#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y0J8 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00454 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) EDGEBROOK CARE CENTER (L1)245560 1. Initial 2. Recertification (L4) 505 TROSKY ROAD WEST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 56128 767842800 (L2)(L5) EDGERTON, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 02 7. PROVIDER/SUPPLIER CATEGORY 8. Full Survey After Complaint (1.9)13 PTIP 01 Hospital **05 HHA** 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 04/13/2015 (L34) 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: \_\_ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) (L18)\_1. Acceptable POC 8. Patient Room Size 56 5. Life Safety Code \_\_\_ 9. Beds/Room Not in Compliance with Program (L17) 13. Total Certified Beds 56 Requirements and/or Applied Waivers: (L12)\* Code: A\* 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)56 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: Date: Kathy Serie, Supervisor Anne Kleppe, Enforcement Specialist 04/13/2015 04/13/2015<sub>(L20)</sub> (L19) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: \_\_\_\_ 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 06/01/1991 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24) (L25) (1.41)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00140 (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

**DETERMINATION APPROVAL** 

03/26/2015

(L32)



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,

Are Klagge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulation Division

Minnesota Department of Health Email: <a href="mailto:anne.kleppe@state.mn.us">anne.kleppe@state.mn.us</a>

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,

Dire Klegge

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

### 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 245560	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(	(5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5) I	Date
		Correction				Correction					Correction
ID Prefix	F0241	Completed 04/07/2015	ID Prefix	F0278		Completed <b>04/07/2015</b>		ID Prefix	F0279		Completed <b>04/07/2015</b>
	483.15(a)			483.20(g) - (j)					483.20(d), 483		_
LSC			LSC					LSC			=
		Correction				Correction					Correction
ID D ('	<b>5000</b>	Completed	ID D "	<b>5000</b>		Completed		ID D ("	<b>E</b> 0404		Completed
ID Prefix		04/07/2015	ID Prefix			04/07/2015		ID Prefix		(-)	_04/07/2015
Heg. # LSC	483.20(d)(3), 483.10(l	<u>()(</u> 2)	Heg. #	483.25				Reg. # LSC	483.60(b), (d)	, (e)	_
		Correction				Correction					Correction
ID Prefix		Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #											_
			LSC					LSC			_
		Correction				Correction					Correction
ID Prefix		Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #			Reg. #								
LSC		_	LSC					LSC			<del>-</del> -
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix		_	ID Prefix			·		ID Prefix			=
Reg. #			Reg. #					Reg. #			=
LSC			LSC					LSC			
Reviewed E	By Review	ed By	Date:	Signature	of Sur	veyor:	,			Date:	
State Agen	cy KS/A	K	04/13/20	15				03	048	04/13	3/2015
	By Review	ed By	Date:	Signature	of Sur	veyor:				Date:	
CMS RO											
Followup t	o Survey Completed	on:		Check for any					Summary of the Facility?		
	2/27/2015			Uncorrecte	u Della	Jencies (CIV	13-230	n) Sent to	ine racility?	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

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	(L6) <b>56128</b>	4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 767842800  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	(L5) EDGERTON, MN         7. PROVIDER/SUPPLIER CATEGORY         01 Hospital       05 HHA       09 ESI         02 SNF/NF/Dual       06 PRTF       10 NF         03 SNF/NF/Distinct       07 X-Ray       11 ICH         04 SNF       08 OPT/SP       12 RH	02 (L7)   RD   13 PTIP   22 CLIA   14 CORF   F/IID   15 ASC	5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)  12/31
11LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  56 (L18)  13.Total Certified Beds	10.THE FACILITY IS CERTIFIED AS:  A. In Compliance With  Program Requirements  Compliance Based On:	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF 56 (L37) (L38) (L39)	ICF IID (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICATION OF LIGHT II - TO BE  17. SURVEYOR SIGNATURE  PART II - TO BE  19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	Date:  03/20/2015 (L19  COMPLETED BY HCFA REGION  20. COMPLIANCE WITH CIVIL RIGHTS ACT:	NAL OFFICE OR SINGLE S  21. 1. Statement of Final	Enforcement Specialist 03/25/2015 (L20)  TATE AGENCY  ncial Solvency (HCFA-2572)  ol Interest Disclosure Stmt (HCFA-1513)
A. Suspension (L27) B. Rescind S		26. TERMINATION ACTION:  VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	INVOLUNTARY  05-Fail to Meet Health/Safety  ement  06-Fail to Meet Agreement
(L28)  31. RO RECEIPT OF CMS-1539  (L32)	00140 (L31 2. DETERMINATION OF APPROVAL DATE (L33		ROVAL



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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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 <u>Kathryn.serie@state.mn.us</u> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

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

PRINTED: 03/20/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		245560	B. WING _		02/27/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	OULD BE COMPLÉTION
F 000	as your allegation of	of correction (POC) will serve f compliance upon the	F 00	00	
	enrolled in ePOC, y at the bottom of the	otance. Because you are rour signature is not required first page of the CMS-2567 nic submission of the POC will ion of compliance.			
F 241 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with	F 24	41	4/7/15
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observatoreview the facility facili	ion, interview, and document alled to provide a dignified or 1 of 26 residents (R18) ired staff assistance with  p.m. R18 was observed lichair (w/c) in the dining room neal service. A nursing observed approaching the The NA stood over R18,		All resident will have a dignified experience.  Staff was given education on Ma 2015 on serving food to the resitimely manner and on interaction with the residents. This education given to the dietary department nursing department.  Audits will be conducted 2x per weeks, then weekly for 1 months the timeliness of meals being services.	arch 12 idents in a n of staff on was and the week for 4 to monitor
ABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	(X6) DATE

