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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Y0J8
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 **04/13/2015** (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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Kathy Serie, Supervisor 04/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/13/2015 (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)
00

VOLUNTARY
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
03/26/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5560

April 13, 2015

Mr. Philip Samuelson, Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, Minnesota 56128

Dear Mr. Samuelson:

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

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

Effective April 7, 2015 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 about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 13, 2015

Mr. Philip Samuelson, Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, Minnesota 56128

RE: Project Number S5560024

Dear Mr. Samuelson:

On March 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 27, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On April 13, 2015, 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 February 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 7, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 27, 2015, effective April 7, 2015 and therefore remedies outlined in our letter to you dated March 10, 2015, 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. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245560	A. Building B. Wing	4/13/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**04/07/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	**04/07/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**04/07/2015**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**04/07/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	**04/07/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**04/07/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/AK	04/13/2015	03048	04/13/2015
CMS RO				

Followup to Survey Completed on: 2/27/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Y0J8
Facility ID: 00454

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

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

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

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

13.Total Certified Beds 56 (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 03/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/25/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 10, 2015

Mr. Philip Samuelson, Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, Minnesota 56128

RE: Project Number S5560024

Dear Mr. Samuelson:

On February 27, 2015, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
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 April 8, 2015, 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 May 27, 2015 (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 August 27, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING ______ B. WING ______	02/27/2015

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a dignified dining experience for 1 of 26 residents (R18) observed who required staff assistance with dining services. Findings include: On 2/24/15, at 5:18 p.m. R18 was observed seated in her wheelchair (w/c) in the dining room during the supper meal service. A nursing assistant (NA) was observed approaching the table at that time. The NA stood over R18,	F 241	All resident will have a dignified dining experience. Staff was given education on March 12 2015 on serving food to the residents in a timely manner and on interaction of staff with the residents. This education was given to the dietary department and the nursing department. Audits will be conducted 2x per week for 4 weeks, then weekly for 1 month to monitor the timeliness of meals being served and	4/7/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 03/18/2015

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 ______	02/27/2015

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 241	Continued From page 1 assisted the resident to eat a bite of applesauce, then walked away to assist other residents. At 5:20 p.m. another NA approached R18's table, sat next to R18 and assisted her with eating. On 2/26/15, at 8:10 a.m. R18 was observed being pushed in her w/c to the dining room by staff, who transported her to the assigned table. On the table there was a pre-poured glass of water, juice, and milk at the place setting in front of R18; R18 was not offered any of the fluids by the staff who transported her to the table. R18 remained seated alone at the table without staff assistance and/or interaction until 8:33 a.m. (23 minutes later) when staff transported R36 into the dining room and pushed her w/c up to R18's table. The staff who transported R36 into the dining room, approached NA-A (the only staff assisting residents with breakfast) who was loacted at an adjacent table where R18 was seated. NA-A obtained a breakfast meal for R36, helped set up her meal items and then assisted other residents located in the vicinity of the dining room. No interaction occurred with R18 nor was any fluids offered R18 when NA-A helped R36 with breakfast. At 8:56 a.m., staff assisted R19 into the dining room to the location of R18's table. NA-A approached R19 shortly after arrival and asked whether R19 preferred breakfast right away or whether her preference was to wait for her spouse; R19 chose to wait. At 9:01 a.m., NA-A finally obtained hot cereal to serve R18, who had been waiting at the table since 8:10 a.m. (51 minutes after arrival). NA-A applied a clothing protector to R18 and then offered her a drink of cranberry juice. NA-A then stood up to assist R19 (who was seated next to R18) with adjusting	F 241	the resident interaction. These audits will be completed by the dietary director or designee. Results of the audits will be brought to the QAPI (Quality Assurance Performance Improvement) committee for review. Completion date is April 7 2015.	

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F 241	Continued From page 2	F 241		

her sleeve. After handwashing was completed, NA-A continued to assist R18 with the breakfast meal. NA-A was observed talking and conversing with the other residents located at the table. NA-A provided R18 with total assistance with eating but minimal interaction occurred throughout the entire meal. It was observed during the course of the meal that NA-A held a spoonful of cereal near R18's mouth as she conversed with the other resident's located at the same table. R18 held her mouth open in anticipation of being served the food item while NA-A completed her conversation. After NA-A finished conversing, she placed the spoonful of cereal into R18's mouth.

R18's care plan with last revision noted 11/24/14, indicated: "Resident requires total assistance to eat."

When interviewed on 2/26/15, at 1:16 p.m. NA-B and NA-C stated that typically there are 3 NA's available during breakfast to assist with feeding resident in the dining room; one NA from each wing and the NA working in restorative therapy. NA-B further stated it also depends upon when the NA's on the wings get everyone up for the day as to when they would arrive in the dining room to assist.

