and the resident has been discharged. To identify other residents who have been affected who received anticoagulant medications, care plans will be reviewed and updates made as necessary. To ensure systemic change, staff involved with care plan implementation were re-educated on 8/1/18 on the importance of care plan needs for resident receiving anticoagulant medications. To monitor performance and solution, effective random audits will be completed on anticoagulant care plans by the DNS or designee once weekly for four weeks and once monthly for two months and results brought QAPI for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST EDGERTON, MN 56128**

(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 656	Continued From page 3	F 656		

-7/6/18 at 3:41 p.m., Resident has large bruises on bilateral arms. He says they came overnight. Did an INR-2.7 & did fax physician his current dose of Coumadin & his last dose of doxycycline was on am of July 3. Resident does not use his call light & has been encouraged in this often. His ambulates/ transfers without calling. He walks fast & is noted to be unsteady/jerky. He does not want to wear his boot that Dr. prescribed last week.

-7/6/18 at 5:57 p.m., faxed response from Dr. "no changes".

-7/19/18 at 5:27 p.m., new bruise noted on left arm, above the antecubital area of arm. Bruise measures 9.5 x 8.5 cm. Bruise is purple/red in color. He does deny pain related to this. Resident states that someone was grabbing him around his arm. He does deny any harm/abuse related to this bruise.

Lab work revealed a INR done on 6/29/18 of 2.5, (normal range 2-3)

During a interview on 7/20/19 at 9:35 a.m., with nursing assistant (NA-C) revealed that she was not aware a concern of bruising on the arms of R40. She stated that new concerns were communicated on the nursing assistant work sheet and produced the sheet from her pocket, there were no notes on the nursing assistant worksheet regarding R40.

During a interview on 7/20/18 at 9:44 a.m., NA-A confirmed she assisted R40 with morning cares, and that she was not aware of any new concerns, regarding his care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 656	Continued From page 4	F 656		

During a interview on 7/20/18 at 10:02 a.m., with the physical therapy assistant (PTA) he confirmed that he works with R40 on a daily basis. He revealed he was not aware of and updates in his change in condition or that R40 stated that he thought a bruise was caused by someone grabbing him on the arm.

During a interview on 07/19/18 at 2:55 p.m., the director of nursing (DON) revealed her expectation for following up on new wounds, bruises or injuries would be that the progress note including measurements every shift for 24 hours. Follow up monitoring should include weekly documentation and monitoring until resolved. She confirmed there was a skin observation note on 7/3/18 at 12:28 p.m., "entire back of hand is bruising, small dark bruising 3 x 3 cm" and no further documentation until 7/6/18 at 4:28 p.m., when the Dr. was notified by fax of large bruising now including bilateral arms. The fax revealed the bruises had extended up the forearms, revealing scattered bruising on the left and a 5 x 3 centimeter bruise on the right forearm. The DON confirmed that in the next weekly assessment the bruises were not monitored for improvement of decline, stating "it must have been missed." The DON was not aware that there was a new bruise, above the antecubital area on the left arm that measures approximately 9 x 8 cm, and confirmed that there was no documentation in the record. The DON further revealed her expectation would be for the Coumadin use and monitoring to be included the care plan and confirmed that it was not.