**Electronically Signed** 

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) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245560	B. WING			02/2	27/2015
AND PLAN OF CORRECTION  PASSESSED STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 241  Continued From page 1  assisted the resident to eat a bite of applesaud then walked away to assist other residents. A 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 be pushed in her w/c to the dining room by staff, a 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 was not offered any of the fluids by the st who transported her to the table. R18 remains seated alone at the table without staff assistar 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. I staff who transported R36 into the dining room approached NA-A ( the only staff assisting residents with breakfast) who was loacted at a adjacent table where R18 was seated. NA-A obtained a breakfast meal for R36, helped set her meal items and then assisted other reside located in the vicinity of the dining room. No interaction occurred with R18 nor was any fluid offered R18 when NA-A helped R36 with breakfast.				5	STREET ADDRESS, CITY, STATE, ZIP CODE 105 TROSKY ROAD WEST EDGERTON, MN 56128		
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241	assisted the resider then walked away to 5:20 p.m. another Nosat next to R18 and On 2/26/15, at 8:10 pushed in her w/c to transported her to to table there was a pijuice, and milk at the R18 was not offered who transported he seated alone at the and/or interaction ulater) when staff transported now and pushed his staff who transported approached NA-A (residents with breal adjacent table when obtained a breakfasther meal items and located in the viciniti interaction occurred offered R18 when Noreakfast.  At 8:56 a.m., staff room to the location approached R19 shwhether R19 prefer whether her prefere spouse; R19 chose finally obtained hot been waiting at the minutes after arrival protector to R18 and cranberry juice.	nt to eat a bite of applesauce, or assist other residents. At JA approached R18's table, assisted her with eating.  a.m. R18 was observed being to the dining room by staff, who he assigned table. On the re-poured glass of water, e place setting in front of R18; drany of the fluids by the staff or to the table. R18 remained table without staff assistance intil 8:33 a.m. (23 minutes insported R36 into the dining iter w/c up to R18's table. The red R36 into the dining room, the only staff assisting staff was seated. NA-A at meal for R36, helped set up then assisted other residents by of the dining room. No di with R18 nor was any fluids	F 2	241	the resident interaction. These and be completed by the dietary director designee. Results of the audits will brought to the QAPI (Quality Assur Performance Improvement) common review.  Completion date is April 7 2015.	or or be ance	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245560	B. WING _		02	/27/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	NA-A continued to meal. NA-A was of with the other resid NA-A provided R18 eating but minimal throughout the entitiduring the course of spoonful of cereal reconversed with the same table. R18 hanticipation of being NA-A completed he finished conversing cereal into R18's manual R18's care plan with indicated: "Resident eat."  When interviewed and NA-C stated the available during bre resident in the dining wing and the NA wo NA-B further stated the NA's on the wing as to when they wo assist.  When interviewed a confirmed that she assisting residents what had happened would usually assist 7:30 a.m. until approdepending upon houp for the day and work in the day	andwashing was completed, assist R18 with the breakfast oserved talking and conversing ents located at the table. With total assistance with interaction occurred re meal. It was observed of the meal that NA-A held a near R18's mouth as she other resident's located at the eld her mouth open in g served the food item while er conversation. After NA-A is, she placed the spoonful of	F 24	.1		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	2) MULTIPLE CONSTRUCTION BUILDING		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241 F 278 SS=D	during breakfast. Nusually served according the dining room. Si waited a long time if NA-A probably shout to request help with further stated due to required, she assist did not want to get times to assist other dining room.  When interviewed director of nursing is R18's lack of assist extended period of additional assistance summoned.  The facility form title dated February 201 Residents are served basis.  Residents do not with minutes to be served 483.20(g) - (j) ASSI ACCURACY/COOF.	If from restorative to assist IA-A stated the residents are ording to when they arrive in the confirmed that R18 had for assistance with eating and all have approached nursing assisting residents. NA-A to the level of assistance R18 ted other residents first as she tup and leave R18 multiple ar residents who arrived in the service (DNS) confirmed that ance with dining for an time was undignified and the should have been sed, Guidelines Open Dining 3 included: and a first-come, first-served at more than 10 minutes to 15 and.	F 24			4/7/15
	each assessment v participation of hea	vith the appropriate Ith professionals.  must sign and certify that the				
						<b> </b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245560	B. WING		02/27/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION	
F 278	assessment must see that portion of the auxiliary and knowing false statement in a subject to a civil most \$1,000 for each asswillfully and knowing to certify a material resident assessment penalty of not more assessment.	o completes a portion of the sign and certify the accuracy of issessment.  d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each	F 278			
	by: Based on observative review the facility fathe Minimum Data of 1 resident (R19) (ROM) with contract of the left hand.  Findings include: On 2/24/15, at 7:02 seated in her reclin pinkie finger (4th ar were observed to be residents palm. R1 voluntarily straighter	NT is not met as evidenced tion, interview, and document alled to ensure accuracy of the Set (MDS) assessment for 1 reviewed for range of motion stures to the 4th and 5th digits  p.m. R19 was observed er in her room. R19's ring and and 5th digits) on the left hand e curled in towards the 9 was asked if she could in the the 4th and 5th digits on the stated, "No, it hurts".		Resident 19 had her MDS modifie 3/16/15 and her care plan updated 2/27/15 to record and addresses he limited functional mobility.  To monitor other residents for this sproblem, the licensed nurses will a each resident for any limited functionalities, document the findin update the MDS or care plan as need to be a support of the nursidepartment on functional limitations. Random audits will be done weekly month, then monthly for 1 month. For the audits will be brought to the support of the support	on er same ssess gs and eded. ng s. ofor 1 Results	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245560	B. WING		02/	27/2015
	PROVIDER OR SUPPLIER		Ę	STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279 SS=D	R19's significant chidentified R19 had in ROM. However, the progress and dischidentified R19 as had digit contractures.  When interviewed of MDS coordinator respond to the had not conside contracted 4th and as a functional limit stated that with pass the resident could of RN-A further stated the left hand even we curled in and it didirelated to activities confirmed that R19 5th fingers voluntar performed; she furt not be able to grass the left hand which ability.  483.20(d), 483.	ange MDS dated 2/6/15, no functional limitations in e occupational therapy (OT) arge summary dated 11/10/14 aving left hand 4th and 5th on 2/27/15, at 9:11 a.m. the egistered nurse (RN)-A stated ered documenting the 5th digits on R19's left hand ation on the MDS. RN-A sive range of motion (PROM) get the fingers to open up. that R19 was still able to use with the 4th and 5th digits of daily living. RN-A could not extend the 4th and ily without PROM being her confirmed that R19 would of an object with all fingers of could limit her functional and revise the resident's	F 278	committee for review. The audits we completed by DNS or designee.  Completion date is April 7 2015.	ill be	4/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245560	B. WING			02/2	27/2015
	PROVIDER OR SUPPLIER	1		50	REET ADDRESS, CITY, STATE, ZIP CODE 5 TROSKY ROAD WEST DGERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	The care plan mus to be furnished to a highest practicable psychosocial well-k §483.25; and any significant be required under a due to the resident §483.10, including under §483.10(b)(a). This REQUIREME by:  Based on observative care with a facility facomprehensive care (R14) reviewed for conditions.  Findings include:  R14's care plan daindicators of skin critication related to During observation a.m. R14 was note of a pencil eraser of into her left brow a reddened but was flaking skin.  The current diagnod diagnosis list in me unspecified disorders subcutaneous tissuof the skin (site unsbehavioral disturbation and Alzheimer's diagno 2/10/15, a Nursignification and subcutaneous tissuon 2/10/15, a Nursignificant skin (site unsbehavioral disturbation and Alzheimer's diagno 2/10/15, a Nursignificant skin (site unsbehavioral disturbation and Alzheimer's diagno 2/10/15, a Nursignificant skin (site unsbehavioral disturbation and Alzheimer's diagnosis list in me unspecified disorders and Alzheimer's diagnosis list in me unspecified d	at describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise \$483.25 but are not provided its exercise of rights under the right to refuse treatment it).  NT is not met as evidenced ition, interview and document ailed to develop a re plan for 1 of 3 residents non-pressure related skin ited 1/14/15, lacked any oncerns other than the risk for incontinence.  of R14 on 2/25/15, at 10:19 d to have a scaly area the size over her left eye that extended rea. The area was not raised and scaly and had sees identified on the medical edical record for R14 included: er of the skin and use, squamous cell carcinoma specified), dementia with unce, chronic kidney disease,	F 2	279	Resident 14 care plan was updated 3/10/15 and will be seen by physicia 3/18/15.  To monitor other resident for skin concerns, the licensed nurse will as each resident for any skin conditions 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 monthen monthly for 1 month. Results of audits will be brought to the QAPI committee for review. The audits with completed by the DNS or designee.  Completion date is April 7 2015.	sess s and th	