When interviewed on 2/26/15, at 1:24 p.m. NA-A confirmed that she usually receives help with assisting residents at breakfast but didn't know what had happened today. NA-A stated she would usually assist residents on her own from 7:30 a.m. until approximately 8:30 a.m., depending upon how soon residents are gotten up for the day and when other NA's are available to help. NA-A confirmed there is usually an NA

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F 241	Continued From page 3 from each wing and from restorative to assist during breakfast. NA-A stated the residents are usually served according to when they arrive in the dining room. She confirmed that R18 had waited a long time for assistance with eating and NA-A probably should have approached nursing to request help with assisting residents. NA-A further stated due to the level of assistance R18 required, she assisted other residents first as she did not want to get up and leave R18 multiple times to assist other residents who arrived in the dining room. When interviewed on 2/26/15, at 1:50 p.m. the director of nursing service (DNS) confirmed that R18's lack of assistance with dining for an extended period of time was undignified and additional assistance should have been summoned. The facility form titled, Guidelines Open Dining dated February 2013 included: Residents are served on a first-come, first-served basis. Residents do not wait more than 10 minutes to 15 minutes to be served.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		4/7/15

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F 278	Continued From page 4 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure accuracy of the the Minimum Data Set (MDS) assessment for 1 of 1 resident (R19) reviewed for range of motion (ROM) with contractures to the 4th and 5th digits of the left hand. Findings include: On 2/24/15, at 7:02 p.m. R19 was observed seated in her recliner in her room. R19's ring and pinkie finger (4th and 5th digits) on the left hand were observed to be curled in towards the residents palm. R19 was asked if she could voluntarily straighten the the 4th and 5th digits on her left hand and she stated, "No, it hurts".	F 278	Resident 19 had her MDS modified on 3/16/15 and her care plan updated on 2/27/15 to record and addresses her limited functional mobility. To monitor other residents for this same problem, the licensed nurses will assess each resident for any limited functionalities, document the findings and update the MDS or care plan as needed. Education will be given to the nursing department on functional limitations. Random audits will be done weekly for 1 month, then monthly for 1 month. Results of the audits will be brought to the QAPI	

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F 278	Continued From page 5 R19's significant change MDS dated 2/6/15, identified R19 had no functional limitations in ROM. However, the occupational therapy (OT) progress and discharge summary dated 11/10/14 identified R19 as having left hand 4th and 5th digit contractures. When interviewed on 2/27/15, at 9:11 a.m. the MDS coordinator registered nurse (RN)-A stated she had not considered documenting the contracted 4th and 5th digits on R19's left hand as a functional limitation on the MDS. RN-A stated that with passive range of motion (PROM) the resident could get the fingers to open up. RN-A further stated that R19 was still able to use the left hand even with the 4th and 5th digits curled in and it didn't affect the use of the hand related to activities of daily living. RN-A confirmed that R19 could not extend the 4th and 5th fingers voluntarily without PROM being performed; she further confirmed that R19 would not be able to grasp an object with all fingers of the left hand which could limit her functional ability.	F 278	committee for review. The audits will be completed by DNS or designee. Completion date is April 7 2015.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		4/7/15

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F 279	Continued From page 6 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan for 1 of 3 residents (R14) reviewed for non-pressure related skin conditions. Findings include: R14's care plan dated 1/14/15, lacked any indicators of skin concerns other than the risk for irritation related to incontinence. During observation of R14 on 2/25/15, at 10:19 a.m. R14 was noted to have a scaly area the size of a pencil eraser over her left eye that extended into her left brow area. The area was not reddened but was raised and scaly and had flaking skin. The current diagnoses identified on the medical diagnosis list in medical record for R14 included: unspecified disorder of the skin and subcutaneous tissue, squamous cell carcinoma of the skin (site unspecified), dementia with behavioral disturbance, chronic kidney disease, and Alzheimer's disease. On 2/10/15, a Nurse Documentation form used to identify concerns identified R14 free of any skin	F 279	Resident 14 care plan was updated on 3/10/15 and will be seen by physician on 3/18/15. To monitor other resident for skin concerns, the licensed nurse will assess each resident for any skin conditions and document findings, and follow up with physician as necessary. Education will be given to the nursing department on skin conditions. Audits will be done weekly for 1 month, then monthly for 1 month. Results of the audits will be brought to the QAPI committee for review. The audits will be completed by the DNS or designee. Completion date is April 7 2015.	

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F 279	Continued From page 7 concerns. During review of nursing progress notes it was documented that R41's family had expressed a concern related to the area located near R14's left eye. The progress note dated 1/14/15, at 1:20 p.m. identified the plan of care was reviewed and R14's family member had contacted social services and requested that nursing staff schedule an appointment with R14's medical doctor to look at areas of irritation on her face. The family member indicated she had concerns that identified areas could possibly be facial cancer spots. The note identified nursing staff would check into R14's next 60 day appointment and if coming up, they would put the concern on the physician referral to be addressed. On 2/26/15, at 9:40 a.m. during interview with the director of nursing services (DNS) it was verified there was no documentation in the medical record to indicate the physician had followed up on the concern on 1/20/15 when R14 was seen. The DNS further verified there was no problem, goal or interventions in the care plan related to the current area on R14's forehead or her history of squamous cell carcinoma. The DNS stated it appeared staff failed to address the concern with R14's physician. The DNS further identified there was no assessment to identify the area on R14's forehead.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		4/7/15

