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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KHYT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00454

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/23/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 05/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00140 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
05/23/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245560

May 24, 2016

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

Dear Mr. Redinger:

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

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

Effective May 4, 2016 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 24, 2016

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

RE: Project Number S5560025

Dear Mr. Redinger:

On April 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 13, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 23, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 13, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 13, 2016, effective May 4, 2016 and therefore remedies outlined in our letter to you dated April 25, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245560 Y1	A. Building B. Wing Y2	5/23/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0371	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.35(i)	Completed
LSC	05/04/2016	LSC	05/03/2016	LSC	05/02/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/28/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	05/24/2016	03048	05/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
4/13/2016	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KHYT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00454

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(L4) **505 TROSKY ROAD WEST**
(L5) **EDGERTON, MN** (L6) **56128**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/13/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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From (a) :
To (b) :

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

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 05/04/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/23/2016 (L20)

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

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B. Rescind Suspension Date: (L45)

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/23/2016** (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 25, 2016

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

RE: Project Number S5560025

Dear Mr. Redinger:

On April 13, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved

and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 13, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by October 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		5/4/16

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

Electronically Signed | 05/04/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an unwitnessed fall with serious injury to the State Agency (SA) for 1 of 3 residents (R57) reviewed for allegations of neglect and/or injuries of unknown source. Findings include: During review of the Fall Scene Huddle Worksheet dated 3/17/16, at 5:55 p.m. it was documented that R57 experienced an unwitnessed fall and sustained a fracture while located in his bedroom. Prior to the fall it was documented that R57 was confused. Documentation indicated R57 was unable to give a description of the incident but that staff had toileted the resident at 5:30 p.m., 25 minutes earlier. Documentation on the worksheet indicated that R57 was discovered on the floor in his room near his dresser when an alarm sounded. R57 was noted to have only one shoe	F 225	All alleged violations involving mistreatment, neglect, or abuse will be reported immediately to the administrator and within the reporting timeframes to the State Agency. Nursing staff education was completed on 3-24-16 on the criteria for incidents that should be reported to the state and the timeline associated with it. Further education will be provided on 5-3-16 on critical incident reporting and the abuse and neglect policy and procedure. R57□s incident was submitted to the State Agency. Reviewed incident reports from the previous 6 months. Reviewed to ensure reporting timeframes to the State Agency were followed. Audits will be performed one time a week for 4 weeks, then one time a month for one month to ensure incidents are	

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	245560	A. BUILDING _____ B. WING _____	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 on but had grippy socks on both feet. R57 was yelling and screaming that his hip hurt. R57 was transported to the local hospital and later transferred to a larger Regional hospital for surgery due to a left hip fracture. Documentation on the worksheet signed and dated 4/1/16 identified the care plan interventions were followed at the time of the fall. However, this incident was not reported immediately to the State Agency (SA). Review of the care plan with a revision date of 3/21/16, identified that R57 had diagnoses including: Alzheimer's disease, anxiety disorder and short term memory loss. The care plan also identified R57 as having impaired decision making skills and being at risk for falls due to Alzheimer's disease and a shuffling gait . The quarterly Minimum Data Set (MDS) dated 1/26/16 identified a Brief Interview for Mental Status (BIMS) score of 3/15 (severe cognitive impairment) and required assistance of one staff with walking and transferring. During an interview on 4/12/16, at 4:15 p.m. the director of nursing (DON) and social worker (SW) verified the administrator, family and physician were notified 3/17/16, but they were not aware of the fall resulting in a fracture until the following morning and read the care management notes in the electronic medical record (EMR). The DON indicated the fall with serious injury should have been reported immediately to the SA and it would be the expectation that the charge nurse, at the time of the unwitnessed fall with serious injury, follow facility protocol/procedure. In addition, the DON verified an investigation was initiated on 3/21/16, the day R57 was returned from the hospital following the surgical repair of the left hip. When the Incident Submission report to the SA	F 225	reported to the State Agency in a timely manner. These audits will be performed by the Director of Nursing Services or designee. Results will be brought to the QAPI (Quality Assurance Performance Improvement) committee for review.	

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F 225	Continued From page 3 was reviewed, it was noted the injury was not reported until 3/21/16, 4 days after the unwitnessed fall with hip fracture on 3/17/16. When the facility's policy related to Reporting of (Maltreatment) of Vulnerable Adults Procedure, last revised 9/15, was reviewed, it specified that a mandated reporter who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately report the information to the Office of Health Facility Complaints (OHFC). The Fall Prevention and Management Policy and Procedure, dated July 2015, specifies a Falls Tool UDA for fall screening and identifying fall risk factors is to be completed upon admission and re-admission to the facility and includes choosing appropriate interventions. The policy further directs a procedure that when a resident falls both with or without injury; Specifically, (2.) Report to the state regulatory agency as appropriate. An undated document/policy and procedure submitted by the facility indicated the following criteria to report to the State if occur: (1) Fall with a major injury (bone fractures, joint dislocations, closed head injuries with altered mental consciousness or subdural hematoma).	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226		5/3/16

