Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2023

Administrator
Edenbrook Of St Cloud
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: February 2, 2023

Dear Administrator:

On March 1, 2023, we notified you a remedy was imposed. On March 31, 2023 and April 3, 2023 the Minnesota Department(s) of Health and 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 March 20, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 2, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 1, 2023, 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 May 2, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 20, 2023, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 1, 2023

Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: February 2, 2023

Dear Administrator:

On February 2, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 2, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 2, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 2, 2023.

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.

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 $11,292; 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 May 2, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Talahi Nursing And Rehab Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 2, 2023. 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 this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 August 2, 2023 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 42 CFR § 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.

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:

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/30/23 through 2/2/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/30/23 through 2/2/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H54387959C (MN85453) and H5438173C (MN82555), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be SUBSTANTIATED: H54387953C(MN83183), with a deficiency cited at (F580 and F755). The following complaints were found to be UNSUBSTANTIATED: H5438176C (MN82841), H54387954C (MN83103), H54387962C (MN84115), H54387960C (MN85151), H54387963C (MN85083), H54388035C	F 000		

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

Electronically Signed | 03/10/2023

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.

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F 000	Continued From page 1 (MN85493), H54387961C (MN85934), H5438170C (MN80841), H5438172C (MN81017), H5438171C (MN81328), H5438175C (MN82499), H5438174C (MN82553), H5438177C (MN82556), and H54388052C (MN90551). 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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		3/20/23

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F 550	Continued From page 2 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure 12 of 17 residents Resident (R) R6, R9, R16, R24, R26, R29, R40, R47, R49, R54, R57 and R215, eating in the memory care dining room, were severed at the same time. In addition, the facility failed to ensure that R16 received her medication administered in a private setting. The sample size was 24 residents. Findings include: Review of the facility's policy titled, "Privacy and Dignity," revised 01/10/22, revealed, "It is the	F 550	F550 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth, or the facts alleged, or the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42CFR 483. This plan of correction constitutes the facility□s written credible allegation of compliance. 1.What corrective actions will be accomplished for those residents found to	

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F 550	Continued From page 3 policy of Eden Senior Care to provide dignity and privacy for our residents at all times. Privacy is provided during cares. Resident is appropriately covered." 1. During dining observation in the memory care unit on 01/30/23 between 12:45 PM-1:17 PM revealed the following dignity concerns: At table two, at 12:45 PM, R26 already had her tray delivered, and was eating, but R16 did not receive their tray until 12:52 PM. At table five, R24's family member was assisting R24 with her lunch tray at 12:45 PM; however, R40 and R57 had not been served their trays. R40's tray was served at 12:50 PM, and R57's tray not delivered until 12:51 PM. At table six, at 12:45 PM, R29 was observed eating her food, along with R215; however, R47 and R49 were sitting at the table without food. R47 was not served until 12:54 PM and R49 was not served until 12:59 PM. 2. During medication observation for R16 with Licensed Practical Nurse (LPN) A on 01/31/23 between 8:43 AM-8:52 AM revealed that R16 was sitting in the dining room with 16 other residents when LPN A administered R16's 11 medications by mouth (PO), one inhaler and muscle cream that was rubbed on R16's left knee after lifting R16's pant leg. Interview with the Clinical Manager A on 02/01/23 at 11:30 AM, she confirmed that all residents sitting at the same table should be served at the same time, and that medication should not be given to residents in the dining room.	F 550	have been affected by the deficient practice: R6,R9, R16,R24,R26,R29,R40,R47,R49,R54,R57 ,and R215. On 3/3/2023 education provided to memory care nursing and dietary staff to ensure all residents at the same table receive their meals at the same time. LPN-A was immediately re-educated regarding providing dignity with medication passes. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Dietary and Nursing staff re-educated on serving all residents sitting at the same table at the same time. Nursing educated on administration of medications in appropriate place to ensure residents privacy. Dining rooms will be audited to ensure compliance with all residents at the same table are being served at the same time and dignity is provided with medication passes. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Audits will be completed 3 x week for 1 month, 2x per week for 1 month, then 1x per week for 1 month. The results and analysis of these audits will be brought to the QAPI committee to determine ongoing need and frequency of audits.	

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F 550	Continued From page 4 Interview with the Director of Nursing (DON) on 02/01/23 at 4:45 PM, confirmed that all residents at the same table in the dining room should be served at the same time, and that medication should not be given in the dining room.	F 550	Responsible for compliance: Administrator Date of compliance: 3/20/2023	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		3/20/23

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F 580	Continued From page 5 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, interviews the facility failed to notify the responsible party (RP) for 1 of 2 residents (R)18 reviewed for change in condition related to missing anti-seizure medication in December 2022 out of a total sample size of 24 residents. Findings include: Review of the facility provided "Face Sheet" revealed R18 was admitted to the facility on 07/20/16 with a diagnosis of epilepsy. Further review revealed that R18 was not his own responsible party but a family member was his RP. Review of the December 2022 "Medication Administration Record (MAR)," provided by the facility, revealed, "Vimpat [antiseizure	F 580	F580 Notification of Change. 1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Responsible party was notified of missed medications that occurred in December 2022 on 2/1/2023 by surveyor and facility staff also notified the responsible person 3/3/2023 R18 had no negative effect from the missed medication. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. 3. Address what measures will be put into place or systemic changes made to	

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F 580	Continued From page 6 medication]100 mg BID" was not available from the pharmacy on the following dates for the morning shift: 12/18/22, 12/27/22, and/or 12/28/22. Further review revealed that the evening dose was not available on 12/10/22, and 12/27/22. However, on 12/11/22 for the evening shift revealed that the MAR was left blank. Cross Reference: F:755 -D. Interview with R18's family member on 02/01/23 at 12:43 PM, revealed he was not notified of the medication missed in December. He confirmed that he was the RP and would be the one to be notified. Interview with the Clinical Manager A on 02/01/23 at 11:30 AM, confirmed that R18 was not his own responsible party, but a family member was his RP, and confirmed that his family member should have been informed of the missed doses of R18's medication in December 2022. Review of the facility's policy titled, "Change in Condition," revised 07/06/21, revealed "The physician and Durable Power of Attorney/responsible party (RP) will be notified when there has been a change that is sudden in onset, a change that is marked difference in usual sign/symptoms and/or the signs/symptoms are unrelieved by measures already prescribed."	F 580	ensure that the deficient practice will not recur: Nursing staff re-educated on need to notify resident or their responsible party with any changes in condition due to missed medications. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Audits will be conducted 1x per week x 1 month, and every other week x 1 month, then monthly x 1 month. The results and analysis of these audits will be brought to the QAPI committee to determine ongoing need and frequency of audits. Responsible for Compliance: Administrator Date of compliance: 3/20/2023	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		3/10/23