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F 280	Continued From page 8 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the plan of care was revised for 1 of 3 residents (R36) reviewed for non-pressure related skin conditions. Findings include: R36's most recent Minimal Data Set (MDS) dated 1/13/15, indicated a Brief Interview of Mental Status (BIMS) score of 15/15, indicating intact cognition and indicated she required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, grooming and personal hygiene. The admission Initial Interdisciplinary data collection tool dated 10/28/13, indicated contractures: "trigger finger" 5th finger of R36's left hand. The care plan with a revision date of 10/16/14, indicated: (1) Focus: R36 has actual	F 280	Resident 36 care plan was updated on 2/27/15 to monitor skin, and on 3/10/15 a palm protector was received and is being worn by the resident. To monitor other resident for skin conditions or functional limitations, the licensed nurse will assess each resident for any skin conditions or functional limitations and document findings. They will follow up with physician and update care plan as necessary. Education will be given to the nursing department on skin conditions and functional limitations. Audits will be done weekly for 1 month, then monthly for 1 month by the DNS or designee. Results of the audits will be	

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F 280	Continued From page 9 impairment to skin integrity R/T (related to) fragile skin, easily bruises E/B pressure ulcers, bruising and skin tears. (2) Goal: dated 4/29/14: Resident will be free from skin injury through the review date. Revision date: 12/29/14 Goal: Resident will have no complications R/T areas of pressure through the review date. (3) Interventions include: Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Keep skin clean and dry. Use lotion on dry skin to arms, legs, hands and feet twice daily and as needed. There is no revision made in the plan of care to monitor or use padding for R36's left hand to protect the condition of the skin as the 4th finger was observed curled into the palm of the hand, causing redness. On 2/25/15, at 12:54 p.m. R36 was observed seated in her wheelchair (w/c) with her left hand resting in her lap. R36's 4th finger on her left hand was curled inward with the nail pushing against her palm. R36 used her right hand to straighten the finger on her left hand. A reddened area was observed on the skin of the left palm at the location where an indentation was evident from the fingernail. When interviewed at 12:54 p.m., R36 stated that prior to admission to the nursing home, she would tape her fingers at night so that they didn't bend and push into the palm of her hand. R36 further stated she was unaware of any treatment implemented since admission, to protect the skin. R36 demonstrated she was able to straighten the identified finger of her left hand with the use of the right hand. R36 stated it was during the night when she had increased problems with her fingers curling into the palm of her left hand but not during the day as much.	F 280	brought to the QAPI committee for review. Completion date is April 7 2015.	

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F 280	Continued From page 10 On 2/25/15, at 2:00 p.m. R36 was observed seated in the recliner located in her room. The left wrist curled inward and the fingers curled tightly into the skin on the palm of the hand. . It was noted during observation on 2/26/15, at 7:15 a.m. that R36 was resting in bed and again it was noted that the left wrist was bent inward and the fingers of her left hand curled tightly into her palm. On 2/26/15, at 8:30 a.m. R36 was observed eating breakfast with the fingers of her left hand curled into the palm. When R36 straightened the fingers of her left hand a reddened area was noted in the location where the nail of her fourth finger made an visible indentation against the skin of her palm. On 2/27/15, at 8:00 a.m. R36 was observed receiving morning cares. It was noted that a reddened area remained where the fourth finger (nail) pressed against the skin in the palm of her left hand. On 02/25/15, at 1:15 p.m. nursing assistant (NA)-R indicated she wasn't aware of any skin issue with R36's left hand or the fourth finger pressing against and into the skin on the palm of the hand. During interview on 2/27/15, at 8:45 a.m. RN-A confirmed she was aware that R36 had a "trigger finger" issue with her left hand but was uncertain whether any attempts had been made related to the resulting skin pressure issue with R36's finger. When interviewed on 2/27/15, at 9:03 a.m. NA-Q	F 280		

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F 280	Continued From page 11 stated she didn't notice the nail pushing into R36's her palm, nor any redness. During an interview on 2/27/15, at 9:52 a.m. the DNS stated she was unaware that R36 had any skin issues. On 2/27/15, at 10:20 a.m. the DNS and RN-A observed R36's left hand with the visible indentation, resulting from the fourth finger and nail pushing against her palm. RN-A asked R36 about wearing a splint to keep her hand open to protect the skin and R36 responded she would like one to use at night. The DNS and RN-A confirmed R36 is at risk for skin breakdown and weekly skin assessments are completed yet it had not been identified. The DNS and RN-A also asked R36 whether she was agreeable with clipping the nail shorter on the fourth finger of her left hand. R36 readily agreed.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary cares and services for 2 of 3 residents (R14 and R36) reviewed who had non-pressure related skin conditions.	F 309	Resident 14 care plan was updated on 3/10/15 and will be seen by physician on 3/18/15. Resident 36 care plan was updated on 2/27/15 to monitor skin, and on 3/10/15 a palm protector was received and is being worn by the resident.	4/7/15