				(X3) DATE SURVEY COMPLETED		
		245560	B. WING _		02/	27/2015
	PREFIX TAG    CAN   ID PREFIX TAG     CAN   ID PREFIX TAG     CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    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 p.m. identified the plan of care was reviewed a 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 concern that identified areas could possibly be facial cancer spots. The note identified nursing staff would check into R14's next 60 day appointmen and if coming up, they would put the concern of 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 ure 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 is appeared staff failed to address the concern we R14's physician. The DNS further identified the was no assessment to identify the area on R14 forehead.    F 280   483.20(d)(3), 483.10(k)(2) RIGHT TO			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	•	
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 279	concerns. During review of nu documented that R concern related to the left eye. The progrep.m. identified the pR14's family members services and requeschedule an appoint doctor to look at are that identified areas cancer spots. The rewould check into R and if coming up, the physician referron the progression of the concern on the DNS further very goal or intervention the current area on of squamous cell cappeared staff faile R14's physician. The was no assessment.	rsing progress notes it was 41's family had expressed a he area located near R14's as note dated 1/14/15, at 1:20 plan of care was reviewed and er had contacted social sted that nursing staff atment with R14's medical eas of irritation on her face. Indicated she had concerns a could possibly be facial note identified nursing staff 14's next 60 day appointment new would put the concern on all to be addressed.  a.m. during interview with the services (DNS) it was verified mentation in the medical ne physician had followed up 1/20/15 when R14 was seen. In the care plan related to R14's forehead or her history arcinoma. The DNS stated it d to address the concern with the DNS further identified there	F 21	79		
F 280 SS=D	483.20(d)(3), 483.1 PARTICIPATE PLA	NNING CARE-REVISE CP e right, unless adjudged	F 28	30		4/7/15
	incapacitated under	r the laws of the State, to ng care and treatment or				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (	(X3) DATE SURVEY COMPLETED	
		245560	B. WING			02/2	7/2015
	PROVIDER OR SUPPLIER	1		50	TREET ADDRESS, CITY, STATE, ZIP CODE 05 TROSKY ROAD WEST DGERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)		х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	within 7 days after comprehensive assinterdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent pathe resident, the re- legal representative	age 8 care plan must be developed the completion of the sessment; prepared by an am, that includes the attending ered nurse with responsibility d other appropriate staff in rmined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 2	280			
	by: Based on observa review the facility fa was revised for 1 of for non-pressure re Findings include: R36's most recent 1/13/15, indicated a Status (BIMS) scor cognition and indicassistance with bed locomotion on the opersonal hygiene. The admission Initi collection tool date contractures: "trigg left hand. The care	tion, interview and document ailed to ensure the plan of care f 3 residents (R36) reviewed elated skin conditions.  Minimal Data Set (MDS) dated a Brief Interview of Mental re of 15/15, indicating intact ated she required extensive d mobility, transfers, unit, dressing, grooming and al Interdisciplinary data d 10/28/13, indicated ger finger" 5th finger of R36's e plan with a revision date of l: (1) Focus: R36 has actual			Resident 36 care plan was updated 2/27/15 to monitor skin, and on 3/10 palm protector was received and is k 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. 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 monthen monthly for 1 month by the DNS designee. Results of the audits will be	/15 a peing he dent They ate g	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245560	B. WING		02/2	27/2015
	PROVIDER OR SUPPLIER ROOK CARE CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	impairment to skin skin, easily bruises and skin tears. (2) Resident will be fre review date. Revision Resident will have a pressure through the Interventions included transfers and bed in arms, legs and han surface. Keep skindry skin to arms, lega and as needed. The plan of care to more left hand to protect 4th finger was obset the hand, causing in her lap. In the straighten the finger area was observed the location where a from the fingernail. p.m., R36 stated the nursing home, she so that they didn't be her hand. R36 furtly any treatment imple protect the skin. Rable to straighten the hand with the use of was during the night problems with her face in the skin. Rable to straighten the hand with the use of was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems with her face in the skin was during the night problems.	integrity R/T (related to) fragile E/B pressure ulcers, bruising Goal: dated 4/29/14: e from skin injury through the on date: 12/29/14 Goal: no complications R/T areas of the review date. (3) le: Use caution during mobility to prevent striking ds against any sharp or hard clean and dry. Use lotion on gs, hands and feet twice daily there is no revision made in the litor or use padding for R36's the condition of the skin as the erved curled into the palm of	F 280	brought to the QAPI committee for Completion date is April 7 2015.	review.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	` '	E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	On 2/25/15, at 2:00 seated in the reclinileft wrist curled inwitightly into the skin. It was noted during 7:15 a.m. that R36 was noted that the the fingers of her lepalm.  On 2/26/15, at 8:30 eating breakfast wire curled into the palm fingers of her left handed in the location finger made an visis skin of her palm.  On 2/27/15, at 8:00 receiving morning or reddened area rem (nail) pressed again left hand.  On 02/25/15, at 1:1 (NA)-R indicated shissue with R36's left pressing against ar the hand.  During interview on confirmed she was finger" issue with he whether any attempt the resulting skin profinger.	op.m. R36 was observed er located in her room. The ard and the fingers curled on the palm of the hand  observation on 2/26/15, at was resting in bed and again it left wrist was bent inward and off hand curled tightly into her  a.m. R36 was observed the fingers of her left hand in. When R36 straightened the land a reddened area was in where the nail of her fourth ble indentation against the  a.m. R36 was observed cares. It was noted that a lained where the fourth finger inst the skin in the palm of her  5 p.m. nursing assistant in the wasn't aware of any skin in thand or the fourth finger and into the skin on the palm of a 2/27/15, at 8:45 a.m. RN-A aware that R36 had a "trigger er left hand but was uncertain ofts had been made related to ressure issue with R36's	F 2	80			