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F 226	Continued From page 4 Based on interview and document review the facility failed to implement their policy related to the immediate reporting of serious injury to the designated State Agency (SA) for 1 of 3 residents (R57) reviewed for allegations of neglect and/or injury. Findings include: When the facility's policy related to Minnesota Reporting of (Maltreatment) of Vulnerable Adults Procedure, last revised 9/15, was reviewed, it specified that a mandated reporter who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately report the information to the Office of Health Facility Complaints (OHFC). An undated document/policy and procedure submitted by the facility indicated the following criteria to report to the State if any occur: (1) Fall with a major injury (bone fractures, joint dislocations, closed head injuries with altered mental consciousness or subdural hematoma). During review of the Fall Scene Huddle Worksheet dated 3/17/16, at 5:55 p.m. it was documented that R57 experienced an unwitnessed fall and sustained a fracture while located in his bedroom. Prior to the fall it was documented that R57 was confused. Documentation indicated R57 was unable to give description of the incident but that staff had toileted the resident at 5:30 p.m., 25 minutes earlier. Documentation on the worksheet indicated that R57 was discovered on the floor in his room near his dresser when an alarm sounded. R57 was noted to have only one shoe on but had grippy socks on both feet. R57 was yelling and screaming that his hip hurt. R57 was transported to the local hospital and later transferred to a larger Regional hospital for	F 226	The facility will follow the abuse and neglect policy and procedure as outlined in our Nursing Services Manual. The abuse and neglect policy is available to all nurses via the online service manual. Further staff education provided on 5-3-16 to ensuring all nurses understand how to use it and access it. Audits will be performed one time a week for 4 weeks, then one time a month for one month to ensure timely reporting of vulnerable adult situations to the designated State Agency according to our policy. Audits will be completed by the Director of Nursing Services or designee. Results of the audits will be brought to the QAPI committee for review.	

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F 226	Continued From page 5 surgery due to a left hip fracture. Documentation on the worksheet signed and dated 4/1/16 identified the care plan interventions were followed at the time of the fall. However, this incident was not reported immediately to the State Agency (SA). Review of the care plan with a revision date of 3/21/16, identified that R57 had diagnoses including: Alzheimer's disease, anxiety disorder and short term memory loss. The care plan also identified R57 as having impaired decision making skills and being at risk for falls due to Alzheimer's disease and a shuffling gait . The quarterly Minimum Data Set (MDS) dated 1/26/16 identified a Brief Interview for Mental Status (BIMS) score of 3/15 (severe cognitive impairment) and required assistance of one staff with walking and transferring. During an interview on 4/12/16, at 4:15 p.m. the director of nursing (DON) and social worker (SW) verified the administrator, family and physician were notified 3/17/16, but they were not aware of the fall resulting in a fracture until the following morning and read the care management notes in the electronic medical record (EMR). The DON indicated the fall with serious injury should have been reported immediately to the SA and it would be the expectation that the charge nurse, at the time of the unwitnessed fall with serious injury, follow facility protocol/procedure. In addition, the DON verified an investigation was initiated on 3/21/16, the day R57 was returned from the hospital following the surgical repair of the left hip. When the Incident Submission report to the SA was reviewed, it was noted the injury was not reported until 3/21/16, 4 days after the unwitnessed fall with hip fracture on 3/17/16.	F 226		

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F 371	Continued From page 6	F 371		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to dish up food in a sanitary manner when handling soiled menu cards and then food items for 50 of 51 residents who ate their evening meal in the main dining room. Findings include: During observation of the evening meal located in the main dining room on 4/11/16, at 5:10 p.m. dietary cook (DA)-A served pizza and fish patties on buns, potato wedges, chips, corn, coleslaw and pears. Located on top of the steam table were three stacks of serving trays. Located to the right of the trays were white plastic menu cards which identified resident name, type of diet, room number and likes/dislikes. These items were written in black ink. However, these menu cards were visibly soiled with dark brown matter and dried food particles. During observation of the evening meal dish-up at	F 371	The facility will dish up food in a sanitary manner. Dietary staff members were educated on 5-2-16 and have implemented that the servers/dietary aides place the menu cards on the serving trays for the cooks. Menu cards will be sanitized on a daily basis, and menu cards and the card holders will be cleaned in the dishwasher once weekly. Audits will be completed two times a week for 4 weeks, then one time for one month, to ensure residents are receiving their meals in a sanitary manner. Audits will be performed by the Dietary Director or designee. Results of the audits will be brought to the QAPI committee for review.	5/2/16

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	245560	A. BUILDING _____ B. WING _____	04/13/2016

