Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 11, 2025

Administrator
EDENBROOK OF ROCHESTER
1875 19TH STREET NORTHWEST
ROCHESTER, MN 55901

RE: CCN: 245409
Cycle Start Date: **May 1, 2025**

****This letter replaces the letter dated Sept 10 to show the cycle start date**

Dear Administrator:

On June 26, 2025, we notified you a remedy was imposed.

On August 13, 2025, the Minnesota department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 1, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 1, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of June 26, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 1, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 1, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 26, 2025

Administrator
Edenbrook of Rochester
1875 19th Street Northwest
Rochester, MN 55901

RE: CCN: 245409
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 22, 2025, we informed you that we may impose enforcement remedies.

On June 16, 2025, the Minnesota Department of Public Safety completed a revisit, and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility 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), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

- K353 - Sprinkler System - Maintenance and Testing S/S B
- K374 - Subdivision of Building Spaces - Smoke Barrier S/S F
- K761 - Maintenance, Inspection & Testing - Doors S/S F

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 1, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 1, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 1, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 1, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Edenbrook Of Rochester will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 1, 2025. You will receive further information regarding this from the State agency. 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. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 November 1, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at

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.

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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST , ROCHESTER, Minnesota, 55901

(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
K0000	INITIAL COMMENTS Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	K0000		
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	K0353	Wires relocated or suspended to not rest on sprinkler water line. Identified sprinkler heads have been repaired/replaced in Med Supply Room and dishwasher area All residents have the potential to be affected by this deficient practice. Maintenance Director educated on Standards For Inspection, Testing, and Maintenance of water-based Fire Protection Systems. To prevent recurrence, repairs will be visually inspected by the Maintenance Director/designee, to ensure compliance with requirements. Identified areas will be inspected twice a month for 3 months. The Maintenance Director and/or Administrator is responsible for monitoring for compliance. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	07/01/2025
K0374 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING	K0374	1) All identified doors have been repaired to ensure smoke barrier is maintained. 2) All residents have the potential to be affected by this deficient practice. 3) Maintenance Director educated on Smoke Barrier	07/01/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST , ROCHESTER, Minnesota, 55901

(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
K0374 SS = F	Continued from page 1 Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	K0374	Continued from page 1 Inspection. To prevent recurrence, the maintenance director/designee is to follow scheduled maintenance and inspection tasks as assigned in property management system (TELS). The maintenance director to inspect doors monthly to ensure compliance. 4) Maintenance Director and/or Administrator is responsible for monitoring for compliance. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	K0761	1) Identified door has been repaired to close, seal, and latch appropriately. 2) All residents have the potential to be affected by this deficient practice. 3) Inspections scheduled through maintenance scheduling system (TELS). To prevent recurrence, proper door operation of doors to be audited weekly for 4 weeks and monthly for 2 months. 4) The Maintenance Director and/or Administrator is responsible for monitoring for compliance. Compliance will be reviewed in QAPI monthly.	07/01/2025

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 22, 2025

Administrator
Edenbrook of Rochester
1875 19th Street Northwest
Rochester, MN 55901

RE: CCN: 245409
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 1, 2025, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 August 1, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by November 1, 2025 (six months after the identification of noncompliance), your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 4/28/25-5/1/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited. : H54093633C (MN00108678), H54093632C (MN00110044), H54093631C (MN00108605), H54093629C (MN00111066), H54093627C (MN00109690), H54093634C (MN00110973) The following complaints were reviewed. H54093630C (MN00110360), Deficient practice was identified related to incidental finding The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		7/1/25