During a interview with the DON on 7/20/18, the DON confirmed that the facility did not complete a incident report on the bruises, and that changes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 656	Continued From page 5 in condition would be passed on to staff in report, she was not aware that the information was not communicated to the therapy department or to the nursing assistants. A policy was requested for care plan development and skin monitoring, none were provided.	F 656		
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 ensure nail care was provided for 1 of 2 residents (R10) reviewed for activities of daily living, who was dependent upon staff for assistance with grooming. Findings include: R10's annual Minimum Data Set (MDS) assessment dated 7/10/18, identified R10 as having a Brief Interview for Mental Status (BIMS) of 10 indicating moderately impaired cognition. The MDS further identified R10 required extensive assistance with bed mobility, transfers, dressing, toilet use, bathing, personal hygiene, was frequently incontinent of bowel movements and had no behaviors. R10's care plan reviewed 7/18/18 indicated the resident required assistance of 1 staff with personal hygiene. R10's activities of daily living (ADL) care area	F 677	R10□s care plan has been reviewed and updated for interventions to address the need for nail care. A monitoring system has been put in place. To address other residents who may have been affected by this practice, care plans of residents needing assistance with grooming have been reviewed and updated as needed. To ensure systemic change has been implemented, staff involved with nail care will be re-educated by 8/29/18 on the importance of nail care for residents needing assistance with grooming. To monitor performance and solution, effective random audits of nail care will be performed by the DNS or designee once weekly for four weeks and once monthly for two months and results brought to QAPI for review.	8/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 677	Continued From page 6	F 677		

assessment (CAA) dated 7/18/18, identified R10 required staff assistance with all daily ADL's.

On 7/19/18, at 7:52 a.m. R10 was observed with a dark brown substance present on sides of left hand fingernails and under nail bed.

On 7/19/18, at 12:21 p.m. R10 was observed seated in his wheelchair in the dining room eating lunch independently. R10 continued to have a dark brown substance on sides and under nail bed of left hand.

During observation and interview on 7/19/18, at 3:21 p.m. nursing assistant (NA)-A confirmed R10's left hand nails were dirty and stated R10 needed assistance from staff to clean his nails. NA-A stated nail care is provided at baths and as needed. NA-A further stated R10 had a habit of digging in his incontinence brief and indicated it could be feces under nail bed. However, the fingernails remained dirty under nail beds and NA-A did not offer clean R10's fingernails.

During observation on 7/20/18, at 9:35 a.m. R10 continued to have dirty brown nail beds on left hand. During interview at this time, NA-B confirmed R10's fingernails were dirty and would need to assist R10 in cleaning them at this time. NA-B further stated R10 had a habit of digging in his incontinence brief indicating it could be feces under nail bed.

During interview on 7/20/18, at 9:44 a.m. director of nursing (DON) stated her expectation is for staff to clean nails as needed when identified.

A facility policy titled Nail Care last revised 10/17 included: keep nails clean and trimmed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 677	Continued From page 7 promote well-being.	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 monitor and treat skin lesions for 1 of 5 resident (R40) reviewed for unnecessary medication who was on daily Coumadin, and developed significant bruising which continued to spread, and 1 of 1 resident (R10) reviewed for non-pressure related skin conditions. Findings include: R40 diagnosis listed on the admission record dated 7/18/18 were type 2 diabetes, heart failure, chronic atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease, pain, major depressive disorder, and pain. R40's minimum data set (MDS) dated 6/20/18 revealed R40 received anticoagulation medication 7 days per week. R40 's medication administration record revealed he was receiving Warfarin (blood thinner) 5 milligrams (mg) orally every Sunday, Tuesday, and Thursday and 2.5 mg every Monday,	F 684	R40 and R10□s care plans have been reviewed and interventions updated to monitor lesions and bruising. Resident R40 has been discharged. To implement systemic change, skin observations will be implemented on all residents by 8/29/18. To ensure systemic changes are effective, staff involved with weekly skin observations will be re-educated on the requirements on monitoring and treating non-pressure related skin conditions by 8/29/18. To monitor performance and solutions, effective random audits of non-pressure related skin conditions will be performed by the DNS or designee once daily for five days, once weekly for four weeks, and once monthly for two months and results brought to QAPI for review.	8/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 684	Continued From page 8	F 684		