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NAME OF PROVIDER OR SUPPLIER  EDGEBROOK CARE CENTER	50	FREET ADDRESS, CITY, STATE, ZIP CODE D5 TROSKY ROAD WEST DGERTON, MN 56128		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
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 309 SS=D  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 3/10/15 and will be seen by physicia 3/18/15. Resident 36 care plan was updated on 2/27/15 to monitor skin on 3/10/15 a palm protector was re-	an on ; , and	4/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245560	B. WING			02/:	27/2015
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F 309	Findings include:  During observation a.m. R14 was noted of a pencil eraser of into her left brow arreddened but was reddened between the skin (site unsubstantial behavioral disturbation and Alzheimer's dis R14's care plan dai indicators of skin contribution related to incompart of the concerns.  During review of nut documented that R concern related to the left eye. The progrepum. identified the progrepum. identified the progrepum. identified the progrepum identified areas cancer spots. The reduction of the physician referrity when interviewed to the physician referrity.	of R14 on 2/25/15, at 10:19 d to have a scaly area the size ver her left eye that extended ea. The area was not aised and scaly and had ses identified on the medical dical record for R14 included: er of the skin and e, squamous cell carcinoma epecified), dementia with nce, chronic kidney disease, lead 1/14/15, lacked any oncerns other than the risk for	F3	09	To monitor other resident for skin conditions, the licensed nurse will each resident for any skin condition document findings. They will follow with physician and update the plantas necessary.  Education will be given to the nursidepartment on skin conditions.  Audits will be done weekly for 1 methen monthly for 1 month by the Didesignee. Results of the audits will brought to the QAPI committee for Completion date is April 7 2015.	ns and w up of care ing onth, NS or I be	