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

Electronically Signed | 05/30/2025

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
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 554	Continued From page 1 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a self-administration of medication (SAM) assessment was completed and a provider order obtained to self-administer medications for 1 of 1 residents (R20) reviewed for medication administration. Findings include: R20's admission Minimum Data Set (MDS) assessment, dated 3/17/25 indicated R20 had intact cognition, with diagnoses of atrial fibrillation (an abnormal heartbeat), heart failure, respiratory failure, cataracts (clouding over the eyes lens), glaucoma or macular degeneration. R20's order summary indicated R20 had orders for the following medications: Brimonidine Tartrate Ophthalmic Solution 0.2% - instill 1 drop in both eyes two times a day related to glaucoma, and Dorzolamide HCl-Timolol Mal Ophthalmic Solution 22.3-6.8mg/mg - instill 1 drop in both eyes two times a day related to glaucoma. R20's record lacked evidence an assessment was completed or a provider order obtained for R20 to self-administration medications. During an observation on 4/29/25 at 9:05 a.m., a white bottle with a blue cap was noted to be sitting on the bedside table and within reach of R20. Licensed practical nurse (LPN)-C entered the room, picked up the bottle and placed it in her	F 554	" This plan of correction constitutes my written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R20 self-administration assessment completed. Care plan updated and order obtained. " How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk for this deficient practice. All residents to be assessed for Self-Administration and no resident will be permitted to self-administer without this assessment in place. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Residents assessed for self-administration of medications as appropriate. Care plans updated as appropriate. All licensed nurses to be educated on Policy and Procedure Medication Self-administration. " How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 554	Continued From page 2 front right pocket. R20 stated to LPN-C "I finished the blue one". LPN-C then left the room. R20 stated staff would bring her eye drops into the room and leave them for her to self-administer. During an interview on 4/29/25 at 2:08 p.m., LPN-C stated she took both of R20's prescribed eye drops into R20's room during the morning medication administration and had left one sitting on the bedside table and identified the medications was Dorzolamide-Timolol eye drops. LPN-C then reached into her front right pocket and removed the white bottle with a blue lid labeled with R20's name and identified the medication as Dorzolamide HCl-Timolol Mal Ophthalmic Solution 22.3-6.8mg/mg. LPN-C stated R20 did not have an order to self-administer medications. During interview on 5/1/25 at 1:58 p.m., Director of Nursing (DON) stated any residents who wished to administer their own medications require a self-administration of medication assessment and a physician order to do so. DON confirmed R20 did not have an order to self-administer medications and expected staff to verify a SAM assessment was completed in order to determine is a resident was appropriate to safely self-administer medications. DON added a physician order was to be in place before leaving any medications at bedside. She went on to say this was important to ensure the resident knew how to safely administer their medications. Facility policy Medication Self Administration dated 2/12/24, indicated the resident shall have a screen completed by a licensed nurse to determine factors that may impact the safe administration of medications. The ability to	F 554	will not recur. Audits for compliance of self-administration of medications for residents to be performed 3 times a week for 4 weeks, weekly for 1 month, and monthly for 3 months. Director of Nursing or designee is responsible for the completion of audits. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 554	Continued From page 3 self-administer medications will indicate: A) able to self-administer medications independently, B) able to self-administer medications with supervision, cueing and/or set-up, C) not able to self-administer medications safely. Residents who have been deemed appropriate to self-administer medications independently or with supervision/cueing or after set-up shall have a physician order to do so. The self-administration of medications will be care planned with interventions specific to the individual resident.	F 554		
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	F 584		7/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 584	Continued From page 4 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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident equipment was kept in a clean and in a sanitary manner to promote resident well-being for 1 of 1 resident (R31) observed for wheelchair cleanliness. In addition, the facility failed to provide comfortable sound levels for 1 of 1 resident (R44) observed for uncomfortable noise levels. Findings Include: R31 R31's Quarterly Minimum Data Set (MDS) assessment dated 4/14/25, indicated R31 is unable to speak and uses an iPad for communication needs. R31 has impaired vision requiring glasses, adequate hearing, and understands himself and others. R31's had intact cognition. R31 had functional impairment of both lower extremities requiring an electric wheelchair and functional limitations of both upper	F 584	" How corrective action will be accomplished for those residents found to have been affected by the deficient practice. A) R31 wheelchair cleaned when identified on 4/30/25. B) R23 was provided with headphones for TV use on 4/30/25. R44 was offered a different room during care conference on 5/28/25 and declined. " How the facility will identify other residents having the potential to be affected by the same deficient practice. A) Residents who utilize wheelchairs have potential to be affected by this deficient practice. B) All residents have the potential to be affected by excessive noise. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. A) All resident wheelchairs inspected for cleanliness. Wheelchair cleaning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 584	Continued From page 5 extremities requiring supervision and intermittently assistance for feeding task. R31 was admitted on 9/9/24 with a diagnosis of right-sided cerebrovascular disease (disease affecting blood flow to the brain), quadriplegia, dysphagia-oropharyngeal phase (difficulty swallowing, coughing, or choking when eating), muscle weakness, diffuse traumatic brain injury, and recurrent pneumonia. During observation and interview on 4/28/25 at 12:29 p.m., R31 was going to lunch in a personal electric wheelchair. R31's wheelchair foot plate, under seat platform, and right wheel and wheel cover had a thick layer of a dried substance of varying colors. R31 communicated on his iPad the substance was food and covered the bottom right side of the wheelchair for some time. R31 indicated he is unable to control his food when he eats and spills onto his wheelchair. R31 indicated he sometimes drops partially chewed food from his mouth because of his dysphagia. R31 indicated he is unable to clean his wheelchair due to his physical disabilities. R31 indicated he does not like the dried foods on his wheelchair. During observation and interview on 4/29/25 at 8:18 a.m., R31 was returning to his room from the dining room. R31's wheelchair continued to have chewed or spilled food dried on his wheelchair. Nursing assistant (NA)-A stated R31's wheelchair often had spilled or chewed food on it . NA-A stated she thought the night shift was responsible for cleaning the wheelchairs. NA-A stated she does not know how often residents' wheelchairs are cleaned. During interview on 5/01/25 at 12:08 p.m.,	F 584	schedule implemented. Nursing staff educated on Policy and Procedure Cleaning and Disinfection of Resident Care Equipment. B) Residents with roommates interviewed for noise concerns and addressed accordingly. IDT educated on Policy and Procedure Grievance/Concerns. Grievances reviewed and addressed as received. The color of grievance form changed to be more visible for residents and staff. " How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. A) Random audit performed for resident wheelchair cleanliness 3 times a week for 4 weeks, weekly for 1 month, and monthly for 3 months. B) Random audits of 5 rooms with roommates for noise concerns, weekly for 1 month, and monthly for 3 months. Director of Nursing or designee is responsible for the completion of audits. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 584	Continued From page 6	F 584		