Wednesday, Friday, and Saturday, for chronic atrial fibrillation. The resident was also on doxicycline (antibiotic) for a cellulitis infection of his lower extremities 6/28/18 - 7/3/18. (antibiotics increase the risk of bleeding when used with warfarin).
R40's care plan last updated 7/11/18 did not have a focus to identify anticoagulation loose, or identify a high risk for bleeding, and significant bruising.
During a observation on 7/18/18 at 2:50 p.m., the entire back of both hands were covered with large dark burgundy color bruises, there were multiple large bruises as large as 3x5 centimeters noted on both fore arms.
R40's interdisciplinary progress notes revealed:
-7/6/18 at 3:41 p.m. - Resident has large bruises on bilateral arms. He says they came overnight. Did an INR-2.7 & did fax current dose of Coumadin & his last dose of doxycycline was on am of July 3. Resident does not use his call light & has been encouraged in this often. His ambulates/ transfers without calling. He walks fast & is noted to be unsteady/jerky. He does not want to wear his boot that Dr. prescribed last week.
-7/6/18 at 5:57 p.m., faxed response from Dr. "no changes".
-7/19/18 at 5:27 p.m., new bruise noted on left arm, above the antecubital area of arm. Bruise measures 9.5 x 8.5 cm. Bruise is purple/red in color. He does deny pain related to this. Resident states that someone was grabbing him around his arm. He does deny any harm/abuse related to this bruise.
Lab work revealed a INR done on 6/29/18 of 2.5, (normal range 2-3)
During a interview on 7/20/19 at 9:35 a.m., with nursing assistant (NA-C) revealed that she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 684	Continued From page 9	F 684		

not aware a concern of bruising on the arms of R40. She stated that new concerns were communicated on the nursing assistant work sheet and produced the sheet from her pocket, there were no notes on the nursing assistant worksheet regarding R40.
During a interview on 7/20/18 at 9:44 a.m., NA-A confirmed she assisted R40 with morning cares, and that she was not aware of any new concerns, regarding his care.
During a interview on 7/20/18 at 10:02 a.m., with the physical therapy assistant (PTA)-A stated that he worked with R40 on a daily basis. He revealed he was not aware of an updates in his change in R40's condition.
During a interview on 07/19/18 at 2:55 p.m., the director of nursing (DON) revealed her expectation for following up on new wounds, bruises or injuries would be that the progress note including measurements every shift for 24 hours. Follow up monitoring should include weekly documentation and monitoring until resolved. She confirmed there was a skin observation note on 7/3/18 at 12:28 p.m., "entire back of hand is bruising, small dark bruising 3 x 3 cm" and no further documentation until 7/6/18 at 4:28 p.m., when the Dr. was notified by fax of large bruising now including bilateral arms. The fax revealed the bruises had extended up the forearms, revealing scattered bruising on the left and a 5 x 3 centimeter bruise on the right forearm. The DON confirmed that in the next weekly assessment the bruises were not monitored for improvement of decline, stating "it must have been missed." The DON was not aware that there was a new bruise, above the antecubital area on the left arm that measures approximately 9 x 8 cm, and confirmed that there was no documentation in the record. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 684	Continued From page 10 further revealed her expectation would be for the Coumadin use and monitoring to be included the care plan and confirmed that it was not. During a interview with the DON on 7/20/18, the DON confirmed that the facility did not complete a incident report on the bruises, and that changes in condition would be passed on to staff in report, she was not aware that the information was not communicated to the therapy department or to the nursing assistants. A policy was requested for care plan development and skin monitoring, none were provided. R10's annual Minimum Data Set (MDS) assessment dated 7/10/18, identified R10 with a Brief Interview for Mental Status (BIMS) of 10	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 684	Continued From page 11	F 684		

indicating moderately impaired cognition. The MDS further identified R10 required extensive assistance for activities of daily living (ADL's).

R10's care plan last revised 7/18/18, indicated R10 had a goal to have intact skin, free of redness, blisters or discoloration. Interventions included to notify nurse of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc noted during bath or daily care. The care plan did not identify any skin lesions.