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	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

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F 641	Continued From page 7 Based on interview, observation, and record review of the Resident Assessment Instrument (RAI) Manual, the facility failed to accurately code the "Minimum Data Set (MDS)" for hospice services for 1 of 3 residents (R) 22 receiving hospice services out of a total sample of 24 residents. By not ensuring the accuracy of the "MDS," these failures placed the resident at risk for unmet care needs of residents. Findings include: During an observation 01/30/23 at 1:34 PM, R22 was observed lying in bed. At this time when attempting to communicate, R22 was using word salad (confused random words) and would only mumble vague words and was not able to make her needs known. Review of R22's undated "Face Sheet," found in R22's electronic medical record (EMR) under the "Face Sheet" tab, revealed R22 was admitted to the facility on 09/18/20. Diagnosis included Multiple Sclerosis (progressive damage to brain and spinal cord), Malignant Neoplasm of Bladder, and Malaise. The face sheet indicated R22 was also receiving Hospice services. Review of a "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" for R22 (with the benefit period dates of 12/02/22 to 01/30/23), dated 01/10/23 and located in a white hospice binder at the nurse's station, indicated R22's "Start of Hospice Care" began on 04/06/22. Hospice diagnosis related to a terminal prognosis included Multiple Sclerosis, weakness and malignant neoplasm of bladder. Further review of the document indicated, "Hospice nurse to provide instructions related to nutrition/hydration	F 641	F641 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R22s MDS was modified on 3/5/2023 to reflect the terminal diagnoses in section J. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: MDS nurse or designee to review most recent MDS for all residents receiving hospice services to ensure appropriate coding of section J. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Corporate MDS float nurse was re-educated on importance of accuracy of coding section J on the MDS on 3/6/2023. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Facility MDS nurse will audit section J for accuracy 1x per week x 1 month, every other week for 1 month, then monthly for 1 month. The results and analysis of these audits will be brought to the QAPI committee to determine ongoing need and frequency of audits. Responsible for compliance: Administrator	

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F 641	Continued From page 8 status in the terminal patient, and the Hospice physician has reviewed the following on this patient and agrees with the current plan of care." Review of a "Hospice Physician Order," dated 06/20/22 and located in the white hospice binder indicated, "Order Date: 06/20/22." "Order Type: Hospice Recertification Plan of Care Update." "Order Description: Patient continues to have 6 months or less prognosis if disease runs it's normal course. Proceed with recertification of hospice services under terminal diagnosis of multiple sclerosis." Review of a "Hospice Physician Verbal Order," dated 06/22/22 and located in the white hospice binder, indicated, "Order Description: I certify that the patient's prognosis is six months or less if the disease runs its normal course." Review of a "Hospice Physician Narrative," dated 06/30/22 and located in the white hospice binder indicated, "Patient ...currently being recertified for hospice with a primary diagnosis of multiple sclerosis with related functional quadriplegia and overactive bladder ...This patient has end stage disease ...dependent on others for assistance ...Based on review and evidence of ongoing decline, I believe this patient has a terminal prognosis of six months or less as her disease state worsens as anticipated." Review of a "Hospice Face-to-Face Encounter Acknowledgement Report," dated 01/05/23 and located in the white hospice binder, indicated, "Patient seen at [name of facility] for completion of Hospice Face-to-Face examination to assist in determining continued hospice eligibility. Patients primary terminal diagnosis is Multiple Sclerosis	F 641		

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F 641	Continued From page 9 ...Assessment: End Stage Multiple Sclerosis with severe debility, cognitive impairment, and dysphagia ...Plan: Recommend continuation of hospice services as examination reveals an estimated life expectancy of six months or less if disease runs its normal course." Review of R22's quarterly "Minimum Data Set (MDS)," found in the EMR under the "MDS" tab, with an Assessment Reference Date (ARD) of 01/05/23, revealed this "MDS" was completed by a corporate RN (Registered Nurse) on 01/05/23. The "MDS" was coded as R22 had no terminal prognosis of less than 6 months but was also coded as receiving hospice services. Review of an undated "Care Plan," found in the EMR under the "Care Plan" tab, indicated, "[name of R22] is on hospice services r/t (related to) Multiple Sclerosis. Enrolled in [name of hospice services] on 04/06/22." Goals were: "Notify hospice and family if resident passes. Follow hospice instructions for release of body." Review of a "Hospice Physician Verbal Order," dated 01/16/23 and located in the white hospice binder, indicated, "Order Description: I certify that the patient's prognosis is six months or less if the disease runs its normal course." The document further indicated, "I attest that I have completed the face-to-face encounter. The clinical findings of this encounter have been provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course." During an interview on 02/01/23 at 8:45 AM, the Assistant Director of Nursing (ADON) stated,	F 641		

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F 641	Continued From page 10 "She [referring to R22] has been on hospice since 04/06/22 and yes, she has a terminal diagnosis." The ADON stated, "Hospice usually sends their documentation and we upload it in our electronic charts. She has never come off hospice services. No." When reviewing the quarterly MDS dated 01/05/23 regarding hospice services, the ADON stated, "She does have a terminal diagnosis. Yes. But I see where it is checked no. I think a corporate person filled it out." During an interview on 02/01/23 at 8:55 AM, regarding the coding of the "MDS," the MDS Coordinator stated, "She [referring to R22] is on hospice and has been enrolled since 04/06/22. She has never come off hospice services. Her terminal diagnosis is Multiple Sclerosis." The MDS Coordinator stated, "My process when completing the MDS is to review all the hospice notes, progress notes, all documentation the three months before, MD notes, and basically the whole chart." When reviewing the 01/05/23 quarterly "MDS" with the MDS Coordinator, she stated, "I didn't complete that section. Our corporate RN completed it. On Section J under the terminal prognosis section, I'm seeing what you're seeing, and it is not coded as her having a terminal diagnosis of less than six months. That was checked incorrectly because she does have a terminal diagnosis of less than six months." The MDS Coordinator stated, "At the time, I was having her [corporate RN] help me out completing the MDS in January and I can see where its not correct. Sections J and O should match since she does have a terminal diagnosis and is receiving hospice services." During a phone interview on 02/01/23 at 9:17 AM, the Hospice Nurse of Clinical Services confirmed	F 641		