director of nursing (DON) stated she knew R31 had old dried partially chewed food on his personal wheelchair and verified it was there for a while. DON stated the facility has a policy to clean facility and resident wheelchairs on the night shift. DON was unable to confirm the last time R31's wheelchair was cleaned and stated it would be in a progress note if it was completed. DON stated R31's wheelchair looks unsightly after every meal. DON stated R31's wheelchair should be cleaned after every meal as he does spill a lot. DON confirmed there is no interventions in R31's care plan to protect the wheelchair during meals.

Per facility policy titled Cleaning and Disinfection of Resident Care Equipment dated 5/8/24, how often resident equipment was cleaned was not specified.

R44
R44's Minimum Data Set (MDS) assessment dated 2/28/25 was incomplete, although included, R44 did not have any vision or hearing disabilities and was cognitively intact.
R44 was observed using bilateral upper extremities, required assistance from staff for mobility and toileting.

R44 was admitted on 11/27/24 with a diagnosis of muscle weakness, adult failure to thrive, severe obesity, chronic fatigue, rheumatoid arthritis, and need for assistance with person cares.

During observation and interview on 4/28/25 at 4:20p.m., upon entering R44's room, the sound level in the room was loud and unpleasant. R44 stated her roommate's television (TV) was always

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 584	Continued From page 7 very loud. R44 stated she had made multiple complaints about the noise of the roommate's television at all hours, but nothing has been done. R44 stated she told the social worker (SW) approximately one month ago about the unpleasant sound levels in her room. R44 stated she is unable to get up without assistance, or she would lower the volume herself. R44 stated her roommate leaves the room frequently throughout the day but she leaves the TV volume loud even when she's not in the room. R44 stated she will put her call light on during the day to have staff the lower the volume when the resident is not in the room; staff have told her they can't turn the volume down because it is the roommate's choice to have the TV volume up. During interview on 4/29/25 at 8:18 a.m., nursing assistant (NA)-A stated R44's roommate's TV is very loud; the roommate doesn't like to hear any of the other facility sounds. NA-A stated R44 will ask to have the volume turned down, informs R44 it is roommate's right to have her TV loud. NA-A stated if the staff notice the roommate is not in the room, they will try to turn the volume of the TV down, things are busy so they don't' always notice when the roommate leaves the room. NA-A confirms R44 is unable to turn the volume down due to her physical limitations. During observation and interview on 4/29/25 at 2:00 p.m., R44's roommate's TV is very loud, and can be heard halfway down the hall. Upon entering the room, R44 had facial wincing, when asked indicated because of the volume of the TV. R44 stated she had asked staff to turn it down, but resident just turns it back up when she returned to the room.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 584	Continued From page 8 During interview on 4/30/25 at 1:25 p.m., social services (SS)-A stated she was aware the roommate's TV volume could be loud at times. SS-A stated she had asked facility staff to keep an eye on the volume and turn it down when the resident was not in the room. SS-A confirmed no other interventions were in place to reduce the sound levels. SS-A confirmed R44 had told her approximately one month ago she was not sleeping well due to the volume of the roommates TV. SS-A stated this was when she asked facility staff to turn the TV volume down; no other interventions were initiated. During interview on 5/01/25 at 12:08 p.m., director of nursing (DON) confirmed she was not aware there was a potential roommate incompatibility with R44. DON confirmed R44's roommate leaves the room frequently as she can walk without assistance. DON stated social services would evaluate a situation; if the residents in the room aren't compatible, one resident can be moved to another room. DON confirmed there were no current plans to move either resident. The facility does not have a policy regarding roommate incompatibility or appropriate sound levels in each room.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		7/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 9 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement specific resident-centered interventions for 2 of 2 residents (R35, R20) reviewed for care plans. Findings Include: R35's minimum data set (MDS) assessment dated 3/11/25 indicated moderately impaired cognition and moderately severe depression. R35 had a history of refusing cares and treatments. R35 was admitted on 6/20/24 with a diagnosis of chronic obstructive pulmonary disease (COPD, lung disease causing breathing problems), obstructive and reflex uropathy (blockage preventing urine from flowing normally), liver transplant, chronic kidney disease, major depressive disorder, and hydronephrosis with renal and ureteral calculous obstruction (urine buildup in the kidney due to blockage caused by kidney stones). R35's orders included, monitor for signs and symptoms of liver rejection including fever, pain in abdomen, yellowing skin, itching, increase in tiredness/weakness, swelling in abdomen or legs, and pale in color; notify provider and transplant coordinator immediately. Further, weigh every morning before breakfast; perform in the same manner (same scale, same method) every day and notify provider and transplant coordinator if weight increases by more than 5 pounds in one week. R35's daily weight record reviewed from 4/4/25 to	F 656	" How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R20 and R35 providers notified regarding weights and refusal of care (obtaining weight). Ace wraps applied to R20 " How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have potential to be affected by this deficient practice. Care Plans for all residents reviewed for accuracy and ensure up-to-date interventions/plans of care. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Nursing staff educated on Policy and Procedure for Resident Height and Weight. Nursing staff educated on Activities of Daily Living (ADLs). " How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audit residents for proper weight frequency 3 times a week for 4 weeks, weekly for 1 month, and monthly for 3 months. Audit for proper ADL completion 3 times a week for 4 weeks, weekly for 1 month, and monthly for 3 months. Ensure procedures followed through audits and review during daily stand up meetings. Discrepancies to be addressed immediately. Provider notification as appropriate. Director of Nursing or designee responsible for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 11 4/30/25 revealed R35 was not weighed daily and when completed was not according to provider orders (perform in same manner): -4/4/25 at 11:14 a.m. (166 pounds) -4/5/25 at 2:24 p.m. (166 pounds) -4/8/25 at 12:57 p.m. (165 pounds) -4/10/25 at 10:54 a.m. (164 pounds) -4/20/25 at 2:31 a.m. (166.5 pounds) -4/30/25 at 3:31 p.m. (165.8 pounds) R35's missed daily weights were documented as: -17 days were documented as refused R35's progress notes lacked a provider had been notified of R35's refusal of daily weights. During interview on 4/29/25 at 2:12 p.m., licensed practical nurse (LPN)-A stated R35 does refuse cares and medications sometimes. LPN-A stated due to R35's poor kidney function, the provider team ordered to have weights done daily. LPN-A stated accurate daily weights are important because if R35 was gaining weight rapidly it could indicate liver transplant rejection or if his kidney function gets worse, he could also have a rapidly increase in weight. LPN-A confirmed it is an expectation when a resident refuses cares or medication more than 2 days in a row, the provider would be notified. LPN-A confirmed provider notification would be a progress note and phone call. During interview on 4/29/25 at 2:52 p.m., registered nurse (RN)-A stated R35 will agree to medications and cares if staff explain the purpose of the medications and cares to him. RN-A stated R35's liver transplant anti-rejection medications and daily weights are important. RN-A stated R35 likes to remain in bed a lot, and needs a lot of encouragement to get up for eating, weights,	F 656	audit. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 12	F 656		