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F 309	Continued From page 12 Findings include: During observation of R14 on 2/25/15, at 10:19 a.m. R14 was noted to have a scaly area the size of a pencil eraser over her left eye that extended into her left brow area. The area was not reddened but was raised and scaly and had flaking skin. The current diagnoses identified on the medical diagnosis list in medical record for R14 included: unspecified disorder of the skin and subcutaneous tissue, squamous cell carcinoma of the skin (site unspecified), dementia with behavioral disturbance, chronic kidney disease, and Alzheimer's disease. R14's care plan dated 1/14/15, lacked any indicators of skin concerns other than the risk for irritation related to incontinence. On 2/10/15, a Nurse Documentation form used to identify concerns identified R14 free of any skin concerns. During review of nursing progress notes it was documented that R41's family had expressed a concern related to the area located near R14's left eye. The progress note dated 1/14/15, at 1:20 p.m. identified the plan of care was reviewed and R14's family member had contacted social services and requested that nursing staff schedule an appointment with R14's medical doctor to look at areas of irritation on her face. The family member indicated she had concerns that identified areas could possibly be facial cancer spots. The note identified nursing staff would check into R14's next 60 day appointment and if coming up, they would put the concern on the physician referral to be addressed. When interviewed on 2/26/15, at 8:50 a.m. registered nurse (RN)-A stated she was not	F 309	To monitor other resident for skin conditions, the licensed nurse will assess each resident for any skin conditions and document findings. They will follow up with physician and update the plan of care as necessary. Education will be given to the nursing department on skin conditions. Audits will be done weekly for 1 month, then monthly for 1 month by the DNS or designee. Results of the audits will be brought to the QAPI committee for review. Completion date is April 7 2015.	

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F 309	Continued From page 13	F 309		

aware of the area on R14's forehead and stated the health information manager (HIM) would know more whether the area had been followed up by R14's physician.

During interview with the HIM on 2/26/15, at 9:00 a.m. it was verified R14 was seen by her physician on 1/20/14. The progress note from the physician dated 1/20/15 did not identify any follow-up related to the identified area on R14's forehead.

On 2/26/15, at 9:40 a.m. during interview with the director of nursing services (DNS) it was verified there was no documentation in the medical record to indicate the physician had followed up on the concern on 1/20/15 when R14 was seen. The DNS further verified there was no problem, goal or interventions in the care plan related to the current area on R14's forehead or her history of squamous cell carcinoma. The DNS stated it appeared staff failed to address the concern with R14's physician. The DNS further identified there was no assessment to identify the area on R14's forehead.
R36's most recent Minimal Data Set (MDS) dated 1/13/15, indicated a Brief Interview of Mental Status (BIMS) score of 15/15, indicating intact cognition and indicated she required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, grooming and personal hygiene.

On 2/25/15, at 12:54 p.m. R36 was observed seated in her wheelchair (w/c) with her left hand resting in her lap. R36's 4th finger on her left hand was curled inward with the nail pushing against her palm. R36 used her right hand to straighten the finger on her left hand. A reddened

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 ______	02/27/2015

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 309	Continued From page 14	F 309		

area was observed on the skin of the left palm at the location where an indentation was evident from the fingernail. When interviewed at 12:54 p.m. R36 stated that prior to admission to the nursing home, she would tape her fingers at night so that they didn't bend and push into the palm of her hand. R36 further stated she was unaware of any treatment implemented since admission, to protect the skin. R36 demonstrated she was able to straighten the identified finger of her left hand with the use of the right hand. R36 stated it was during the night when she had increased problems with her fingers curling into the palm of her left hand but not during the day as much.

On 2/25/15, at 2:00 p.m. R36 was observed seated in the recliner located in her room. The left wrist curled inward and the fingers curled tightly into the skin on the palm of the hand. .

It was noted during observation on 2/26/15, at 7:15 a.m. that R36 was resting in bed and again it was noted that the left wrist was bent inward and the fingers of her left hand curled tightly into her palm.

On 2/26/15, at 8:30 a.m. R36 was observed eating breakfast with the fingers of her left hand curled into the palm. When R36 straightened the fingers of her left hand a reddened area was noted in the location where the nail of her fourth finger made an visible indentation against the skin of her palm.

On 2/27/15, at 8:00 a.m. R36 was observed receiving morning cares. It was noted that a reddened area remained where the fourth finger (nail) pressed against the skin in the palm of her left hand.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING ______ B. WING ______	02/27/2015

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 309	Continued From page 15 On 02/25/15, at 1:15 p.m. nursing assistant (NA)-R indicated she wasn't aware of any skin issue with R36's left hand or the fourth finger pressing against and into the skin on the palm of the hand. During interview on 2/27/15, at 8:45 a.m. RN-A confirmed she was aware that R36 had a "trigger finger" issue with her left hand but was uncertain whether any attempts had been made related to the resulting skin pressure issue with R36's finger. When interviewed on 2/27/15, at 9:03 a.m. NA-Q stated she didn't notice the nail pushing into R36's her palm, nor any redness. During an interview on 2/27/15, at 9:52 a.m. the DNS stated she was unaware that R36 had any skin issues. On 2/27/15, at 10:20 a.m. the DNS and RN-A observed R36's left hand with the visible indentation, resulting from the fourth finger and nail pushing against her palm. RN-A asked R36 about wearing a splint to keep her hand open to protect the skin and R36 responded she would like one to use at night. The DNS and RN-A confirmed R36 is at risk for skin breakdown and weekly skin assessments are completed yet it had not been identified. The DNS and RN-A also asked R36 whether she was agreeable with clipping the nail shorter on the fourth finger of her left hand. R36 readily agreed. When the electronic and paper record was reviewed, documentation was lacking related to the R36's left hand with the fingers curled inward causing redness and pressure on the skin of her palm. The admission Initial Interdisciplinary data	F 309		