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F 641	Continued From page 11 that R22 had been receiving hospice services since 04/06/22 and did have a terminal diagnosis. The Hospice Nurse of Clinical Services then stated, "Either our hospice nurse will bring a copy of all our documentation, or we also fax it to the facility to include all of our recertifications and physician attestations of a qualifying diagnosis of less than 6 months." During an interview on 02/01/23 at 4:15 PM, regarding the coding of the "MDS" when a resident is receiving hospice services, the Regional Director of Clinical Services stated, "It would be our expectation that both of the sections of the MDS match if a resident is receiving hospice. They should be coded the same. At the time, we had an assistant who was assisting us with the MDS." Review of the MDS-3.0 R-A-A Manual-v1.17.1 October 2019 under Section J1400 Prognosis: indicated, "Definition: Condition or chronic disease that may result in a life expectancy of less than 6 months; In the physician's judgement, the resident has a diagnosis or combination of clinical conditions that have advanced or will continue to advance to a point that the average resident with that level of illness would not be expected to survive more than 6 months. This judgement should be substantiated by a physician note . . . Steps for Assessment: 1. Review the medical record for documentation by the physician that the resident's condition or chronic disease may results in a life expectancy of less than 6 months, or that they have a terminal illness. 2. If the physician states that the resident's life expectancy may be less than 6 months, request that he or she document this in the medical record ...3. Review the medical	F 641		

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F 641	Continued From page 12 record to determine whether the resident is receiving hospice services . . . Coding Instructions; Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services. Code 1, yes: if the medical record includes physician documentation: 1) that the patient is terminally ill; or 2) the resident is receiving hospice services ...'Terminally ill' means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course ...Section O0100: Special Treatments, Procedures, and Programs: O0100K, Hospice care: Code residents identified as being in a hospice program for terminally ill persons ...is provided ..."	F 641		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		3/20/23

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F 693	Continued From page 13 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure tube feeding equipment was maintained and stored appropriately for 1 of 1 resident (R)12 reviewed for tube feeding out of a total sample of 24 residents. The facility's deficient practice increased the resident's risk of infectious complications. Findings include: Review of R12's undated "Admission Record," revealed he was admitted to the facility on 08/29/19 with diagnoses which included dysphagia (difficulty swallowing) and dementia. Review of R12's admission "Minimum Data Set (MDS)" dated 01/19/23, revealed a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 indicating R12 was cognitively intact. Continued review of the "MDS" revealed R12 received food via an abdominal feeding tube. Review of R12's Physician's Orders, revealed "OK to slurry meds and give per J-tube [jejunostomy tube-feeding tube] ...Enteral feed every night shift. Change syringe daily." Review of R12's comprehensive Care Plan revealed no intervention to maintain R12's tube feeding materials, prevent nutritional complications, or store products used for feeding in a sanitary manner.	F 693	F693 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R12 tube feeding equipment and environment was cleaned and sanitized. How the facility will identify other residents having the potential to be affected by the same deficient practice: Facility identified other residents receiving nutrition via tube feeding as having the potential to be affected by this practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nursing staff was re- educated on proper storage and cleanliness of all tube feeding supplies. Housekeeping also educated on monitoring cleanliness of tube feeding poles and environment with routine room cleaning. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Audits will be completed 1 x per week x 1 month, every other week for 1 month, then once weekly x 1 month. The results and analysis of these audits will be brought to the QAPI committee to determine ongoing need and frequency of audits. Responsible for Compliance: Director of Nursing	

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F 693	Continued From page 14 During an interview on 01/30/23 at 5:02 PM with R12, an opened undated bottle of Two Cal feeding material was sitting on his mini refrigerator. The tube feeding pole was unclean. There was a plastic syringe, dated 01/21/23, in a plastic container with powdery white liquid in the bottom sitting on a table uncovered. R12 stated those items were from when staff crush up his medicines and inject them in his tube feeding. During an interview and observation on 01/31/23 at 1:45PM, the Assistant Director of Nursing (ADON) stated she expects tube feeding bottles to be dated and refrigerated once opened. The ADON read the directions on the bottle and stated the bottle could sit out no longer than 24 hours. The ADON confirmed the bottle from yesterday should have been dated to prevent any complications with R12's tube feeding. The ADON stated it was also her expectation for any syringe used to inject medications must be changed at least weekly. The ADON also confirmed that the syringe should not be left sitting in a container with slurry remains in the bottom. She stated that it was her expectation for the syringe and tubing to be clean, lying flat to air dry, and covered to prevent infection. During an interview on 02/02/23 at 9:25 AM, Licensed Practical Nurse (LPN) C stated if R12's tube feeding nutrition is in a carton, it may be left out. She then stated if it is in a bottle, it should be refrigerated. She stated the syringe used to provide R12 his medications should be changed out every 24 hours. LPNC stated it was her expectation to store the syringe in a plastic baggie or covered during the 24-hour period.	F 693	Date of compliance: 3/20/2023	

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F 695	Continued From page 15	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure respiratory equipment was maintained and stored appropriately for 1 of 1 residents (R) 19 reviewed for respiratory care out of a total sample of 24 residents. The facility's deficient practice increased the resident's risk of respiratory complications. Findings include: Review of R19's undated "Admission Record," revealed she was admitted to the facility on 03/09/21 with diagnoses which included respiratory failure with hypoxia (low oxygen levels). Review of R19's admission "Minimum Data Set (MDS)" assessment 1/18/23 revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 indicating R19 was cognitively intact. Continued review of the "MDS" revealed R19 was provided oxygen therapy. Review of R19's "Physician's Orders," revealed	F 695	F695 1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The oxygen tubing was changed and dated and concentrator filter cleaned for R19. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving supplemental oxygen have the potential to be affected by this practice. Every resident on oxygen was rechecked to ensure oxygen tubing was dated and filters were cleaned on 3/3/2023. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nurses were re-educated on the facility process for the management of oxygen equipment. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	3/20/23