daily cares. RN-A confirmed the expectation is to notify the provider if R35 refuses medications and cares; providers are notified by a progress note and phone call.

During interview on 4/30/25 at 10:50 a.m. RN-B stated she works with R35's transplant team. RN-B stated daily weights are important because a rapid increase in weight could indicate liver transplant rejection. RN-B confirmed she had not been notified of R35 refusals of daily weights up to 10 days in a row.

During interview on 4/30/25 at 2:18 p.m., nurse practitioner (NP)-A stated she works with R35's nephrology (kidney) team. NP-A stated daily weights for R35 are very important; daily weights allow the nephrology team to make specific medication changes based on weight increases or decreases. NP-A stated an acute increase in weight could indicate a decrease in kidney function and the sooner the team is aware of weight changes, the sooner they can begin to make medication changes to help kidney function. NP-A confirmed she had not been notified of R35 refusals.

During interview on 5/01/25 at 12:08 p.m., director of nursing, (DON) stated it is an expectation ordered daily weights are completed per provider instructions. DON confirmed daily weights are ordered in the morning for R35 as this is the most accurate time of day to obtain weights. DON confirmed R35 had daily weights ordered so his provider teams can monitor liver transplant status and kidney function status. DON confirmed if R35 was refusing daily weights, it is the expectation to notify the provider as soon as possible. DON stated the provider would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 13 notified by progress note or phone call. Per facility policy titled Resident Height and Weight policy dated 1/7/25, the stated purpose of this document is to provide guidelines for MD notification and documentation of weight changes. R20 R20's admission Minimum Data Set (MDS) assessment dated 3/17/25, indicated R20 admitted on 3/11/25, was cognitively intact, had no behaviors, did not refuse cares and had the following pertinent diagnoses: A-fib (irregular heartbeat), congestive heart failure (the heart does not pump enough to adequately supply the body with blood or oxygen), and high blood pressure. R20's order summary indicated the following cardiac related orders: -Apply gradient compression garments to lower extremities-on during the day and off at night -CHF monitoring: monitor respiratory status (i.e. Orthopnea and dyspnea), edema, (i.e. leg or abdominal swelling), fatigue, change in mental status every shift and document findings in PCC (Point Click Care). Update provider with any signs/symptoms of worsening CHF. -Daily weights upon admission for residents with heart failure unless directed otherwise by provider. Notify [provider] if weight greater than 198.41 lbs one time a day. Process for weight: every morning before breakfast, perform in same manner (e.g. use same scale, same method)	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 14	F 656		