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 505 TROSKY ROAD WEST EDGERTON, MN 56128			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	the health informat know more whether up by R14's physic.  During interview wire a.m. it was verified physician on 1/20/1 physician dated 1/2 follow-up related to forehead.  On 2/26/15, at 9:40 director of nursing there was no docurrecord to indicate the on the concern on The DNS further versus goal or intervention the current area on of squamous cell cappeared staff failed R14's physician. The was no assessment forehead.  R36's most recent 1/13/15, indicated a Status (BIMS) scorcognition and indicassistance with beel locomotion on the expersonal hygiene.  On 2/25/15, at 12:5 seated in her wheeresting in her lap. In hand was curled in against her palm.	on R14's forehead and stated ion manager (HIM) would r the area had been followed	F 30				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		<del></del>	(X3) DATE SURVEY COMPLETED			
		245560	B. WING		<del></del>	02/2	27/2015
	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CIT 505 TROSKY ROAD V EDGERTON, MN 5	VEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	'S PLAN OF CORRECTIOI ECTIVE ACTION SHOULD ENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	the location where from the fingernail. p.m. R36 stated that nursing home, she so that they didn't be her hand. R36 furt any treatment imple protect the skin. Fable to straighten the hand with the use of was during the night problems with her fable to her left hand but not on 2/25/15, at 2:00 seated in the reclin left wrist curled inwestightly into the skin. It was noted during 7:15 a.m. that R36 was noted that the the fingers of her left hand but not on 2/26/15, at 8:30 eating breakfast with curled into the palm fingers of her left hand but noted in the location finger made an visit skin of her palm.  On 2/27/15, at 8:00 receiving morning of reddened area remarks.	age 14 I on the skin of the left palm at an indentation was evident When interviewed at 12:54 at prior to admission to the would tape her fingers at night bend and push into the palm of her stated she was unaware of emented since admission, to R36 demonstrated she was he identified finger of her left of the right hand. R36 stated it when she had increased fingers curling into the palm of ot during the day as much.  O p.m. R36 was observed er located in her room. The rard and the fingers curled on the palm of the hand.  O observation on 2/26/15, at was resting in bed and again it left wrist was bent inward and eff hand curled tightly into her  O a.m. R36 was observed that he fingers of her left hand her hand a reddened area was nowhere the nail of her fourth ble indentation against the  O a.m. R36 was observed cares. It was noted that a lained where the fourth finger not the skin in the palm of her	F3	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		ATE SURVEY DMPLETED
		245560	B. WING		0:	2/27/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	(NA)-R indicated shissue with R36's left pressing against arthe hand.  During interview on confirmed she was finger" issue with how whether any attempthe resulting skin profinger.  When interviewed a stated she didn't not R36's her palm, no During an interviewed DNS stated she waskin issues. On 2/2 and RN-A observed visible indentation, and nail pushing ag R36 about wearing open to protect the would like one to us RN-A confirmed R3 and weekly skin as it had not been ider also asked R36 who clipping the nail shouleft hand. R36 read When the electronic	5 p.m. nursing assistant ne wasn't aware of any skin thand or the fourth finger and into the skin on the palm of 2/27/15, at 8:45 a.m. RN-A aware that R36 had a "trigger er left hand but was uncertain ots had been made related to ressure issue with R36's on 2/27/15, at 9:03 a.m. NA-Quice the nail pushing into rany redness.  Ton 2/27/15, at 9:52 a.m. the sunaware that R36 had any 27/15, at 10:20 a.m. the DNS d R36's left hand with the resulting from the fourth finger gainst her palm. RN-A asked a splint to keep her hand skin and R36 responded she se at night. The DNS and 66 is at risk for skin breakdown sessments are completed yet of tified. The DNS and RN-A ether she was agreeable with orter on the fourth finger of her dily agreed.	F3	09		
	the R36's left hand causing redness ar	ntation was lacking related to with the fingers curled inward and pressure on the skin of her on Initial Interdisciplinary data				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245560	B. WING		02/	27/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431 SS=D	contractures: "trigg left hand and the 3r hand). The care pla 10/16/14, indicated impairment to skin iskin, easily bruises and skin tears. (2) Resident will be free review date. Revision Resident will have repressure through the Interventions included transfers and bed narms, legs and hansurface. Keep skin dry skin to arms, legand as needed. The monitor or use paddereduce pressure from the skin of the palmed 483.60(b), (d), (e) ELABEL/STORE DR.  The facility must enalicensed pharmacof records of receip controlled drugs in accurate reconciliate records are in order controlled drugs is reconciled.  Drugs and biological labeled in accordant professional princip appropriate accessional princip appropriate accessional skin in the skin of the palmed the skin of the skin of th	d 10/28/13, indicated fer finger" 5th finger of R36's d finger of the her rt (right an with a revision date of an an are also feel for a feel for a feel feel feel feel feel feel feel fe	F 4			4/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245560	B. WING			02/27/2015	
	PROVIDER OR SUPPLIER			50	TREET ADDRESS, CITY, STATE, ZIP CODE D5 TROSKY ROAD WEST DGERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	facility must store locked compartme controls, and perm have access to the The facility must p permanently affixe controlled drugs list Comprehensive D Control Act of 1970 abuse, except who package drug distributed.	n State and Federal laws, the all drugs and biologicals in ents under proper temperature nit only authorized personnel to e keys.  rovide separately locked, and compartments for storage of sted in Schedule II of the rug Abuse Prevention and 6 and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose can	F4	31			
	by: Based on observareview the facility for solution was not an expiration date idea for 1 of 1 nursing a tuberculin skin test expired Tubersol sto affect any reside tuberculin skin test Findings include: It was observed duroom on 2/24/15, and Tubersol solution and available for unindicated it had be days prior). When	ention, interview and document railed to ensure Tubersol vailable for use after the 30 day entified on the multi-dose vial assistant (NA)-S who had a transistered with the use of solution. This has the potential entrand/or staff who required a transistered with the use of solution. This has the potential entrand/or staff who required a transistered with the use of solution. This has the potential entransistered with the use of solution. This has the potential entransistered with the required a transistered in the refrigerator use. The date on the vial en opened on 1/16/15, (39 interviewed on 2/24/15, at practical nurse (LPN)-A			The vial of expired Tubersol solution destroyed on 2/24/15. All other medications in carts and refrigerator reviewed on 2/25/15 to ensure no expired medications were present.  Education was provided to nurses at TMAs to provide a date on medicing when opened and to make sure it is expired before administering it.  A weekly audit for 1 month, then month or 1 month will be completed by the or designee to monitor expiration data Results of the audits will be brought QAPI committee for review.	r were ther and es s not onthly e DNS ates.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245560	B. WING			02/2	27/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, C 505 TROSKY ROAD EDGERTON, MN	-	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTIC RECTIVE ACTION SHOULI RENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 431	discarded after 30 dose administered day expiration date vial should have be the TST administer When interviewed director of nursing (administer the TST date of the solution DON indicated the monitor the medica twice weekly for our Tubersol solution a outdated and shoul indicated a follow u outdated medicatio The Tubersol packa	ge 18 sol solution was to be days and confirmed the last was on 2/23/15 (over the 30). LPN-A verified that a new en opened and accessed for ed the prior day (2/23/15). On 2/26/15, at 8:11 a.m. the (DON) confirmed the staff who should check the expiration to verify it is not outdated. The night staff are expected to tion carts and storage areas tdates. She further verified the dministered on 2/23/15, was d have been discarded. She p with NA-S who received the n would be contacted. age directions read: Tubersol d in use for 30 days should be	F 4		ate is April 7 2015.			

F5560023

Printed: 03/03/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A, BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245560

B. WING

02/26/2015

NAME OF PROVIDER OR SUPPLIER

**EDGEBROOK CARE CENTER** 

STREET ADDRESS, CITY, STATE, ZIP CODE

505 TROSKY ROAD WEST EDGERTON. MN 56128

EDGEDROOK CARE CENTER		EDGERTON, M	N 56128		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL F OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS	K 00	0		
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Fire Marshal Division, on February 26, 22 the time of this survey, Edgebrook Care Edgerton Building 01 was found to be in compliance with the requirements for pain Medicare/Medicaid at 42 CFR, Subpated 483.70(a), Life Safety from Fire, and the edition of National Fire Protection Association of National Fire Protection Association (NFPA) Standard 101, Life Safety Code Chapter 19 Existing Health Care Occupated Edgebrook Care Center, Edgerton was constructed as follows:  Building 01 of Edgebrook Care Center is one-story in height, has a partial baseme is fully sprinklered. The original building in 1968, with building additions in 1992 at All were determined to be of Type II(111) construction.	State 2015. At Center, Intricipation Intrici			
	The facility has a fire alarm system with detection at smoke barrier doors and in open to the corridors, which is monitored automatic fire department notification. Thas a capacity of 56 beds and had a cer at time of the survey.	spaces d for The facility			
	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESE		TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

Printed: 03/03/2015 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 02 - 2003 ADDITION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 245560 B. WING 02/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **505 TROSKY ROAD WEST** EDGEBROOK CARE CENTER **EDGERTON, MN 56128** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 INITIAL COMMENTS K 000 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.