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 ______	02/27/2015

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 309	Continued From page 16 collection tool dated 10/28/13, indicated contractures: "trigger finger" 5th finger of R36's left hand and the 3rd finger of the her rt (right hand). The care plan with a revision date of 10/16/14, indicated: (1) Focus: R36 has actual impairment to skin integrity R/T (related to) fragile skin, easily bruises E/B pressure ulcers, bruising and skin tears. (2) Goal: dated 4/29/14: Resident will be free from skin injury through the review date. Revision date: 12/29/14 Goal: Resident will have no complications R/T areas of pressure through the review date. (3) Interventions include: Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Keep skin clean and dry. Use lotion on dry skin to arms, legs, hands and feet twice daily and as needed. There is no documentation to monitor or use padding for R36's left hand to reduce pressure from the 4th finger curled into the skin of the palm.	F 309		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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	F 431		4/7/15

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 ______	02/27/2015

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 431	Continued From page 17 applicable. 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. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure Tubersol solution was not available for use after the 30 day expiration date identified on the multi-dose vial for 1 of 1 nursing assistant (NA)-S who had a tuberculin skin test administered with the use of expired Tubersol solution. This has the potential to affect any resident and/or staff who required a tuberculin skin test (TST). Findings include: It was observed during review of the medication room on 2/24/15, at 2:30 p.m. that an opened vial of Tubersol solution was stored in the refrigerator and available for use. The date on the vial indicated it had been opened on 1/16/15, (39 days prior). When interviewed on 2/24/15, at 2:30 p.m. licensed practical nurse (LPN)-A	F 431	The vial of expired Tubersol solution was destroyed on 2/24/15. All other medications in carts and refrigerator were reviewed on 2/25/15 to ensure no other expired medications were present. Education was provided to nurses and TMAs to provide a date on medicines when opened and to make sure it is not expired before administering it. A weekly audit for 1 month, then monthly for 1 month will be completed by the DNS or designee to monitor expiration dates. Results of the audits will be brought to the QAPI committee for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING ______ B. WING ______	02/27/2015

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 431	Continued From page 18 indicated the Tubersol solution was to be discarded after 30 days and confirmed the last dose administered was on 2/23/15 (over the 30 day expiration date). LPN-A verified that a new vial should have been opened and accessed for the TST administered the prior day (2/23/15). When interviewed on 2/26/15, at 8:11 a.m. the director of nursing (DON) confirmed the staff who administer the TST should check the expiration date of the solution to verify it is not outdated. The DON indicated the night staff are expected to monitor the medication carts and storage areas twice weekly for outdates. She further verified the Tubersol solution administered on 2/23/15, was outdated and should have been discarded. She indicated a follow up with NA-S who received the outdated medication would be contacted. The Tubersol package directions read: Tubersol which is entered and in use for 30 days should be discarded.	F 431	Completion date is April 7 2015.	

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

F5560023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 26, 2015. 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 56 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.

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

F5560023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING **02 - 2003 ADDITION** B. WING ______	**02/26/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 26, 2015. At the time of this survey, Edgebrook Care Center Building 2, Edgerton 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 18 New Health Care Occupancies.. Edgebrook Care Center, Edgerton was constructed as follows: Building 02 of Edgebrook Care Center consists of the 2003 building addition, which includes a kitchen, meeting room and offices. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. 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 56 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.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
March 10, 2015

Mr. Philip Samuelson, Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, Minnesota 56128

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5560024

Dear Mr. Samuelson:

The above facility was surveyed on February 24, 2015 through February 27, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie at (507) 476-4233.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00454	A. BUILDING: ______ B. WING ______	02/27/2015

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00454	A. BUILDING: ______ B. WING ______	02/27/2015

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) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/24/15-2/27/15 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00454	A. BUILDING: ______ B. WING ______	02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan for 1 of 3 residents (R14) reviewed for non-pressure related skin conditions. Findings include: During observation of R14 on 2/25/15, at 10:19 a.m. R14 was noted to have a scaly area the size of a pencil eraser over her left eye that extended into her left brow area. The area was not reddened but was raised and scaly and had	2 555	Corrected	4/7/15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00454	A. BUILDING: ________ B. WING ________	02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
2 555	Continued From page 3 flaking skin. The current diagnoses identified on the medical diagnosis list in medical record for R14 included: unspecified disorder of the skin and subcutaneous tissue, squamous cell carcinoma of the skin (site unspecified), dementia with behavioral disturbance, chronic kidney disease, and Alzheimer's disease. R14's care plan dated 1/14/15, lacked any indicators of skin concerns other than the risk for irritation related to incontinence. On 2/10/15, a Nurse Documentation form used to identify concerns identified R14 free of any skin concerns. During review of nursing progress notes it was documented that R41's family had expressed a concern related to the area located near R14's left eye. The progress note dated 1/14/15, at 1:20 p.m. identified the plan of care was reviewed and R14's family member had contacted social services and requested that nursing staff schedule an appointment with R14's medical doctor to look at areas of irritation on her face. The family member indicated she had concerns that identified areas could possibly be facial cancer spots. The note identified nursing staff would check into R14's next 60 day appointment and if coming up, they would put the concern on the physician referral to be addressed. On 2/26/15, at 9:40 a.m. during interview with the director of nursing services (DNS) it was verified there was no documentation in the medical record to indicate the physician had followed up on the concern on 1/20/15 when R14 was seen. The DNS further verified there was no problem, goal or interventions in the care plan related to the current area on R14's forehead or her history of squamous cell carcinoma. The DNS stated it appeared staff failed to address the concern with	2 555		