R 20's medical record indicated 22 of 29 weights recorded exceeded 198.4 lbs. for the month of April 2025 :
4/29/25 recorded weight 201.0 lbs.
4/28/25 recorded weight 200.4 lbs.
4/27/25 recorded weight 202.2 lbs.
4/25/25 recorded weight 209.0 lbs.
4/24/25 recorded weight 200.8 lbs.
4/23/25 recorded weight 199.2 lbs.
4/21/25 recorded weight 201.6 lbs.
4/20/25 recorded weight 199.3 lbs.
4/17/25 recorded weight 201.0 lbs.
4/16/25 recorded weight 201.4 lbs.
4/15/25 recorded weight 204.0 lbs.
4/14/25 recorded weight 201.8 lbs.
4/13/25 recorded weight 200.4 lbs.
4/12/25 recorded weight 199.8 lbs.
4/11/25 recorded weight 200.6 lbs.
4/10/25 recorded weight 202.6 lbs.
4/9/25 recorded weight 199.0 lbs.
4/8/25 recorded weight 199.6 lbs.
4/5/25 recorded weight 202.0 lbs.

During observation and interview on 04/29/25 at 09:11 a.m., resident was in her room seated in wheelchair, feet in dependent position. Two ace wraps noted on counter above dresser. Resident stated her feet swell up and they should be wrapped up but staff "don't always do it". Bilateral feet swollen and puffy. Resident stated she had too much fluid on her heart and sometimes had shortness of breath with talking.

During observation on 04/29/25 at 12:45 p.m., resident noted in room seated in wheelchair, feet in dependent position. Ace wraps were not on. Feet swollen.