During observation on 7/18/18, at 9:52 a.m. a transparent dressing was on the back of R10's left hand. It appeared to have a small amount of bloody drainage, and R10 did not know why he had the dressing on.

During observation on 7/19/18, at 3:29 p.m. transparent dressing was still in place to R10's left hand. The resident was observed to be touching the transparent dressing and picking at site. During interview at this time, nursing assistant (NA)-A stated R10 had a cancerous lesion to left hand and the clear dressing was to protect it.

Review of R10's progress notes dated 6/12/18 to 7/19/18, included an entry from 6/12/18, where the resident had voiced complaints regarding a lesion to his left hand. A physician's order dated 6/12/18 included: Efudex cream (an anti-cancer chemotherapy drug) 5% apply to left hand topically two times a day to lesion for 4 weeks. No further documentation was found describing the resident's lesions/treatment.

Review of R10's medication administration sheets for 6/18 and 7/18 included the Efudex twice daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 684	Continued From page 12	F 684		

from 6/12/18 to 7/10/18. Review of R10's treatment sheets for 6/18 and 7/18 did not include a treatment to monitor resident's skin lesion to the left hand.

Review of R10's skin observation assessments included an entry completed 7/6/18. There was no documentation of a left hand lesion. The nursing admit re-admit data collection dated 7/17/18, identified a clear opsite (transparent dressing) was in place on the residents left hand indicating it was from an intravenous (IV) insertion site. No other documentation was found describing/monitoring or treatment of the lesion.

During interview on 7/20/18, at 8:29 a.m. licensed practical nurse (LPN)-A stated R10 had a lesion to left hand that was "pre-cancerous" and had been receiving treatment with Efudex cream. LPN-A confirmed there was no treatment set up to monitor R10's skin and was not aware of a current dressing to his left hand.

During a subsequent observation and interview at 11:27 a.m. LPN-A removed the dressing to R10's left hand. Left hand lesion was superficially open and measured 2 centimeters (cm) long by 1.5 cm wide and another lesion on left hand near site identified by LPN-A as "an abrasion" from hospital IV measured 1 cm long by 0.5 cm wide. LPN-A verified both areas should be monitored and confirmed there was no monitoring or treatment in place.

During interview on 7/20/18, at 11:55 a.m. the director of nursing (DON) stated skin assessments should be completed during treatment of skin lesions and R10's left hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 684	Continued From page 13 dressing should've been removed during readmission to facility for proper assessment of skin for appropriate treatments, monitoring, and care planning. The DON further indicated her expectation is nursing would be monitoring these areas for healing A facility policy titled Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements last revised 4/16 included: The bruise/contusion/skin tar/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation User Defined Assessment (UDA) and on the resident's care plan.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		8/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 690	Continued From page 14 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess and develop a plan of care for 1 of 1 residents (R1) reviewed for urinary incontinence. Findings include: R1's face sheet dated printed 7/20/18 included diagnoses of urinary tract infection, chronic kidney disease, urgency of urination, and obstructive and reflux uropathy (a condition in which the flow of urine is blocked). R1's annual Minimum Data Set (MDS) dated 6/26/18, identified R1 was cognitively intact and required extensive assistance with activities of daily living (ADL) including bed mobility, transfers and toileting. The MDS further identified R1 was frequently incontinent of bladder and was not on a toileting program. R1's annual urinary incontinence Care Area	F 690	R1□s care plan has been reviewed and updated with interventions to address urinary incontinence. To implement systemic change, all residents with urinary incontinence will be reviewed and care plans updated by 8/29/18. To ensure systemic changes are effective, staff involved with bladder assessments were re-educated on the requirements of bladder assessments and developing a plan of care related to urinary incontinence on 8/1/18. To monitor performance and solutions, effective random audits of care plans will be performed by DNS or designee once weekly for four weeks and once monthly for two months and results brought to QAPI for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 690	Continued From page 15	F 690		

Assessment (CAA) dated 7/9/18, identified R1 had a diagnosis of congestive heart failure (CHF), required extensive assistance for toilet use and was frequently incontinent. The CAA did not identify whether R1 was on a toileting program, had a change in continence or identify any contributing factors of the incontinence.