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F 371	Continued From page 7 5:10 p.m. DC-A grabbed several of the visibly soiled white plastic menu cards with both of her gloved hands and placed the cards onto the serving trays to the right of the steam table. With the same gloved hands, DC-A picked up two plates from the warming unit and placed them onto the steam table counter. DC-A proceeded to pick up two hamburger buns placing one on each plate. After opening a foil package from the steam table with her right gloved hand, she removed the pizza burgers from the foil package and placed them onto the buns. At 5:13 p.m. DA-A picked up one of the plates with her right gloved hand and proceeded to place potato wedges onto the plate with her left gloved hand. After the items were served onto the plates, the trays were set on top of the steam table for the dietary aides to deliver the food to the designated resident on the menu card. With the same gloved hands, DC-A continued to serve the evening meal in the same manner; touching the visibly soiled menu cards with her gloved hands and then touching the food items such as pizza and fish burgers, buns, potato wedges and chips. The entire supper meal for all of the residents in the dining room was dished up without any change in gloves until completion at 5:42 p.m. On 4/11/16 at 5:50 p.m. DC-A confirmed the white plastic menu cards were visibly soiled with dark brown matter and dried food particles and stated "I did not realize the tickets were visibly soiled." The DC-A verified she should not be touching any food after touching the dirty menu cards and stated "this is not good." The DC-A verified staff clean the menu cards on a weekly basis but not daily. DC-A stated the dietary aids should be moving the menu cards from their location onto the trays during meal service if they are dirty.	F 371		

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F 371	Continued From page 8 She stated "because if these are dirty, then grabbing the buns, ya this is not good infection control, contamination, possibility for food borne illness." On 4/12/16 at 1:36 p.m. dietary manager (DM) confirmed the DC-A should not be touching soiled menu cards during meal service. DM verified that either activity people and/or other dietary aids were suppose to be placing the menu cards onto the trays for the cook. The DM confirmed the menu cards were visibly soiled with dark brown matter and dried food particles and they are only cleaned weekly. The DM stated "this is an easy fix and we can clean them more." The DM also stated, "I would not want anyone to do that to my food" , in reference to serving food after handling soiled menu cards. The DM verified this was not good infection control practice because of cross contaminating going from dirty to clean and stated "its bad practice, infection, and germs." Review of facility policy titled, Food Handling, dated 2/2013 indicated staff would handle food in a manner that minimizes the risk of contamination. Ready to eat foods will not be touched with bare hands; proper utensils such as tissue, spatula, tongs, single use gloves and etc. will be used for food handling.	F 371		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		4/28/16

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	245560	A. BUILDING _____ B. WING _____	04/13/2016

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F 465	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide an environment free of odors for 1 of 41 resident rooms (room 116) reviewed for a sanitary and odor free environment. Findings include: During the initial observation of room 116 on 4/11/16, at 3:19 p.m. a strong urine odor was noted throughout the room but most prominent in the bathroom. A catheter urine collection bag placed in a plastic bin was located on the floor of the resident bathroom. The collection bag was uncovered and the tubing attached to the collection bag was lying on the floor. The urine odor was also notable outside of the room in the hallway adjacent to the room. Throughout the survey from 4/11/16 to 4/13/16 a strong urine odor was evident in the resident room, bathroom and the hallway outside of room 116. When interviewed on 4/12/16, at 1:45 p.m. the director of nursing (DON) confirmed that a strong urine odor was noted in room 116. The DON stated she was unsure of the source of the odor but that it may be due to the catheter supplies stored in the bathroom. She also verified the urine smell had been noted previously. When interviewed on 4/12/16, at 1:48 p.m. nursing assistant (NA)-A also verified a strong urine smell was notable in resident room 116. She indicated she was unsure of the source, but the room often had a urine odor.	F 465	The staff will provide a safe, functional, and sanitary environment for residents, staff and the public. Survey identified room 116, was deep cleaned on 4-28-16. This room is cleaned daily along with a deep cleaning weekly. All rooms were checked for odor. Education was provided to the nursing staff on 4-15-16, for the proper procedure of disinfecting and deodorizing catheter leg bags. Also received an order to change catheter leg bag weekly. Audits will be done two times a week for 4 weeks, then one time a month to ensure environment is odor free and sanitary. Audits will be completed by Director of Nursing Services or designee. Results of the audits will be brought to the QAPI committee for review.	

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F 465	Continued From page 10 During observation on 4/12/16, at 2:32 p.m. room 116 was still noted to smell of strong urine. At this time, a pink basin containing a graduate (tool for collecting urine from catheter bag) container was located on the bathroom floor. The graduate was noted upside down with discolored white paper towels underneath. The paper towels were dry but stained with a brown/yellow substance. During interview on 4/14/16, at 9:42 a.m. housekeeper (H)-A stated room 116 was cleaned daily, with extensive cleaning completed once weekly. H-A confirmed the urine odor in room 116, including the bathroom. Upon entering the bathroom, H-A noted the graduate container with the stained paper towels underneath and stated the stains appeared to be urine. H-A explained that nursing staff was responsible to change the bin and/or the catheter equipment as necessary.	F 465		

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	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2016**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 12, 2016. At the time of this survey, Edgebrook Care Center, Edgerton Building 01 was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.. Edgebrook Care Center, Edgerton was constructed as follows: Building 01 of Edgebrook Care Center is one-story in height, has a partial basement, and is fully sprinklered. The original building was built in 1968, with building additions in 1992 and 1997. All were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 51 at time of the survey.	K 000		

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

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

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	245560	A. BUILDING **02 - 2003 ADDITION** B. WING _____	**04/12/2016**

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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.