During observation and interview on 04/30/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 15 10:33 a.m., resident in her room seated in wheelchair, feet in dependent position, watching TV. Ace wraps not on at the time; stated "I think the pollen is up I've been short of breath today". Feet swollen and an indent from socks observed on both feet. During observation on 4/30/25 at 12:39 p.m., resident in her room seated in wheelchair, feet swollen and in dependent position. Ace wraps noted rolled up on counter area above dresser. During interview on 4/30/25 at 3:48 p.m., licensed practical nurse (LPN)-B stated he was familiar with R20 and her diagnoses. LPN-B stated residents with congestive heart failure should be closely monitored for edema, shortness of breath and weighed daily. He went on to say residents with ACE wraps or compression wraps should have them applied in the morning before they got up for the day and started to accumulate fluid in their legs. LPN-B stated nurses were responsible for applying ACE wraps and monitoring for any weight gain, and then follow their orders for increased weight such as updating a provider or giving an extra diuretic (medications to assist with fluid excretion). During interview on 4/30/25 at 4:03 p.m., LPN-C stated she was familiar with R20 and worked with her almost daily. LPN-C stated R20 had CHF, wore ACE wraps and took a 'water pill'. LPN-C stated resident weights should be completed at the same time each day using the same scale and ideally before the first meal of the day. She stated either nurses or aides could obtain the resident weights, but the nurses were responsible for monitoring for any increase in weight. LPN-C stated ACE wraps should be put on in the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 16 morning when residents get up, but sometimes she put them on late or after lunch due to time constraints. During interview on 4/30/25 at 4:15 p.m. Director of Nursing (DON) stated residents with CHF should be monitored for changes in mental status, increased weight, shortness of breath or difficulty breathing. DON stated a resident with daily weights should be weighed before the first meal of the day, and using the same scale, this would be the truest reflection of the residents' weight. DON stated if there was an increase in weight the nurse would be able to immediately identify this in the electronic medical record (EMR) because the weight would be highlighted in red to alert staff a change. In this instance she expected the nurses to assess the resident, notify the provider, document the assessment and put in a progress note in the resident's chart. She went on to state for residents wearing compression stockings they should be applied first thing in the morning before any fluid had accumulated and these were scheduled between 6:00 a.m. and 10:00 a.m... DON reviewed R20's weights for April 2025, acknowledged staff was to notify the provider for weights over 198 lbs, and confirmed there was no progress notes or provider notification of when weights were over 198 lbs in R20's record. DON stated it was important to follow an individual residents' orders to prevent an exacerbation of CHF and avoid potential hospitalizations.	F 656		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		7/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 761	Continued From page 17 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were properly labeled with open dates, expired medications were removed and disposed of properly and discharged and/or expired residents' medications were removed from the cart in a timely manner to decrease the potential for drug diversion for 2 of 2 medication carts reviewed for medication storage. This deficient practice had the potential to affect all residents receiving medications from these medications' carts. Findings include:	F 761	" How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R20, R16, R5, R40 medications audited and labelled or disposed of according to policy. Medication carts audited and medications disposed of and labelled as necessary. " How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have potential to be affected by this deficient practice. All medication carts and medication room audited to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 761	Continued From page 18 On 4/29/25 during continuous observation from 2:41 p.m. through 3:01 p.m., -2:41 p.m. an unidentified staff wearing dark blue scrub pants and top and was not wearing a name badge was working at the north medication cart and walked away from the cart and left it unlocked -2:42 p.m. an unidentified resident and guest walked past the unlocked medication cart - 2:44 p.m. the unidentified staff member walked back to the north medication cart, placed box of gloves on cart and walked away but did not lock cart - 2:45 p.m. to 2:53 p.m., the north medication cart remained unlocked and unattended - 2:53 p.m. an unidentified staff member wearing black scrub pants and printed floral scrub top walked by the unlocked medication cart and entered a resident room - 2:53 p.m. registered nurse manager (NM) walked down hallway, passed the unlocked medication cart but did not lock cart - 2:55 p.m. the unidentified staff returned to cart with paper in his right hand, placed paper on top of medication cart and walked away. Medication cart remained unlocked. - 3:01 p.m. the unidentified male staff returned to cart, opened top drawer, locked cart and walked away During an observation and interview on 4/30/25 at 7:10 a.m., licensed practical nurse (LPN)-C was administering medication from the north medication cart. LPN-C placed medications into med cup, did not lock the medication cart and walked into resident room. At 7:13 a.m., LPN-C returned to medication cart, locked the cart and walked away. Upon returning to the medication	F 761	proper dating and storage protocols are followed. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Nurses educated on the following: Policy and Procedure for Medication Storage. " How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Medication carts are to be audited 3 times a week for 4 weeks, weekly for 1 month, and monthly for 3 months. Director of Nursing or designee responsible for the audit. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 761	Continued From page 19 cart LPN-C acknowledged she had left the medication cart unattended when asked. LPN-C opened the north medication cart for a random review of medications and identified the following: R20's opened bottle of saline nasal gel lacked an opened-on date. An opened bottle of Vitamin C approximately one fourth full had an expiration date of 3/2025. LPN-C stated she did not use the expired bottle, and the bottle should have been removed and the medication destroyed. During an observation and interview on 4/30/25 at 10:08 a.m., NM was observed during a medication cart audit of the west medication cart. The following was revealed: R16's opened bottle of liquid Haloperidol lacked an open date. R5's opened bottle of Prednisolone eye drops lacked an opened-on date. R40's opened bottle of Lantoprost eye drops, an opened bottle of Dorzolamide eye drops, an opened bottle of Deep-Sea nasal spray and an opened bottle of Flonase nasal spray all lacked an opened-on date. Additionally, R16's-25 tabs lorazepam 1mg, 20 tabs lorazepam 0.5 mg, 51 tabs hydromorphone 2mg, 60mL hydromorphone 2mg/ml, and 12mL hydromorphone 1mg/ml was identified in the locked narcotic box of the medication cart. NM stated R16 had expired the previous day, and the medications should have been removed and destroyed at that time to prevent potential diversion. During interview on 5/1/25 at 1:58 p.m. director of	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 761	Continued From page 20 nursing (DON) stated she expected multi dose medications like eye drops, nasal sprays and creams to be dated with the date it was opened for use. DON stated this practice is important because medications are good for a limited amount of time after opening and the open date ensures the resident is not getting expired medications. DON stated the NM audits carts to look for outdated/expired medications, undated medications and general cleanliness. She stated this was to be completed at least monthly and as needed. DON stated she expected medications for expired residents to be removed and destroyed the same shift as the resident expired on. She went on to state this was to avoid potential medications errors and drug diversion. Facility policy titled Policy and Procedure Medication Storage with revision date of 2/12/24, indicated the following: No discontinued, outdated, or deteriorated medications should be available for use in the facility. All such medications are destroyed per policy. Expired medications are to be removed from areas/medication carts prior to or at the time of expiration.	F 761		
F 880 SS=E	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.	F 880		7/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 21 §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 §483.71 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 22 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 and interview the facility failed to ensure a mechanical transfer lift was cleaned after resident use for 1 of 1 resident (R14), observed for infection control practices. Findings Include: R14's significant change Minimum Data Set (MDS) assessment dated 4/10/25, indicated R14 was cognitively intact, dependent on staff for toileting, required substantial/maximal assistance with transfers, personal hygiene, and dressing and used a wheelchair for mobility. R14's care plan dated 4/30/24, indicated R14 required the use of a standup lift (EZ stand) for transfers. During observation on 4/30/25 at 7:38 a.m., nursing assistant (NA)-A entered R14's room to answer his call light. NA-A went out of room and	F 880	" How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Lifts cleaned appropriately. " How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have potential to be affected by this deficient practice. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Nursing and therapy staff educated on Policy and Procedure Cleaning and disinfection of Resident Care Equipment. Sanitizing/cleaning wipes placed on lifts and are available for staff to ensure proper cleaning. " How the facility will monitor its corrective actions to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 23 retrieved the EZ stand from the hall and brought into R14's room. The EZ stand had debris of a white flaky substance on it. NA-A and NA-B both assisted R14 from bed to the commode with the EZ stand. After completing task, NA-A removed EZ stand from R14's room and placed in hallway. The EZ stand was not cleaned after use. During observation on 4/30/25 at 9:09 a.m., NA-B removed the previously used EZ stand from the hallway and took into another resident room, the EZ stand was not cleaned prior to using it or after use on the other resident. During interview on 4/30/25 at 12:28 p.m., NA-B stated standard precautions are used to prevent the spread of infection from resident to resident. NA-B stated it is important to clean equipment in between use to prevent infection. NA-B stated it is an expectation to clean equipment such as an EZ stand after use. NA-B confirmed she did not wipe down the EZ stand after use with R14 or before use with second resident. NA-B confirmed staff receive infection control training at hire and annually thereafter. During interview on 4/30/25 at 8:40 a.m., licensed practical nurse (LPN)-A stated standard precautions are used to prevent infection, are used for every resident regardless of infection status, including hand washing, gloves, and cleaning commonly used equipment in between residents. LPN-A stated standard precautions are important because they protect residents from getting infections. LPN-A confirmed it is an expectation to clean commonly used equipment, like the EZ stand, after each use. LPN-A confirmed staff receive infection control training as a new employee and annually thereafter. During interview on 5/01/25 at 12:08 p.m.,	F 880	deficient practice is being corrected and will not recur. Staff to be observed and lifts to be audited for cleaning supplies 3 times a week for 4 weeks, weekly for 1 month, and monthly for 3 months. Director of Nursing or designee responsible for the audit. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 24 director of nursing (DON) stated standard precautions are a set of measures, they are the same for all residents, they are used to prevent infection. DON stated it is an expectation all commonly used equipment, such as an EZ stand, are cleaned after each use. Per facility policy titled Disinfection of Resident Care Equipment dated 5/8/24, reusable equipment will be cleaned and disinfected after each use of resident and before use with another resident.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/30/2025. At the time of this survey, EDENBROOK OF ROCHESTER 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/30/2025