Review of R1's medical record revealed no comprehensive bladder assessments had been completed within the last year.

R1's care plan revised 7/12/18, revealed R1 had a self care deficit, required extensive assistance from facility staff for dressing, personal hygiene and toileting. R1's care plan did not identify R1's urinary continence needs.

During interview on 7/17/18, at 2:33 p.m. R1 stated she was having more trouble holding her urine and indicated she was incontinent of her bladder and wore an incontinent pad.

During interview on 7/18/18, at 12:14 p.m. nursing assistant (NA)-C indicated R1 was occasionally incontinent of her bladder. NA-C further explained R1 was not on a scheduled toileting program but would notify staff when she needed to use the toilet.

During interview on 7/19/18, at 9:10 a.m. NA-D indicated R1 was incontinent at night but able to request toileting needs during the day time. NA-D further verified R1 required assistance from staff to toilet.

On 7/19/18, at 1:36 p.m. the MDS coordinator confirmed R1's medical record lacked a bladder assessment. She further confirmed there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 690	Continued From page 16 plan of care for R1's incontinence stating "this is embarrassing". The MDS coordinator stated anyone that is incontinent should have an assessment and care plan. On 7/19/18, at 2:01 p.m. the director of nursing (DON) stated bladder assessments should be completed at admission and reviewed quarterly with MDS assessment. The DON further verified urinary incontinence should be care planned indicating it was "missed". The facility policy titled Bladder Assessment last revised 3/17, included the following purpose: To review/assess bladder patterns, incontinence and frequency, identify potentially reversible causes of incontinence, and identify the probable type of urinary incontinence and potential toileting programs. The facility policy titled Care Plan last revised 11/16, included: Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed.	F 690		
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	F 880		8/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 880	Continued From page 17 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: §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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 880	Continued From page 18 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 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 provide appropriate hand washing and glove application when providing care to R40 open wounds on the the lower extremity. Findings include: R40 diagnosis listing, dated 7/18/18 indicated: type 2 diabetes, heart failure, chronic atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease, major depressive disorder, and pain. R40's Minimum Data Set (MDS), dated 6/20/18, revealed R40 received anticoagulation medication 7 days per week, and that R40 had open wounds on the lower extremities.	F 880	R40 has been discharged. To implement systemic change, all residents have the potential to be affected by this practice. Wound procedures have been reviewed and no updates are indicated. To ensure systemic changes are effective, all staff involved with wound care will be re-educated by 8/29/18 on the wound care procedure and competencies completed. To monitor performance and solutions, effective random audits of hand washing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 880	Continued From page 19 R40 's medication administration record revealed he had received a course of doxicycline (antibiotic) for a cellulitis infection of his lower extremities 6/28/18 - 7/3/18. R40's care plan last updated 7/11/18 revealed the resident had one stage 2 pressure ulcer to the right foot second toe, and a diabetic foot ulcer on the left foot related to diabetes. R40's skin observation dated 7/15/18 at 10:07 p.m., revealed a open area to right lower leg, measuring 1.8 x 1.4 centimeters (cm). R40 stated that he bumped the shin. Treatment implemented was to apply antibiotic ointment and cover with telfa and hold in place with gauze wrap. During an observation on 7/29/18 at 7:29 a.m., of a dressing change to R40's feet and his left shin, registered nurse (RN)-A removed R40's left protective boot, and right adaptive shoe, which revealed a loose dressing with kerlex over the left shin, and a dressing to the left foot. RN-A did not wash her hands and began to remove the dressing with ungloved hands, the dressing was not entirely covering the open wound and had visible drainage on the dressing, she had removed more then one half of the dressing when she stopped, and gloved without washing her hands. The shin revealed 2 open areas. When reviewing the procedure RN-A confirmed that she should washed her hands and gloved after touching a soiled surface before touching the dressing. During a interview on 07/19/18 at 2:55 p.m., the director of nursing (DON) revealed her expectation for washing hands and gloving during wound care between soiled and clean contact. A policy was requested for hand washing, none was provided.	F 880	during wound care procedure will be performed by the DNS or designee once weekly for four weeks and once monthly for two months and results brought to QAPI for review.	