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F 695	Continued From page 16 "O2 [oxygen] tubing - change weekly date and initial on change, wash filter." Review of R 19's comprehensive "Care Plan," revealed no intervention to maintain R19's oxygen filters or external cleaning. During an observation and interview on 01/30/23 at 7:16 PM, R19 confirmed she was administered oxygen therapy and preferred to use it only in the evenings. R19's oxygen concentrator filter on the back was unclean and covered with dust (color was gray). The front of the concentrator appeared sticky and contained pieces of hair and dust. R19 had oxygen administered via nasal cannula. The tubes were dated 01/08/23, identifying the last date they were changed. During an observation on 01/31/23 at 12:49 PM, R19's oxygen tubes had been changed and dated for 01/30/23. The oxygen concentrator was still unclean, and the external filter had not been washed. During an interview on 01/31/23 at 1:14 PM, Registered Nurse RN B was unsure exactly when R19's oxygen concentrator should be cleaned. She stated that R19 should have a schedule on her TAR (treatment administration record) when the machine should be cleaned. RN B stated staff "working the cart" (medication cart) that day should be the person who maintains R19's oxygen concentrator. RN B stated, "I'm not sure, but I think the tubing should be changed out once a week." RN B did not know how often the filter should be cleaned. During an interview and observation of R19's oxygen concentrator on 01/31/23 at 1:20 PM with	F 695	program will be put into place: Audits will be completed to ensure ongoing compliance 1x per week x 1 month, every other week x 1 month, then monthly x 1 month. The results and analysis of these audits will be brought to the QAPI committee to determine ongoing need and frequency of audits. Responsible for Compliance: Director of Nursing Date of Compliance: 3/20/2023	

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F 695	Continued From page 17 the Assistant Director of Nursing (ADON), she confirmed the facility oxygen concentrator services/maintenance were provided by an outside vendor. She stated that nursing staff oversee weekly maintenance and care of the oxygen concentrator. The ADON confirmed R19's external oxygen concentrator filter was undated (with date of change), unclean, and had dust particles on it. The ADON removed the external filter and stated, "the filter could use a little cleaning." The filter was gray with clumps of lint and debris. She proceeded to hand wash the filter in the R19's bathroom sink with soap and water. She confirmed staff should have been cleaning the filter weekly when they change the tubes. The ADON observed the front of the concentrator and stated "it needs cleaned."	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		3/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

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EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 755	Continued From page 18 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review,and interviews, the facility failed to obtain medication for 1 of 1 residents (R) 18 related to the administration of a twice a day (BID) anti-seizure medication out of a total sample of 24 residents. This failure increased the risk that R18 would have seizure activity. Findings included: Review of the facility provided "Face Sheet" R18 was admitted to the facility on 07/20/16 with a diagnosis of epilepsy. Review of the "Order Summary Report" (facility provided), dated 01/30/23, revealed "Vimpat (anti-seizure medication) 100 milligrams (mg) BID, start date 03/24/20." Review of the December 2022 "Medication Administration Record (MAR)," provided by the facility, revealed, "Vimpat 100 mg BID" was not available from the pharmacy on the following dates for the morning shift: 12/18/22, 12/27/22,	F 755	F755 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R18 currently has all medications on site and no seizure activity was noted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nursing staff re-educated on the importance of providing medications as ordered and the procedure to follow when medications are not available. All concerns related to medications being available to be brought to the morning	

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F 755	Continued From page 19 and/or 12/28/22. Further review revealed that the evening dose was not available on 12/10/22, and 12/27/22. Review of the "Progress Note," provided by the facility and dated 12/07/22, revealed "Request sent to provider for refill for Vimpat. Requested order to be sent to VA [Veteran's Administration] pharmacy." Review of the "Progress Note" dated 12/10/22, revealed that "VA pharmacy called for R18's Vimpat. The pharmacist stated that the medication is in process, so will be sent out on 12/12/22." Review of the "Progress Note" dated 12/11/22, revealed that "The triage line was called to request a refill of R18's Vimpat from Omnicare Pharmacy. The Registered Nurse (RN) from triage sent the order to the Omnicare pharmacy, so the medication will be sent out today per the Pharmacist." Review of the "Progress Note," dated 12/11/22, revealed that "The nurse called the VA pharmacy to check when the medication can be sent out and the Pharmacist stated that the medication will be sent out via regular mail, so it will probably take a week. However, the nurse called Omnicare to request if they can refill the medication. Omnicare stated that they do not have script and if it reverses to them they would be able to refill it. The VA was called and requested to reverse the script and it went through. Medication will be delivered tonight. The evening nurse was made aware." Review of the "Progress Note" dated 12/14/22,	F 755	Interdisciplinary Team (IDT) to review and establish a plan of action to obtain the medications. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Audits will be completed 3x weekly x 1 month, 2x weekly x 1 month, 1x week x 1 month. The results and analysis of these audits will be brought to the QAPI committee to determine ongoing need and frequency of audits. Responsible for compliance: Director of Nursing Date of compliance: 3/20/2023	

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F 755	Continued From page 20 revealed that "The nurse called the VA pharmacy for R18's medication. The Pharmacist stated that the resident's Vimpat will be sent out on 12/22/22 and will take a week." Interview with the Clinical Manager A on 02/01/23 at 11:30 AM, she confirmed that the medication nurse is responsible for checking R18's medication twice a week due to the VA taking five to seven days to deliver R18's medication. She stated that this anti-seizure medication was not available in the facilities Omnicell (emergency supply). Interview with the Director of Nursing (DON) on 02/01/23 at 12:15 PM, she was unaware of R18 missing his medication in December 2022; however, said that the facility put in place a plan to check R18's medications twice a week back in May 2022 because it takes two to three weeks to obtain the medication from the VA. The DON stated that the facility went through their pharmacy and ordered a two-week supply of the medication. Interview with the DON on 02/02/23 at 11:30 AM, the DON confirmed that it would have been her expectation that R18 not miss his medication; however, confirmed that R18 did miss doses of his anti-seizure medication in December 2022. Further interview, she said that moving forward, she has put into place that the nurses will continue to check the need for ordering medication twice a week and the clinical manager will check R18's medication once a week. Review of facility provided policy titled, "Administering Medications," revised 08/15/22 revealed "To ensure safe and effective	F 755		

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F 755	Continued From page 21 administration of medication in accordance with physician orders and state/federal regulations. Medication shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled is labeled according to accepted standards. Should a drug be withheld, refused, or otherwise not given as ordered the appropriate code shall be entered into the electronic Medication Administration Record (eMAR) to indicate why it was not given... . .. Should a medication be withheld or refused, the physician will be notified when three (3) consecutive doses or a pattern of frequent withholding or refusal is noted. Documentation identifying the explanation of withholding or reason for refusal will be documented in the medical record."	F 755		
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 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.	F 761		3/10/23