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
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. EDENBROOK OF ROCHESTER is a 1 story building with partial basement. The building was constructed at two different times. The original building was constructed in 1964 and was determined to be of Type II (111) construction. In 1974 an addition was added to the East Wing and determined to be of Type II (111) construction.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 81 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 353	Continued From page 3 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2.1.1, 5.2.1.1.2(2)(5)(6), 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation in the Sharps Room that cabling was attached too and exhibiting load on the sprinkler system piping. 2. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation in the Basement - Laundry Chute Room that cabling was attached too and exhibiting load on the sprinkler system piping. 3. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation in the Basement - Med Supply Room that sprinkler heads exhibited signs of paint splatter. 4. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that sprinkler head(s) in the Dishwashing Area exhibited signs of debris loading and oxidation.	K 353	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. 1) Wires relocated or suspended to not rest on sprinkler water line. Identified sprinkler heads have been repaired/replaced in Med Supply Room and dishwasher area 2) All residents have the potential to be affected by this deficient practice. 3) Maintenance Director educated on Standards For Inspection, Testing, and Maintenance of water-based Fire Protection Systems. To prevent recurrence, repairs will be visually inspected by the Maintenance Director/designee, to ensure compliance with requirements. Identified areas will be inspected twice a month for 3 months. 4) The Maintenance Director and/or Administrator is responsible for monitoring for compliance. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 353	Continued From page 4 5. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation in the Basement - Boiler Room that cabling was attached too and pex water tubing was exhibiting load on the sprinkler system piping. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to properly document fire extinguisher inspections in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation, that no documentation log was available to confirm and demonstrate that at least the last 12 monthly inspections had been performed.	K 355	1) All fire extinguishers have been inspected and noted appropriately. 2) All residents have the potential to be affected by this deficient practice. 3) Maintenance Director educated on proper documentation of monthly inspections for fire extinguishers. Maintenance Director/designee is to inspect monthly, annotate, and report any deficiencies to the Administrator for correction. To prevent recurrence, the Administrator will audit monthly for 3 months to ensure scheduled inspections occurring. 4) Maintenance Director and/or Administrator is responsible for monitoring for compliance. Analysis of these audits will be brought to the QAPI committee to	6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 355	Continued From page 5 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	determine ongoing frequency and duration of audits	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that the North - smoke barrier door assembly exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke.	K 374	1) All identified doors have been repaired to ensure smoke barrier is maintained. 2) All residents have the potential to be affected by this deficient practice. 3) Maintenance Director educated on Smoke Barrier Inspection. To prevent recurrence, the maintenance director/designee is to follow scheduled maintenance and inspection tasks as assigned in property management system (TELS). The maintenance director to inspect doors monthly to ensure compliance. 4) Maintenance Director and/or Administrator is responsible for monitoring	6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 374	Continued From page 6 2. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that the East Wing - smoke barrier door assembly exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. 3. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that the Basement - smoke barrier door assembly adjacent to the Staff Breakroom exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. 4. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that the Basement - smoke barrier door assembly adjacent to the Human Resources Office exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	for compliance. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be	K 541		6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 541	Continued From page 7 provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the linen chute door and safety measures of the laundry chute system per NFPA 101 (2012 edition), section 19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition), section 5.2.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation in Main Floor linen chute intake door assembly did not have latching hardware to secure the vertical shaft opening. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	1) Identified deficient area has been repaired and in compliance. Latching hardware has been installed to ensure properly secured shaft opening on laundry chute 2) All residents have the potential to be affected by this deficient practice. 3) Maintenance Director educated on proper maintenance of laundry chutes. Identified repair will be inspected monthly for 3 months to ensure proper operation 4) The Maintenance Director and/or Administrator is responsible for monitoring for compliance. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 712	Continued From page 8 conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by review of available documentation that no documentation was presented to confirm that fire drills were conducted: 1st shift - 3rd Quarter and 2nd shift - 1st Quarter. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 712	1) Fire drills are occurring as required 2) All residents have the potential to be affected by this deficient practice. 3) Maintenance Director educated on Fire Drill Documentation. To prevent recurrence, fire drills will be conducted as required and will be audited for completion for 3 months 4) The maintenance Director and/or Administrator is responsible for monitoring for compliance. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits.	
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids,	K 741		6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 741	Continued From page 9 combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the facility smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by a review of available documentation that the smoking policy was generic in content not providing guidance as to the approved smoking location(s) for staff, residents, and visitors.	K 741	1) Smoking policy has been updated to include identified areas for smoking locations. 2) All residents have the potential to be affected by this deficient practice. 3) Smoking policy to be available for all residents, staff, and visitors. To prevent recurrence, monitoring of smoking policy adherence to be completed weekly for 4 weeks and monthly for 2 months. 4) The maintenance Director and/or Administrator is responsible for monitoring for compliance. Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 741	Continued From page 10 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	of audits.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.1.3, 5.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that the Basement corridor fire door, adjacent to the Laundry, did not close, seal, and latch upon test.	K 761	1) Identified door has been repaired to close, seal, and latch appropriately. 2) All residents have the potential to be affected by this deficient practice. 3) Inspections scheduled through maintenance scheduling system (TELS). To prevent recurrence, proper door operation of doors to be audited weekly for 4 weeks and monthly for 2 months. 4) The Maintenance Director and/or Administrator is responsible for monitoring for compliance. Compliance will be reviewed in QAPI monthly.	6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 761	Continued From page 11 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of extension cords and power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.6, 10.2.4, 10.5.2.3, and NFPA 70,	K 920	1) All improper power strips have been corrected and/or removed from designated areas in nurse stations, staff offices, work areas, and resident rooms. 2) All residents have the potential to be	6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 920	Continued From page 12 (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that in the East Nurses Station relocatable power taps were found daisy-chained together and in use. 2. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that in the D.O.N. Office there was a 2-to-6 multi-tap adapter with (2) daisy-chained relocatable power taps connected to the adapter. 3. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that in resident RM 11 there was a relocatable power tap (1363A) resting on the floor with (2) appliances connected to the relocatable power tap. 4. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that in the Basement Linen folding area there was an appliance connected to a relocatable power tap. 5. On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that in the Nurse Managers Office there was an appliance connected to a relocatable power tap. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	affected by this deficient practice. 3) IDT educated on appropriate use of power strips and extensions cords. Residents effected have been informed of proper usage requirements. Audits will be completed 3 times a week for 4 weeks, and monthly for 3 months to ensure proper use of power strips and extension cords. 4) The Maintenance Director and/or Administrator are responsible for monitoring for compliance. Compliance will be reviewed in QAPI monthly.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag	K 923		6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 923	Continued From page 13 CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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 923	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/30/2025 between 9:30 AM and 2:30 PM, it was revealed by observation that the Med Gas (O2) Room had mixed storage. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	1) Med Gas Room (oxygen storage room) is utilized appropriately to ensure no mixed storage. 2) All residents have the potential to be affected by this deficient practice. 3) Nursing staff and Maintenance Director educated on proper Med Gas/Oxygen room storage. Signage posted as reminder for proper use of storage area. Storage room to be inspected 3 times a week for 4 weeks and monthly for 3 months to ensure compliance. 4) The Maintenance Director and/or Administrator is responsible for monitoring for compliance. Compliance will be reviewed in QAPI monthly.	