F 883	Influenza and Pneumococcal Immunizations	F 883		8/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 883 SS=D	Continued From page 20 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 883	Continued From page 21 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 (R1, R7) received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R1's Face Sheet, indicated R1 was admitted to the facility on 4/3/12, was over the age of 65 and had diagnoses including osteoporosis, osteoarthritis, glaucoma, and anxiety. R1's medical records lacked documentation of pneumococcal Conjugated (PCV13) offered, education provided or evidence of consent or refusal of the vaccine. R7's Face Sheet, indicated R7 was admitted to the facility on 12/5/14, was over the age of 65 and had diagnoses including dysphagia (difficulty	F 883	R1 and R7□s immunization records have been reviewed for the need for pneumococcal immunization and consents will be obtained and immunizations will be given according to CDC recommendations. To implement systemic change, all resident immunization records have been reviewed and steps put in place to make all residents current with pneumococcal immunizations. To ensure systemic changes are effective, staff involved with implementation of pneumococcal immunizations were educated on the procedure on 8/1/18. To monitor performance and solutions, effective random audits of pneumococcal immunizations will be performed by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 883	Continued From page 22 swallowing), atrial fibrillation (irregular heart beat), anemia (low red blood cell count) insomnia (difficulty sleeping), anxiety, depression, and edema (excess fluid). R7's medical record lacked documentation pneumococcal polysaccharide vaccine (PPSV23) offered, education provided or evidence of consent or refusal of the vaccine. On 7/20/18, at 10:50 a.m. the director of nursing (DON) verified that R1 and R7 did not have documentation of pneumococcal vaccine being offered, provided or evidence of consent or refusal of the vaccine. The DON further stated everyone should be offered the pneumonia vaccines when they are admitted. The facility's Immunization for Residents policy and procedures revised on 11/16, indicated "upon admission, each resident and/or resident representative will receive the Vaccination Information Statements (VIS) for influenza and pneumococcal vaccines. Discuss the benefits and potential side effects of vaccination with the resident and/or representative". The policy further states It is recommended that both PCV13 and PPSV23 be administered in series to all adults aged 65 and older for prevention of pneumococcal disease.	F 883	DNS or designee once weekly for four weeks and once monthly for two months and results brought to QAPI for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST** **EDGERTON, MN 56128**

(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	K 000		

THE FACILITY'S POC 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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Edgebrook Care Center) was found not 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.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us and

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/01/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST** **EDGERTON, MN 56128**

(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	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Edgebrook Care Center is one-story in height, has a partial basement, and is fully sprinklered. The original building was built in 1968, with building additions in 1992 and 1997. All were determined to be of Type II(111) construction. Building 02 consists of the 2003 building addition, which includes a meeting room and offices. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. Because the original building and the (3) addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST** **EDGERTON, MN 56128**

(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	Continued From page 2 NOT MET as evidenced by:	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain emergency lighting in accordance with 7.9. The deficient practice could affect 50 out of 50 residents. Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 FINDINGS INCLUDE: On facility tour between 1:00 PM and 3:30 PM on 07/17/2018, the emergency light (#9) near the Employee Entrance did not function when tested during the inspection. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	The battery for emergency light #9 was replaced and corrected on 7/18/18. Keith, the Director of Maintenance, or designee will be responsible for correction and monitoring to prevent reoccurrence. Procedure will be reviewed in QAPI and staff will be educated as needed.	7/18/18