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2 555	Continued From page 4 R14's physician. The DNS further identified there was no assessment to identify the area on R14's forehead. SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for resident care plan development for skin monitoring for non-pressure related skin conditions. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 555		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the plan of care was revised for 1 of 3 residents (R36) reviewed for non-pressure related skin conditions.	2 570	Corrected	4/7/15

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2 570	Continued From page 5	2 570		

Findings include:

R36's most recent Minimal Data Set (MDS) dated 1/13/15, indicated a Brief Interview of Mental Status (BIMS) score of 15/15, indicating intact cognition and indicated she required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, grooming and personal hygiene.

The admission Initial Interdisciplinary data collection tool dated 10/28/13, indicated contractures: "trigger finger" 5th finger of R36's left hand. The care plan with a revision date of 10/16/14, indicated: (1) Focus: R36 has actual impairment to skin integrity R/T (related to) fragile skin, easily bruises E/B pressure ulcers, bruising and skin tears. (2) Goal: dated 4/29/14: Resident will be free from skin injury through the review date. Revision date: 12/29/14 Goal: Resident will have no complications R/T areas of pressure through the review date. (3) Interventions include: Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Keep skin clean and dry. Use lotion on dry skin to arms, legs, hands and feet twice daily and as needed. There is no revision made in the plan of care to monitor or use padding for R36's left hand to protect the condition of the skin as the 4th finger was observed curled into the palm of the hand, causing redness.

On 2/25/15, at 12:54 p.m. R36 was observed seated in her wheelchair (w/c) with her left hand resting in her lap. R36's 4th finger on her left hand was curled inward with the nail pushing against her palm. R36 used her right hand to straighten the finger on her left hand. A reddened

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2 570	Continued From page 6	2 570		

area was observed on the skin of the left palm at the location where an indentation was evident from the fingernail. When interviewed at 12:54 p.m., R36 stated that prior to admission to the nursing home, she would tape her fingers at night so that they didn't bend and push into the palm of her hand. R36 further stated she was unaware of any treatment implemented since admission, to protect the skin. R36 demonstrated she was able to straighten the identified finger of her left hand with the use of the right hand. R36 stated it was during the night when she had increased problems with her fingers curling into the palm of her left hand but not during the day as much.

On 2/25/15, at 2:00 p.m. R36 was observed seated in the recliner located in her room. The left wrist curled inward and the fingers curled tightly into the skin on the palm of the hand. .

It was noted during observation on 2/26/15, at 7:15 a.m. that R36 was resting in bed and again it was noted that the left wrist was bent inward and the fingers of her left hand curled tightly into her palm.

On 2/26/15, at 8:30 a.m. R36 was observed eating breakfast with the fingers of her left hand curled into the palm. When R36 straightened the fingers of her left hand a reddened area was noted in the location where the nail of her fourth finger made an visible indentation against the skin of her palm.

On 2/27/15, at 8:00 a.m. R36 was observed receiving morning cares. It was noted that a reddened area remained where the fourth finger (nail) pressed against the skin in the palm of her left hand.

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2 570	Continued From page 7	2 570		

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On 02/25/15, at 1:15 p.m. nursing assistant (NA)-R indicated she wasn't aware of any skin issue with R36's left hand or the fourth finger pressing against and into the skin on the palm of the hand.

During interview on 2/27/15, at 8:45 a.m. RN-A confirmed she was aware that R36 had a "trigger finger" issue with her left hand but was uncertain whether any attempts had been made related to the resulting skin pressure issue with R36's finger.

When interviewed on 2/27/15, at 9:03 a.m. NA-Q stated she didn't notice the nail pushing into R36's her palm, nor any redness.

During an interview on 2/27/15, at 9:52 a.m. the DNS stated she was unaware that R36 had any skin issues. On 2/27/15, at 10:20 a.m. the DNS and RN-A observed R36's left hand with the visible indentation, resulting from the fourth finger and nail pushing against her palm. RN-A asked R36 about wearing a splint to keep her hand open to protect the skin and R36 responded she would like one to use at night. The DNS and RN-A confirmed R36 is at risk for skin breakdown and weekly skin assessments are completed yet it had not been identified. The DNS and RN-A also asked R36 whether she was agreeable with clipping the nail shorter on the fourth finger of her left hand. R36 readily agreed.