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 <u>only a suggestion</u> 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

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 03/20/2015 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00454	B. WING		00/0	7/201 F
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	02/2	7/2015
_		505 TROS	SKY ROAD W	<i>'</i>		
EDGEBE	ROOK CARE CENTER	EDGERTO	ON, MN 5612	28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 03/18/15

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
00454		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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE COMPLETE	
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff, the following correction that you and identify the dat Minnesota Department State Licensing federal software. To assigned to Minnesota Department State Licensing federal software. To assigned to Minnesota Department State Licensing federal software. To assigned to Minnesota Department State Licensing federal software. To assigned to Minnesota Department State Licensing federal software. To assigned to Minnesota Department State Licensing federal software. To state It is a state of the Suggested of t	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  5 surveyors of this visited the above provider and ction orders are issued. Four electronic plan of have reviewed these orders, e when they will be completed.  In ent of Health is documenting. Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left. Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection.  ARD THE HEADING OF THE	2 000			

Minnesota Department of Health STATE FORM

TE FORM 6899 Y0J811 If continuation sheet 2 of 18

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		00454	B. WING		02/2	27/2015
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD V DN, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 555	MN Rule 4658.0405 Plan of Care; Devel	5 Subp. 1 Comprehensive opment	2 555			4/7/15
	must develop a con each resident withir completion of the con assessment as deficomprehensive plan by an interdisciplina attending physician responsibility for the appropriate staff in the resident's needs practicable, with the	lopment. A nursing home apprehensive plan of care for a seven days after the emprehensive resident and in part 4658.0400. The period of care must be developed ary team that includes the a registered nurse with a resident, and other disciplines as determined by a participation of the resident, and arguardian or chosen				
	by: Based on observative review the facility facomprehensive care	ent is not met as evidenced on, interview and document illed to develop a e plan for 1 of 3 residents non-pressure related skin		Corrected		
l	Findings include:					
	a.m. R14 was noted of a pencil eraser of into her left brow ar	of R14 on 2/25/15, at 10:19 d to have a scaly area the size ver her left eye that extended ea. The area was not aised and scaly and had				

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 3 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED	
		00454	B. WING		02/2	27/2015
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, ST BKY ROAD WI DN, MN 5612	EST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 555	flaking skin. The current diagnosic diagnosis list in meunspecified disorder subcutaneous tissured of the skin (site unspecified disturbation and Alzheimer's distriction related to i On 2/10/15, a Nursidentify concerns id concerns. During review of nursidentify concerns documented that Reconcern related to the left eye. The progrep.m. identified the progrep.m. identified the progrep.m. identified areas cancer spots. The result is a service and requeschedule an appoint doctor to look at area that identified areas cancer spots. The result identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots. The result is a service in the family member that identified areas cancer spots.	ses identified on the medical dical record for R14 included: r of the skin and e, squamous cell carcinoma pecified), dementia with nce, chronic kidney disease, ease. ed 1/14/15, lacked any oncerns other than the risk for ncontinence. e Documentation form used to entified R14 free of any skin rsing progress notes it was 41's family had expressed a he area located near R14's as note dated 1/14/15, at 1:20 plan of care was reviewed and er had contacted social sted that nursing staff at them with R14's medical eas of irritation on her face. Indicated she had concerns a could possibly be facial note identified nursing staff 14's next 60 day appointment ney would put the concern on	2 555			

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 4 of 18

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` ´con			SURVEY LETED
			A. BUILDING:			
		00454	B. WING		02/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDGEBF	OOK CARE CENTER		KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ge 4	2 555			
		ne DNS further identified there to identify the area on R14's				
	DON or designee c procedures or facility plan development for non-pressure relate staff could be educate	THOD OF CORRECTION: The ould review any policies, ty processes for resident care or skin monitoring for ed skin conditions. Appropriate ated regarding any changes. Hee could develop a system to impliance.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			4/7/15
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on observati review the facility fa was revised for 1 of	on, interview and document illed to ensure the plan of care f 3 residents (R36) reviewed lated skin conditions.		Corrected		

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 5 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00454	B. WING		02/2	27/2015
	PROVIDER OR SUPPLIER	505 TROS	ORESS, CITY, S KY ROAD W DN, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	pa	ge 5	2 570			
	1/13/15, indicated a Status (BIMS) score cognition and indicate assistance with become to compete the competence of the	ınit, dressing, grooming and				
	collection tool dated contractures: "trigg left hand. The care 10/16/14, indicated impairment to skin skin, easily bruises and skin tears. (2) Resident will be free review date. Revision Resident will have repressure through the Interventions included transfers and bed narms, legs and hand surface. Keep skin dry skin to arms, legand as needed. The plan of care to mon left hand to protect 4th finger was obsethe hand, causing resting in her lap. Feather thand was curled invagainst her palm.	e: Use caution during nobility to prevent striking ds against any sharp or hard clean and dry. Use lotion on gs, hands and feet twice daily ere is no revision made in the itor or use padding for R36's the condition of the skin as the erved curled into the palm of				

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 6 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00454	B. WING		02/2	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	02/2	1/2015
		505 TROS	KY ROAD W			
EDGEB	ROOK CARE CENTER	EDGERTO	ON, MN 5612	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	area was observed the location where a from the fingernail. p.m., R36 stated th nursing home, she so that they didn't be her hand. R36 furth any treatment imple protect the skin. Rable to straighten the hand with the use of was during the night problems with her finer left hand but not on 2/25/15, at 2:00 seated in the reclinic left wrist curled inwitightly into the skin. It was noted during 7:15 a.m. that R36 was noted that the the fingers of her lepalm.  On 2/26/15, at 8:30 eating breakfast with curled into the palm fingers of her left hand the location finger made an visit skin of her palm.  On 2/27/15, at 8:00 receiving morning or reddened area rem	on the skin of the left palm at an indentation was evident. When interviewed at 12:54 at prior to admission to the would tape her fingers at night lend and push into the palm of the stated she was unaware of emented since admission, to take identified finger of her left of the right hand. R36 stated it when she had increased ingers curling into the palm of the during the day as much.  p.m. R36 was observed er located in her room. The lard and the fingers curled on the palm of the hand.  observation on 2/26/15, at was resting in bed and again it left wrist was bent inward and oft hand curled tightly into her  a.m. R36 was observed the fingers of her left hand and a reddened area was in where the nail of her fourth be indentation against the  a.m. R36 was observed that a lained where the fourth finger has the skin in the palm of her last the skin in the palm of her	2 570			