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F 761	Continued From page 22 §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 observations, policy review, and interviews, the facility failed to ensure that: 1. medication was stored in the original container for one resident (Resident (R) 16) in one of three medication carts and 2. expired medications were discarded appropriately in one of three medication carts and two of three medication rooms. Findings include: During medication observation with Licensed Practical Nurse (LPN) A for Resident (R)16 on 01/31/23 between 8:43 AM-8:52 AM revealed LPN-A got two white oblong tablets out of a small bottle had Tylenol 500 written on top of the cap; however, these white oblong tablets were in a used Colace bottle did not have an expiration on it and was labeled Colace. Continued observation revealed an empty big bottle labeled Tylenol was sitting on the top of the medication cart on the left side of the cart. Interview with LPN A, during observation, LPN A said that she placed the Tylenol into the smaller bottle, because the bigger bottle would not fit into the medication cart. Observation of the medication cart in the memory	F 761	F761 F761 Medication Storage Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R16's expired medication was removed from the medication cart and expired medications noted in medication room by surveyor were removed. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this practice. All medication carts and storage areas were audited on 3/7/2023 and any expired medications were discarded. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nurses and TMAs will be educated on storage of medications and keeping	

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F 761	Continued From page 23 care unit with Clinical Manager A on 02/01/23 at 11:15 AM, revealed one bottle of Multi-vitamin (MVI), 3/4 full, with an open date of 08/13/21, and expiration date of 01/23, and one bottle of Vitamin D3 50 microgram (mcg) with opened date of 08/15/22 and no expiration date noted. The Clinical Manager A confirmed these medications should not be in the medication cart and removed them. She stated there should not be any expired medication on the carts. Also, confirmed nurses should not place medication from one bottle to another bottle, confirming the small bottle labeled Tylenol was found yesterday and she removed it from the medication cart. Observation of the second medication room with the Assistant Director of Nursing (ADON) on 02/01/13 at 12:02 PM, revealed one full bottle of Colace 100 milligrams (mg) with open date of 09/27/22, and expired date of 03/22. The ADON confirmed this was expired and should not have been in the medication room. Observation of the third medication room with the ADON on 02/01/23 at 12:30 PM, revealed one expired bottle of full, unopened MVI with expiration date of 05/22, one bottle of unopened aspirin 325 mg with expiration date of 07/22, and an unopened full bottle of Isopropyl Alcohol 70% with expiration date of 07/22. Interview with ADON, at the same time of observation, she said night shift does a weekly check of all medication rooms and medication carts, confirming no expired medication should either be in the medication room and/or medication cart. Interview with the Director of Nursing (DON) on 02/01/23 at 4:45 PM, she confirmed medication either in the medication room and/or medication	F 761	medications in its original container or packaging. Facility contacted the pharmacy representative to see if pharmacy can provide routine cart audits. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Medication storage areas will be audited 1x per week x 1 month, every other week x 1 month, and monthly x 1 month. The results and analysis of these audits will be brought to the QAPI committee to determine ongoing need and frequency of audits.	

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F 761	Continued From page 24 cart should not have expired medication and a nurse should not move medication from one bottle to another bottle.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential for spread of foodborne illness and failed to ensure food used for food preparation/service was stored in a sanitary manner. These failures had the potential to affect all 66 residents in the facility who were served food from the facility kitchen. Findings include:	F 812	F812 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific resident(s) have been noted to be affected by the deficient practice. Ovens and floors have been cleaned and are free from grease and debris. All items not dated or labeled have been discarded. All items stored on the floor have been	3/20/23

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F 812	Continued From page 25 1. The initial kitchen inspection was conducted with the Dietary Manager (DM) on 01/30/23 at 11:50 AM. The following were noted: a. Overflowing trash container with trash and food inside next to a sink where employees wash their hands. b. Very little to no soap in the soap dispenser above one of two kitchen sinks where employees wash hands. Paper towel dispenser above one of two kitchen sinks and next to soap dispenser was not working properly. At this time, the DM asked a dietary aide to bring in a new roll of paper towels. c. Inside the kitchen freezer was observed six bags of vegetables and peas not dated. One large opened bag of potatoes not dated, one large bag of opened tater tots, one bag brussel sprouts, one bag opened cauliflower and two packages of corn beef lunch meat that was opened and not dated. d. During interview at 11:55 AM, the DM stated, "Normally we don't date them (referring to the above items that were identified in the kitchen freezer). We try to use them every 3-4 days and we use them as we take them out. We use these often. Stuff that sits in the freezer longer than a week we try to use." e. Inside the kitchen meat freezer revealed four large bags of tater tots not dated or labeled, and a broken rack located on the top shelf in which frozen items were sitting. Also noted was a one 5 pound bag of cooked sausage crumbles that was not dated or labeled. During interview, the DM stated, "With the broken rack, "This happened	F 812	discarded or placed in appropriate storage. The trash container was emptied. Ice Machine has been cleaned. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. The facility will maintain compliance to ensure no residents are affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All dietary staff members will be educated on the requirement for the kitchen to be maintained in a sanitary manner to prevent the potential for spread of foodborne illness and to ensure food used for prep/service is stored in sanitary manner. Education will more specifically include ensuring appliances and floors are free of grease and food particles, containers with trash and food are not overflowing, ensuring hand soap and paper towels are readily available by hand washing stations, dating and labeling of food items along with recommended timeframes for use, routine cleaning of ovens and floors, not storing food or supplies on the floor, proper cleaning of the ice machine, keeping personal items (such as supplements) out of the kitchen area, maintaining a sink sanitizer log and appropriately maintaining washing and rinsing areas. Staff members who have not received education by 3/20/2023 will be removed from the schedule until education is received.	

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F 812	Continued From page 26 over the weekend when I was gone. I will put a ticket in to get it fixed." Regarding the cooked sausage crumbles and tater tots, the DM stated, "We don't date these. Unless we pull it out to thaw, we don't usually date or label these. We could use it within a week." f. Inside the chest freezer which was located inside the "Paper Room" storage area revealed one large, opened bag garlic bread, two large bags of tater tots, one large package of sliced beef summer sausage all with no dates or labels when they were opened. During interview, the DM stated, "We don't date these until we pull them out of the freezer." At this time in the Paper Room storage area was a broken room temperature socket observed hanging off the wall. During interview, the DM stated, "It has never worked since I've been here. I did not even know it was broken until you pointed it out." g. Observation of an additional freezer which was not in use. It was observed to be a storage area for multiple pots/pans and cutting boards. During interview, the DM stated, "It has not been working and we just use it for storage." h. Observation of the kitchen oven revealed the top of the oven, temperature controls, front and side of the oven to have large pieces of thick blackened grease, and used food particles on top of the oven. The temperature controls, front and side of the oven were observed with multiple grease splatters and buildup of food. There was also a large buildup of food particles on the floor in front of the oven, underneath the oven and under the prep tables in front of the oven. There was also a large loaf of bread on the floor under the oven that could be seen. Next to the kitchen	F 812	These areas of education to be added to all new dietary staff members orientation and education plan. Dietary manager and maintenance supervisor will be educated on the importance to properly maintain the ice machine cleaning schedule by 3/20/2023.	