SUGGESTED METHOD OF CORRECTION:
The DON or designee could review any policies, procedures or facility processes for resident care plan development for skin monitoring for non-pressure related skin conditions and make necessary revisions to facility paperwork. Appropriate staff could be educated regarding

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2 570	Continued From page 8 any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary cares and services for 2 of 3 residents (R14 and R36) reviewed who had non-pressure related skin conditions. Findings include: During observation of R14 on 2/25/15, at 10:19 a.m. R14 was noted to have a scaly area the size of a pencil eraser over her left eye that extended into her left brow area. The area was not reddened but was raised and scaly and had	2 830	Corrected	4/7/15

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2 830	Continued From page 9	2 830		

flaking skin.
The current diagnoses identified on the medical diagnosis list in medical record for R14 included: unspecified disorder of the skin and subcutaneous tissue, squamous cell carcinoma of the skin (site unspecified), dementia with behavioral disturbance, chronic kidney disease, and Alzheimer's disease.
R14's care plan dated 1/14/15, lacked any indicators of skin concerns other than the risk for irritation related to incontinence.
On 2/10/15, a Nurse Documentation form used to identify concerns identified R14 free of any skin concerns.
During review of nursing progress notes it was documented that R41's family had expressed a concern related to the area located near R14's left eye. The progress note dated 1/14/15, at 1:20 p.m. identified the plan of care was reviewed and R14's family member had contacted social services and requested that nursing staff schedule an appointment with R14's medical doctor to look at areas of irritation on her face. The family member indicated she had concerns that identified areas could possibly be facial cancer spots. The note identified nursing staff would check into R14's next 60 day appointment and if coming up, they would put the concern on the physician referral to be addressed.

When interviewed on 2/26/15, at 8:50 a.m. registered nurse (RN)-A stated she was not aware of the area on R14's forehead and stated the health information manager (HIM) would know more whether the area had been followed up by R14's physician.

During interview with the HIM on 2/26/15, at 9:00 a.m. it was verified R14 was seen by her physician on 1/20/14. The progress note from the

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2 830		2 830		

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physician dated 1/20/15 did not identify any follow-up related to the identified area on R14's forehead.

On 2/26/15, at 9:40 a.m. during interview with the director of nursing services (DNS) it was verified there was no documentation in the medical record to indicate the physician had followed up on the concern on 1/20/15 when R14 was seen. The DNS further verified there was no problem, goal or interventions in the care plan related to the current area on R14's forehead or her history of squamous cell carcinoma. The DNS stated it appeared staff failed to address the concern with R14's physician. The DNS further identified there was no assessment related to the identified area on R14's face.

R36's most recent Minimal Data Set (MDS) dated 1/13/15, indicated a Brief Interview of Mental Status (BIMS) score of 15/15, indicating intact cognition and indicated she required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, grooming and personal hygiene.

On 2/25/15, at 12:54 p.m. R36 was observed seated in her wheelchair (w/c) with her left hand resting in her lap. R36's 4th finger on her left hand was curled inward with the nail pushing against her palm. R36 used her right hand to straighten the finger on her left hand. A reddened area was observed on the skin of the left palm at the location where an indentation was evident from the fingernail. When interviewed at 12:54 p.m. R36 stated that prior to admission to the nursing home, she would tape her fingers at night so that they didn't bend and push into the palm of her hand. R36 further stated she was unaware of any treatment implemented since admission, to

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2 830	Continued From page 11	2 830		

protect the skin. R36 demonstrated she was able to straighten the identified finger of her left hand with the use of the right hand. R36 stated it was during the night when she had increased problems with her fingers curling into the palm of her left hand but not during the day as much.

On 2/25/15, at 2:00 p.m. R36 was observed seated in the recliner located in her room. The left wrist curled inward and the fingers curled tightly into the skin on the palm of the hand. .

It was noted during observation on 2/26/15, at 7:15 a.m. that R36 was resting in bed and again it was noted that the left wrist was bent inward and the fingers of her left hand curled tightly into her palm.

On 2/26/15, at 8:30 a.m. R36 was observed eating breakfast with the fingers of her left hand curled into the palm. When R36 straightened the fingers of her left hand a reddened area was noted in the location where the nail of her fourth finger made an visible indentation against the skin of her palm.

On 2/27/15, at 8:00 a.m. R36 was observed receiving morning cares. It was noted that a reddened area remained where the fourth finger (nail) pressed against the skin in the palm of her left hand.

On 02/25/15, at 1:15 p.m. nursing assistant (NA)-R indicated she wasn't aware of any skin issue with R36's left hand or the fourth finger pressing against and into the skin on the palm of the hand.

During interview on 2/27/15, at 8:45 a.m. RN-A confirmed she was aware that R36 had a "trigger

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2 830	Continued From page 12	2 830		

finger" issue with her left hand but was uncertain whether any attempts had been made related to the resulting skin pressure issue with R36's finger.

When interviewed on 2/27/15, at 9:03 a.m. NA-Q stated she didn't notice the nail pushing into R36's her palm, nor any redness.

During an interview on 2/27/15, at 9:52 a.m. the DNS stated she was unaware that R36 had any skin issues. On 2/27/15, at 10:20 a.m. the DNS and RN-A observed R36's left hand with the visible indentation, resulting from the fourth finger and nail pushing against her palm. RN-A asked R36 about wearing a splint to keep her hand open to protect the skin and R36 responded she would like one to use at night. The DNS and RN-A confirmed R36 is at risk for skin breakdown and weekly skin assessments are completed yet it had not been identified. The DNS and RN-A also asked R36 whether she was agreeable with clipping the nail shorter on the fourth finger of her left hand. R36 readily agreed.