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 7 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		E SURVEY PLETED	
		00454	B. WING		02/	27/2015
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S SKY ROAD W DN, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 570	On 02/25/15, at 1:1 (NA)-R indicated shissue with R36's lef pressing against and the hand.  During interview on confirmed she was finger" issue with he whether any attempt the resulting skin profinger.  When interviewed on stated she didn't not R36's her palm, not During an interviewed DNS stated she was skin issues. On 2/2 and RN-A observed visible indentation, and nail pushing ag R36 about wearing open to protect the would like one to us RN-A confirmed R3 and weekly skin assift had not been identalso asked R36 who clipping the nail should be considered as a suggested of the Confirmed R3 and weekly skin assift had not been identalso asked R36 who clipping the nail should be considered as a suggested of the Confirmed R3 and weekly skin assift had not been identalso asked R36 who clipping the nail should be considered as a suggested of the confirmed R3 and weekly skin assift had not been identalso asked R36 who clipping the nail should be confirmed R3 and weekly skin assift had not been identalso asked R36 who clipping the nail should be considered as a suggested of the confirmed R3 and weekly skin assift had not been identalso asked R36 who clipping the nail should be considered as a suggested of the confirmed R3 and weekly skin assift had not been identalso asked R36 who clipping the nail should be considered as a suggested of the confirmed R3 and weekly skin assift had not been identalso asked R36 who clipping the nail should be considered as a suggested of the confirmed R3 and the confirmed R3	5 p.m. nursing assistant the wasn't aware of any skin at hand or the fourth finger and into the skin on the palm of 2/27/15, at 8:45 a.m. RN-A aware that R36 had a "trigger er left hand but was uncertain of the hand been made related to ressure issue with R36's on 2/27/15, at 9:03 a.m. NA-Quatice the nail pushing into rany redness.  on 2/27/15, at 9:52 a.m. the sunaware that R36 had any er/15, at 10:20 a.m. the DNS IR36's left hand with the resulting from the fourth finger than and R36 responded she as a night. The DNS and 6 is at risk for skin breakdown sessments are completed yet of the outh finger of her on the fourth finger of her on the fourth finger of her	2 570			

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 8 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00454	B. WING		02/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDGEBF	OOK CARE CENTER		SKY ROAD W ON, MN 5612			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 570	Continued From pa	ge 8	2 570			
		OON or designee could o monitor staff for compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			4/7/15
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
	by: Based on observati review the facility fa cares and services	ent is not met as evidenced on, interview and document ailed to provide the necessary for 2 of 3 residents (R14 and had non-pressure related skin		Corrected		
	Findings include:					
	a.m. R14 was noted of a pencil eraser of into her left brow ar	of R14 on 2/25/15, at 10:19 d to have a scaly area the size ver her left eye that extended ea. The area was not aised and scaly and had				

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 9 of 18

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00454	B. WING		00/0	7/0015
		00454	B. WING		02/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDGEBF	OOK CARE CENTER		SKY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	flaking skin. The current diagnosidiagnosis list in meunspecified disorde subcutaneous tissure of the skin (site unsubehavioral disturbation and Alzheimer's dis R14's care plan datindicators of skin coirritation related to i On 2/10/15, a Nursidentify concerns id concerns. During review of nursidentify concerns documented that Reconcern related to the left eye. The progrep.m. identified the p.R14's family members services and requeschedule an appoint doctor to look at are The family member that identified areas cancer spots. The removed check into Reand if coming up, the physician referred. When interviewed or registered nurse (Reaware of the area of the health information know more whether up by R14's physician referred.	ses identified on the medical dical record for R14 included: r of the skin and e, squamous cell carcinoma pecified), dementia with nce, chronic kidney disease, ease.  ed 1/14/15, lacked any oncerns other than the risk for ncontinence.  e Documentation form used to entified R14 free of any skin rsing progress notes it was 41's family had expressed a he area located near R14's as note dated 1/14/15, at 1:20 plan of care was reviewed and er had contacted social sted that nursing staff at the standard on her face.  Indicated she had concerns a could possibly be facial note identified nursing staff at snext 60 day appointment ney would put the concern on all to be addressed.  On 2/26/15, at 8:50 a.m.  N)-A stated she was not n R14's forehead and stated on manager (HIM) would r the area had been followed an.	2 830			
	a.m. it was verified	R14 was seen by her 4. The progress note from the				

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 10 of 18

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP		
			71. BOILDING.			
		00454	B. WING		02/2	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDGEBF	ROOK CARE CENTER		SKY ROAD W DN, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 10	2 830			
	physician dated 1/2	20/15 did not identify any the identified area on R14's				
	director of nursing a there was no docur record to indicate the on the concern on The DNS further ver- goal or intervention the current area on of squamous cell cappeared staff faile R14's physician. The	a.m. during interview with the services (DNS) it was verified mentation in the medical ne physician had followed up 1/20/15 when R14 was seen. Earlied there was no problem, as in the care plan related to R14's forehead or her history arcinoma. The DNS stated it at the dot address the concern with the DNS further identified there at related to the identified area				
	1/13/15, indicated a Status (BIMS) scor cognition and indic assistance with bed	Minimal Data Set (MDS) dated a Brief Interview of Mental e of 15/15, indicating intact cated she required extensive d mobility, transfers, unit, dressing, grooming and				
	seated in her whee resting in her lap. I hand was curled in against her palm. I straighten the finge area was observed the location where from the fingernail. p.m. R36 stated than ursing home, she so that they didn't the hand. R36 furt	64 p.m. R36 was observed lchair (w/c) with her left hand R36's 4th finger on her left ward with the nail pushing R36 used her right hand to be on her left hand. A reddened on the skin of the left palm at an indentation was evident. When interviewed at 12:54 at prior to admission to the would tape her fingers at night bend and push into the palm of her stated she was unaware of emented since admission, to				

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 11 of 18

00454 B. WING 02/27/2	7/2015
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  505 TROSKY ROAD WEST  EDGERTON, MN 56128	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 the 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"	