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F 812	Continued From page 27 oven were two additional stacking ovens which revealed them to be very dirty. Inside they were dirty with thick blackened grease and food build up on the doors, handles, inside racks, and top and bottom cooking areas of the ovens. During interview, when the DM was asked how often are the ovens cleaned, the DM stated, "We try to clean them in the spring and fall. We've had three kitchen supervisors that have come and gone, and it has been very challenging to keep everything clean." When the DM was asked if there was a cleaning schedule for when the floors are mopped and when the kitchen is cleaned, the DM stated, "We don't have a cleaning schedule and I don't have a reason why these haven't been cleaned. My goal would be to clean the ovens in the spring and fall and I would expect my staff to clean them though when they are dirty. This has been an ongoing issue. We have the tools available to make sure they are cleaned; it just hasn't been done." i. Observation of a kitchen sink located next to the ovens revealed multiple tools sitting on a rusty metal rack on a bottom shelf. The tools were: tools for cleaning the grill, grill bricks, grill scrubbers, one scrapper, one scrubber, and one pair of vice grips. During interview, the DM stated, "I'm guessing these were things left over from maintenance when he may have been fixing the stoves, but I'm not sure. They should have been kept in our storage area. Further observation of the kitchen sink which the DM stated was used for "Washing and rinsing vegetables and noodles" revealed two buckets containing standing water with dirty towels inside. During interview, the DM stated, "Every four hours we are supposed to change the water out." On the bottom shelf of the kitchen sink was revealed one white bottle of an	F 812		

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EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 812	Continued From page 28 individuals "Herbal tea concentrate pills." During interview, the DM stated, "I'm not even sure what these are or who they belong to." At this time, the DM was observed throwing the bottle of pills into the trash. j. Observation of the kitchen "Dry Storage" room revealed a large ice machine. On the front of the ice machine was a piece of paper taped which read, "Ice Machine Cleaning Log." This was observed to be blank. During interview, the DM stated, "We have a company that comes in to clean it. They tell me that they clean it when they come out and what the temperatures are. They come out quarterly and I've asked them to sign our logs of when the ice machine was last cleaned. We do not clean this.. The last time the company came out to clean this that I'm aware of was September 2022. I told them the last time they were here to fill out our cleaning schedule so we have a record of it." k. Observation of the "Walk in Cooler" revealed two open large packages of thawing lunch meat sitting in its juices inside thawing on a silver tray on the top rack. There was no date on these when they were opened. Also, two pounds of smoked ham thawing with no date. During interview, the DM stated, "This is lunch meat. Typically, this is pulled at the end of the day when we go through everything and date and label everything." The DM then stated, "This is ready to eat and I have no dates on this as of yet. This is thawing out. It's sloppy. Its wet and we will pull it down and date it and put it in a container." At this time, also observed was one large bag of vegetables thawing out with no date. Also noted was one large clear container of uncooked chicken pieces sitting in light brown substance.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 812	Continued From page 29 The DM stated the brown substance was "broth". The container was dated 01/28. During interview, the DM stated, "Normally this would be used in 1-2 days. It is already thawed out and already cooked. It's just sitting in broth." Also noted were two opened large bags of sliced strawberries sitting in a metal rack which had leaked and were sitting in the strawberry fluid. During interview, the DM stated, "This needs to be drained. I don't see a date when they were opened. No, I'm not sure when they were opened. I will have to check with the cook. I will just have to go through everything this afternoon and make sure things are dated." l. Observation of the kitchen chemical room located next to the 3 compartment sink revealed the floor and area to be very dirty. There were 13 boxes of "Sunburst Chemicals Sintinel" sitting on top of each other on the floor in front of the sink. During interview, the DM stated, "We are not using the 3 compartment sink and these are just here for storage." m. Observation of the kitchen floors revealed them to be very dirty with food particles with crumbs of food on the floor. During interview, the DM stated, "We used to have checklists and were doing nightly cleaning. Since the last supervisor left, we have not been doing those checklists. We haven't had a cleaning schedule for at least two months or more. My staff are assigned to certain areas to clean, but we haven't been keeping up with it. The main person should be cleaning and mopping the floors." 2. During a second observation of the kitchen on 01/31/23 at 12:55 PM, the following was revealed: a. Inside the kitchen freezer revealed the same	F 812		

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	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

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EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 812	Continued From page 30 bags of vegetables and peas not dated or labeled from the day before. Also noted were open the same bags of open cauliflower, tater tots, and bag of Brussel sprouts still in the freezer as was the day before with no dates/labels. There was also an opened bag of diced onions and one bag of fajita vegetables with no dates when opened. During interview, the DM stated, "These should have been dated." b. Inside the chest freezer located inside the "Paper Room" storage area revealed there to be the same bags of garlic bread, tater tots, and 1 large package of sliced beef summer sausage all with no dates or labels when they were opened. During interview, the DM stated, "I didn't know when these were taken from the boxes. We don't have dates on these items." c. Inside the kitchen meat freezer revealed the broken rack located on the top shelf on which frozen items were sitting was now fixed. During interview the DM stated, "Our maintenance may came to fix it this morning and he put zip ties to hold it up." Also noted was the one 5 pound bag of cooked sausage crumbles not dated or labeled as was seen the day before. During interview, the DM stated, "We don't date these. Unless we pull it out to thaw, we don't usually date or label these. We could use it within a week." d. On 01/31/23 at 12:59 PM, during a second observation of the kitchen ovens revealed the large oven was now cleaned. During interview the DM stated, "It was washed and cleaned last night." However, observation of the two stacking ovens next to the large oven still revealed them to be very dirty with thick food particles building up, thick grease and dirty doors, handles, cooking	F 812		