When the electronic and paper record was reviewed, documentation was lacking related to the R36's left hand with the fingers curled inward causing redness and pressure on the skin of her palm. The admission Initial Interdisciplinary data collection tool dated 10/28/13, indicated contractures: "trigger finger" 5th finger of R36's left hand and the 3rd finger of the her rt (right hand). The care plan with a revision date of 10/16/14, indicated: (1) Focus: R36 has actual impairment to skin integrity R/T (related to) fragile skin, easily bruises E/B pressure ulcers, bruising and skin tears. (2) Goal: dated 4/29/14: Resident will be free from skin injury through the review date. Revision date: 12/29/14 Goal:

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2 830	Continued From page 13 Resident will have no complications R/T areas of pressure through the review date. (3) Interventions include: Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Keep skin clean and dry. Use lotion on dry skin to arms, legs, hands and feet twice daily and as needed. There is no documentation to monitor or use padding for R36's left hand to reduce pressure from the 4th finger curled into the skin of the palm. SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for resident skin monitoring for non-pressure related skin conditions and make necessary revisions to facility paperwork. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a dignified	21805	Corrected	4/7/15

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dining experience for 1 of 26 residents (R18) observed who required staff assistance with dining services.

Findings include:

On 2/24/15, at 5:18 p.m. R18 was observed seated in her wheelchair (w/c) in the dining room during the supper meal service. A nursing assistant (NA) was observed approaching the table at that time. The NA stood over R18, assisted the resident to eat a bite of applesauce, then walked away to assist other residents. At 5:20 p.m. another NA approached R18's table, sat next to R18 and assisted her with eating.

On 2/26/15, at 8:10 a.m. R18 was observed being pushed in her w/c to the dining room by staff, who transported her to the assigned table. On the table there was a pre-poured glass of water, juice, and milk at the place setting in front of R18; R18 was not offered any of the fluids by the staff who transported her to the table. R18 remained seated alone at the table without staff assistance and/or interaction until 8:33 a.m. (23 minutes later) when staff transported R36 into the dining room and pushed her w/c up to R18's table. The staff who transported R36 into the dining room, approached NA-A (the only staff assisting residents with breakfast) who was loacted at an adjacent table where R18 was seated. NA-A obtained a breakfast meal for R36, helped set up her meal items and then assisted other residents located in the vicinity of the dining room. No interaction occurred with R18 nor was any fluids offered R18 when NA-A helped R36 with breakfast.

At 8:56 a.m., staff assisted R19 into the dining room to the location of R18's table. NA-A

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approached R19 shortly after arrival and asked whether R19 preferred breakfast right away or whether her preference was to wait for her spouse; R19 chose to wait. At 9:01 a.m., NA-A finally obtained hot cereal to serve R18, who had been waiting at the table since 8:10 a.m. (51 minutes after arrival). NA-A applied a clothing protector to R18 and then offered her a drink of cranberry juice. NA-A then stood up to assist R19 (who was seated next to R18) with adjusting her sleeve. After handwashing was completed, NA-A continued to assist R18 with the breakfast meal. NA-A was observed talking and conversing with the other residents located at the table. NA-A provided R18 with total assistance with eating but minimal interaction occurred throughout the entire meal. It was observed during the course of the meal that NA-A held a spoonful of cereal near R18's mouth as she conversed with the other resident's located at the same table. R18 held her mouth open in anticipation of being served the food item while NA-A completed her conversation. After NA-A finished conversing, she placed the spoonful of cereal into R18's mouth.

R18's care plan with last revision noted 11/24/14, indicated: "Resident requires total assistance to eat."

When interviewed on 2/26/15, at 1:16 p.m. NA-B and NA-C stated that typically there are 3 NA's available during breakfast to assist with feeding resident in the dining room; one NA from each wing and the NA working in restorative therapy. NA-B further stated it also depends upon when the NA's on the wings get everyone up for the day as to when they would arrive in the dining room to assist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00454	A. BUILDING: ______ B. WING ______	02/27/2015

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) COMPLETE DATE
21805	Continued From page 16	21805		

Continued From page 16

When interviewed on 2/26/15, at 1:24 p.m. NA-A confirmed that she usually receives help with assisting residents at breakfast but didn't know what had happened today. NA-A stated she would usually assist residents on her own from 7:30 a.m. until approximately 8:30 a.m., depending upon how soon residents are gotten up for the day and when other NA's are available to help. NA-A confirmed there is usually an NA from each wing and from restorative to assist during breakfast. NA-A stated the residents are usually served according to when they arrive in the dining room. She confirmed that R18 had waited a long time for assistance with eating and NA-A probably should have approached nursing to request help with assisting residents. NA-A further stated due to the level of assistance R18 required, she assisted other residents first as she did not want to get up and leave R18 multiple times to assist other residents who arrived in the dining room.

When interviewed on 2/26/15, at 1:50 p.m. the director of nursing service (DNS) confirmed that R18's lack of assistance with dining for an extended period of time was undignified and additional assistance should have been summoned.

The facility form titled, Guidelines Open Dining dated February 2013 included:
Residents are served on a first-come, first-served basis.
Residents do not wait more than 10 minutes to 15 minutes to be served. .

SUGGESTED METHOD OF CORRECTION:
The director of nursing service could monitor the dining room to ensure that staff is available to assist with the breakfast meal as the residents

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21805	Continued From page 17 arrive at the location. A reassignment of duties could be implemented based on the results of the audit. She could inservice staff regarding a dignified meal service. Dining room audits could be conducted to ensure all residents are provided a dignified dining experience and the results could be reported to the quality assurance committee for review and recommendation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		