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 12 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		00454	B. WING		02/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDGEBF	OOK CARE CENTER		KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 12	2 830			
	finger" issue with he whether any attemp	er left hand but was uncertain ots had been made related to ressure issue with R36's				
		on 2/27/15, at 9:03 a.m. NA-Q otice the nail pushing into r any redness.				
	DNS stated she waskin issues. On 2/2 and RN-A observed visible indentation, and nail pushing ag R36 about wearing open to protect the would like one to us RN-A confirmed R3 and weekly skin as it had not been ider also asked R36 wh	on 2/27/15, at 9:52 a.m. the is unaware that R36 had any 27/15, at 10:20 a.m. the DNS id R36's left hand with the resulting from the fourth finger gainst her palm. RN-A asked a splint to keep her hand skin and R36 responded she se at night. The DNS and 36 is at risk for skin breakdown sessments are completed yet nified. The DNS and RN-A ether she was agreeable with orter on the fourth finger of her dily agreed.				
	reviewed, documer the R36's left hand causing redness ar palm. The admissi collection tool dated contractures: "trigg left hand and the 3r hand). The care pl 10/16/14, indicated impairment to skin skin, easily bruises and skin tears. (2) Resident will be fre	c and paper record was nation was lacking related to with the fingers curled inward and pressure on the skin of her on Initial Interdisciplinary data of 10/28/13, indicated ger finger" 5th finger of R36's and finger of the her rt (right an with a revision date of: (1) Focus: R36 has actual integrity R/T (related to) fragile E/B pressure ulcers, bruising Goal: dated 4/29/14: e from skin injury through the on date: 12/29/14 Goal:				

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 13 of 18

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		00454	B. WING		02/2	27/2015
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S SKY ROAD V DN, MN 561:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	pressure through the Interventions include transfers and bed marms, legs and han surface. Keep skindry skin to arms, leg and as needed. The monitor or use paddreduce pressure from the skin of the palm SUGGESTED MET DON or designee coprocedures or facility monitoring for nonconditions and make facility paperwork. educated regarding designee could develop for compliance.	no complications R/T areas of the review date. (3) le: Use caution during mobility to prevent striking ds against any sharp or hard clean and dry. Use lotion on gs, hands and feet twice daily here is no documentation to ding for R36's left hand to the own the 4th finger curled into	2 830			
21805	Residents of HC Fa Subd. 5. Courteo residents have the courtesy and respe	.651 Subd. 5 Patients & ac.Bill of Rights us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a	21805			4/7/15
	by: Based on observati	ent is not met as evidenced ion, interview, and document alled to provide a dignified		Corrected		

6899

Minnesota Department of Health STATE FORM

PRINTED: 03/20/2015 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMP	
		00454	B. WING		02/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02/2	,
EDGEBF	OOK CARE CENTER		KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 14	21805			
		or 1 of 26 residents (R18) ired staff assistance with				
	Findings include:					
	seated in her whee during the supper nassistant (NA) was table at that time. assisted the residenthen walked away to 5:20 p.m. another nat next to R18 and On 2/26/15, at 8:10 pushed in her w/c transported her to the supper nassistant supports the supper nassistant supports the supper nassistant supper nassistant supports the supper nassistant supports the supper nassistant supports the supper nassistant supper nassistant supports the supper nassistant supper	p.m. R18 was observed lchair (w/c) in the dining room neal service. A nursing observed approaching the The NA stood over R18, nt to eat a bite of applesauce, o assist other residents. At NA approached R18's table, d assisted her with eating.  I a.m. R18 was observed being o the dining room by staff, who he assigned table. On the re-poured glass of water,				
	juice, and milk at the R18 was not offere who transported he seated alone at the and/or interaction ulater) when staff tra room and pushed histaff who transporte approached NA-A (residents with brea adjacent table when obtained a breakfasther meal items and located in the vicini interaction occurred offered R18 when Nibreakfast.	the place setting in front of R18; d any of the fluids by the staff of the table. R18 remained table without staff assistance with R18; a.m. (23 minutes ansported R36 into the dining of the only staff assisting kfast) who was loacted at an are R18 was seated. NA-A ast meal for R36, helped set up then assisted other residents the dining room. No divith R18 nor was any fluids NA-A helped R36 with				
		assisted R19 into the dining of R18's table. NA-A				

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 15 of 18

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED	
		00454	B. WING	<del></del>	02/2	7/2015
NAME OF PROVIDER OR SUPPLIER STREET ADD				STATE, ZIP CODE	-	
FDGFBF	ROOK CARE CENTER		KY ROAD W			
	T	EDGERTO	ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 15	21805			
	OOK CARE CENTER					

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00454	B. WING		02/2	7/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
EDGEBR	OOK CARE CENTER		KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	confirmed that she assisting residents what had happened would usually assist 7:30 a.m. until approdepending upon hor up for the day and work to help. NA-A confifrom each wing and during breakfast. Nousually served accounted the dining room. She waited a long time of NA-A probably shout to request help with further stated due to required, she assist did not want to get utimes to assist othe dining room.  When interviewed of director of nursing so R18's lack of assist extended period of additional assistance summoned.  The facility form titled dated February 201 Residents are served basis.  Residents do not worminutes to be served SUGGESTED MET The director of nursidining room to ensure the served single process of the served served served to the served served served to the served to the served to the served to the served served to the se	on 2/26/15, at 1:24 p.m. NA-A usually receives help with at breakfast but didn't know I today. NA-A stated she t residents on her own from oximately 8:30 a.m., w soon residents are gotten when other NA's are available rmed there is usually an NA I from restorative to assist IA-A stated the residents are ording to when they arrive in the confirmed that R18 had for assistance with eating and all have approached nursing assisting residents. NA-A to the level of assistance R18 and leave R18 multiple residents who arrived in the service (DNS) confirmed that ance with dining for an attime was undignified and the should have been sed, Guidelines Open Dining 3 included: and more than 10 minutes to 15	21805			

Minnesota Department of Health

STATE FORM 6899 Y0J811 If continuation sheet 17 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00454	B. WING		02/2	7/2015	
	PROVIDER OR SUPPLIER	505 TROS	DDRESS, CITY, STATE, ZIP CODE SKY ROAD WEST ON, MN 56128				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21805	arrive at the location could be implement audit. She could insidignified meal servible conducted to en a dignified dining excould be reported to committee for review	ge 17  n. A reassignment of duties ted based on the results of the service staff regarding a ce. Dining room audits could sure all residents are provided experience and the results of the quality assurance we and recommendation.  R CORRECTION: Twenty-one	21805				

6899

Minnesota Department of Health STATE FORM