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	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 812	Continued From page 31 racks and inside top and bottom of the ovens. During interview, the DM stated, "The stacking ovens have not been cleaned yet." e. Observation of the sink where vegetables and noodles are washed now revealed the two buckets with water inside to be sitting on the bottom shelf. During interview, the DM stated, "I made the buckets with fresh solution in them. The same solution we take out of the three-compartment sink. We only started to keep a log as of today of the sanitizing solutions. Prior to today, we were not checking the PPM, it just fell by the wayside. We started a "Sink Sanitizer Log" as of January 2023. Observation of the sink sanitizer log revealed on 01/31/23 at 10:30 AM the PPM (Part per Million) was recorded as 200 PPM (parts per million). During interview, the DM stated, "We were using the Sani buckets, but just not recording the PPM. I've had to do a lot of education with my staff. I don't know why these buckets were even in the food prep area." f. Observation of the "Walk in Cooler" still revealed the open large packages of thawing lunch meats within its juices. During interview the DM stated, regarding the large two opened bags of thawing strawberries, "The strawberries that were sitting being defrosted were now tossed." g. Observation of the kitchen floors still remained to be very dirty with food particles. During interview the DM stated, "At the end of each shift, they are to sweep and mop the floors and this should be done at least twice a day." Regarding the kitchen ovens, the DM stated, "They were not cleaned as often as they should have been." Regarding food dating and labeling, the DM stated, "Everyone who is responsible for food	F 812		

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	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 812	Continued From page 32	F 812		

handling is responsible for dating and labeling the food. I expect them to make sure things are covered, and labeled, and everyone that touches the food should be dating and labeling it."

On 01/31/23 at 1:00 PM, during interview regarding the soap dispenser at one of the two kitchen sinks and paper towel holder, the DM stated, "Some of my staff were not aware there is a key to open the soap dispenser and change it out for a new one. I changed that out. We also changed out the paper towel dispenser as well."

3. On 01/31/23 at 1:00 PM, observation of the "Dry Storage" room revealed the "Ice Machine Cleaning Log" was still observed to be blank. At this time, there were still many food particles observed on the dry storage floor. At this time, all policies and procedures regarding dating/labeling food, daily cleaning schedules and cleaning logs for ice machines were requested from the DM.

4. During an interview on 01/31/23 at 1:11 PM, regarding the expectation of kitchen staff ensuring the kitchen it clean and food is dated/labeled, the administrator stated, "It would be my expectation the staff are following safe food practices such as washing their hands, labeling and dating food and making sure nothing is expired. Regarding cleanliness, I don't know when the deep cleaning is for the day to day cleaning, but it should be done after each meal."

5. During an interview on 02/01/23 at 12:50 PM, regarding all the items that were identified in the kitchen that were not dated or labeled, the DM stated, "All the items such as the opened bags of fruit were thrown out this morning. The vegetables observed open in the freezer were

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	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 812	Continued From page 33 thrown in the garbage. With the floor freezer in the paper room, same thing. All items were tossed. The chicken that was in the container sitting in broth was thrown out and thawing lunch meat was thrown out. Instead of looking up all the dates, I wanted to toss them out and start new." During further interview regarding policies and procedures, of dating and labeling food and kitchen cleaning schedules, the DM stated that she could not find a policy specifically related to dating and labeling of food and only provided blank "Checklists" of tasks the kitchen staff should be completing daily. Review of the undated "Food Safety Requirements Policy and Procedure" revealed, "It is the Policy of this company that all facilities provide safe and sanitary storage, handling, and consumption of all foods ...It is also the policy of this facility to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness, including safe food handling by all dietary personnel and other staff handling food, from the point of receiving through the preparation and service of the meal." Review of a 02/09/21, "Ice Machine Cleaning" policy indicated, "Dietary Manager will inspect the ice machine weekly to determine if interior or exterior have visible soil. If soiled, ice machine will be cleaned by dietary staff weekly ...Maintenance will conduct a thorough cleaning of ice machine ...Maintenance and Dietary Manager will initial the log when cleaning is completed ...Completed Ice Machine Cleaning Logs are to be posted on the side of the ice machine."	F 812		
F 880 SS=E	Infection Prevention & Control	F 880		3/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

(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 34 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

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EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 880	Continued From page 35 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents 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 observations, policy review, and interviews, the facility failed to ensure that staff washed their hands between assisting residents in the dining room which affected six of 17 residents (Resident (R) R6, R18, R29, R38, R40 and R47), to prevent possible cross contamination. In addition, the facility failed to ensure that staff washed their hands prior to administering medication and did not pour medication into bare hands during medication	F 880	F880 □ Directed Plan of Correction Hand Hygiene 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R16- LPN-A was immediately re-educated on proper hand hygiene when providing medications. R6, R18, R29, R38, R40, R47-staff present on the memory care unit were re-educated on	

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	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 880	Continued From page 36 pass for R16. The sample size was 24 residents. Findings include: 1. Lunch observation in the memory care unit on 01/30/23 between 12:45 PM-1:17 PM revealed the following: At 12:50 PM, Licensed Practical Nurse (LPN) A went between R6 and R18 assisting these residents with cutting up their food using the same utensils that the residents used, all without washing her hands between residents. At 12:58 PM, LPNA was observed going to the medication cart, which was in the hallway on the unit, obtained two cups of med pass for R38 and R40. Upon return to the dining room, she handed R40 the cup of med pass, touching R40's hand, and then observed giving R38 his med pass, all without washing hands between residents. At 1:02 PM, LPNA washed her hands in the sink in the dining room. At 1:04 PM, LPNA was observed moving R29's water cup on her tray, then going into the unit's kitchenette, and then back out into the dining room. After returning to the dining room, LPN A started gathering the unused cups and placed them in the kitchenette, without washing her hands. LPNA then sat down at the table next to R6, observed moving a baby doll that belonged to R47, then observed picking up the utensil to assist R6 that R6 had been using, without washing her hands. LPNA then got up to move R29's water glass onto her tray, then observed turning around and wiping R18's mouth with his clothing protector, without washing her hands.	F 880	proper hand hygiene during meal tray pass on 2/1/2023. 2.How the facility will identify other residents having potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Review of hand hygiene policies was completed by DON/Infection preventionist on 3/10/2023. Competency assessments for staff on proper hand hygiene will be completed and cross referenced against facility staff roster to ensure all staff have received the training and have been competency tested. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Facility leadership will conduct audits on all shifts, every day for one week, then decrease the frequency based upon compliance. Audits will continue until 100% compliance is met. The Director of Nursing or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.	

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	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

(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 37 LPNA then walked toward the kitchenette to obtain gloves and assist R29, who was coughing. She was observed patting R29 on the back, then at 1:17 PM, LPN A was observed washing her hands after removing her gloves. 2. During medication pass on 01/31/23 between 8:43 AM-8:52 AM with LPNA, she was observed preparing R16's morning medication, when she poured three of 11 by mouth (PO) medications in her bare hand and placed into a clear medication cup. The LPNA was observed first pouring Depakote sprinkle capsule 125 milligrams (mg) directly into her bare hand and placing it into the clear medication cup with other medications. Next, LPNA poured Cymbalta 60 mg pill directly into her bare hand and added it to the clear medication cup. Lastly, LPNA was observed pouring one folic acid 1 mg PO medication directly into her bare hand and placing it into the clear cup with the other medication. Prior to starting process of getting R16's medications together, LPNA did not wash her hands after moving her medication cart from one area of the unit to another area of the unit. Interview with the Clinical Manager A on 02/01/23 at 11:30 AM, she confirmed staff are to wash hands between residents in the dining room. Continued interview, she confirmed that medication should not be poured directly into a bare hand and that hand hygiene should be completed each medication pass. Interview with the Director of Nursing (DON) on 02/01/23 at 4:45 PM confirmed that hand hygiene should be between medications, and between residents. Also, she confirmed that medications should not be directly poured into a bare hand.	F 880		

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	245438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 880	Continued From page 38 Review of the facility's policy titled, "Hand Hygiene," revised 01/16/23, revealed, "To provide guidelines to staff for proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections. Staff will perform hand hygiene by washing hands for at least twenty (20) seconds with antimicrobial or non-antimicrobial soap and water should be performed under the following: when hands are visibly dirty or soiled with blood or other body substances; before applying gloves and after removing gloves or other PPE; after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; after handling items potentially contaminated with blood, body fluids, or secretions; before moving from a contaminated body site to a clean body site during resident care; example after providing peri-care, before applying moisture barrier or other treatments; after providing direct resident care; before eating; after using a restroom; and/or if exposure to an infectious disease is suspected or proven. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: when hands are not visibly soiled; . . .before preparing or handling medications; before applying gloves and after removing gloves or other PPE; . . . before eating. . .and after contact with inanimate objects (e.g. medical equipment) in the immediate vicinity of the resident."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ST CLOUD	**1717 UNIVERSITY DRIVE SOUTHEAST** **SAINT CLOUD, MN 56304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted on 02/01/2023, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Talahi Nursing and Rehab Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2023

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
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. Talahi Nursing and Rehab Center is a 1-story building, plus a partial basement, and the facility was originally constructed in 1967 with additions in 1969, 1984, 1998, and 2005. The 2005 addition had its plan review completed in 2002. The facility was determined to be Type II(000) construction. The facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a complete fire	K 000		

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	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/01/2023**

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K 000	Continued From page 2 alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 77 beds and had a census of 65 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire 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 conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2, 19.7.1.6, and 4.7.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/01/2023, at 10:30 AM, it was revealed during the review of all available fire drill	K 712	K712: Fire Drills A detailed description of the corrective action taken or planned to correct the deficiency. Facility is unable to make up the omitted drills from Q1 and Q2 of prior year. Facility is in compliance with Q3 and Q4 of prior year and Q1 of current year. Address the measures that will be put in place to ensure the deficiency does not reoccur.	3/10/23

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K 712	Continued From page 3 documentation and interview with the Assistant Maintenance Supervisor, that the facility had not conducted overnight shift fire drills in the 1st and 2nd calendar quarters. An interview with the Assistant Maintenance Supervisor verified this deficient finding at the time of the discovery.	K 712	Assistant Maintenance Supervisor and Maintenance Supervisor to be educated on the requirement for quarterly fire drills to occur on each shift. Maintenance Supervisor to ensure quarterly task is scheduled in electronic building management software (Direct Supply TELS) to ensure a fire drill is completed on each shift. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Administrator to audit Q2 of current year to ensure compliance is met. Administrator will bring results of this plan to QAPI for review and determination of further actions, as needed. Identify who is responsible for the corrective actions and monitoring of compliance. Administrator. The actual or proposed date for completion of the remedy. 3/10/2023	
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.	K 761		3/10/23

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K 761	Continued From page 4 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 conduct the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6, and NFPA 80 (2010 edition) Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/01/2023, at 11:13 AM, it was revealed by a review of available fire door test and inspection documentation and an interview with the Assistant Maintenance Supervisor that the facility could not provide documentation verifying what NFPA 80 required elements of a fire door were inspected and the results for each element of the fire door inspections. An interview with the Assistant Maintenance Supervisor verified this deficient finding at the time of the discovery.	K 761	K761: Maintenance, Inspection & Testing - Doors A detailed description of the corrective action taken or planned to correct the deficiency. Maintenance Supervisor will inspect and test all fire door assemblies to enter compliance. Address the measures that will be put in place to ensure the deficiency does not reoccur. Assistant Maintenance Supervisor and Maintenance Supervisor to be educated on the requirement to inspect and test all fire door assemblies at least annually. Maintenance Supervisor to ensure annual task is scheduled in electronic building management software (Direct Supply TELS) to ensure fire door assemblies are inspected and tested. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Administrator to audit completion of current year inspection and test of all fire door assemblies. Administrator will bring results of this plan to QAPI for review and determination of further actions, as needed. Identify who is responsible for the corrective actions and monitoring of compliance.	

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K 761	Continued From page 5	K 761	Administrator The actual or proposed date for completion of the remedy 3/10/2023	
K 901 SS=C	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/01/2023, at 11:55 AM, it was revealed during a review of available documentation, that the utility risk assessment document provided at the time of the survey did not contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of	K 901	K901: Fundamentals - Building System Categories A detailed description of the corrective action taken or planned to correct the deficiency. Maintenance Supervisor to complete the facility risk assessment to include a complete list of electrical and gaseous patient/resident care equipment and the associated risk categories. Address the measures that will be put in place to ensure the deficiency does not reoccur. Assistant Maintenance Supervisor and Maintenance Supervisor to be educated on the requirement to maintain a facility risk assessment to include a complete list of electrical and gaseous patient/resident	3/10/23

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K 901	Continued From page 6 NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Assistant Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	care equipment and associated risk categories. Maintenance Supervisor to ensure annual task is scheduled in electronic building management software (Direct Supply TELS) to ensure annual review of the facility risk assessment specific to electrical and gaseous patient/resident care equipment and associated risk categories. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Administrator to audit completion of facility risk assessment as described above. Administrator will bring results of this plan to QAPI for review and determination of further actions, as needed. Identify who is responsible for the corrective actions and monitoring of compliance. Administrator The actual or proposed date for completion of the remedy 3/10/2023	