Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2024

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

RE: CCN: 245275
Cycle Start Date: October 15, 2024

Dear Administrator:

On November 7, 2024, we notified you a remedy was imposed. On November 26, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 5, 2024.

As authorized by CMS the remedy of:

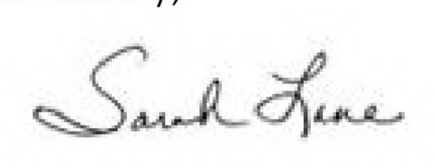
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 15, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 7, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 15, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 5, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,



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

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December 12, 2024

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

Re: Reinspection Results
Event ID: 7CL012

Dear Administrator:

On November 19, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 15, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2024

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

RE: CCN: 245275
Cycle Start Date: October 15, 2024

Dear Administrator:

On October 15, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-272

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by January 15, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 15, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

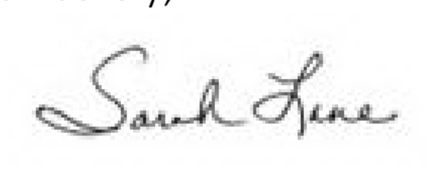
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
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Electronically delivered
October 23, 2024

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

Re: State Nursing Home Licensing Orders
Event ID: 7CL011

Dear Administrator:

The above facility was surveyed on October 14, 2024 through October 15, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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.

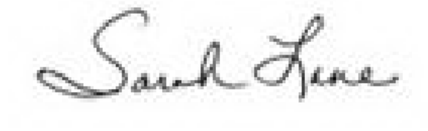
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Terri Ament, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 feel free to call me with any questions.

Sincerely,



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Minnesota Department of Health
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Saint Paul, MN 55164-0900
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF EDINA	6200 XERXES AVENUE SOUTH MINNEAPOLIS, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/14/24 through 10/15/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52759455C (MN00107308) H52759456C (MN00107310) H52759393C (MN00107306) Deficiencies were issued at F684 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		11/15/24

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

Electronically Signed | 11/02/2024

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

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F 684	Continued From page 1 Based on observation, interview and document review, the facility failed to provide treatment to a skin tear and documented it had been completed for 1 of 4 residents (R3) reviewed for wound care. In addition, the facility falsely documented wound care was being provided for 2 of 4 residents (R4, R5) reviewed for wound care whose wounds had been resolved. Findings include: R3 R3's Face Sheet indicated R5 had diagnoses of paraplegia (paralysis caused by spinal injury or disease), peripheral vascular disease (abnormal narrowing of arteries other than those that supply the heart or brain), and methicillin resistant staphylococcus aureus infection (MRSA, a type of bacteria that has developed resistance to antibiotics). R3's quarterly Minimum Data Set (MDS) dated 9/5/24 indicated R3 was cognitively intact and required the assist of two staff for toileting, transfers, and bed mobility. R3's progress note dated 7/20/24, indicated R3 was noted to have a skin tear on his right lower leg. R3 stated it may have been from accidentally hitting a doorway. R3's Physician Orders dated 9/12/24, directed wound care on left lower leg: Cleanse with normal saline and pat dry. Apply a nickel thick Santyl (ointment that removes dead skin) to the wound bed over slough, and cover with foam dressing. Change daily on evening shift and as needed. R3's Wound Evaluation Form dated 10/9/24	F 684	R3 is receiving wound care as ordered. R4 and R5 orders for wound care have been discontinued as their wounds were healed. Residents who have wounds are receiving wound care as ordered or orders have been obtained. Residents whose wounds are healed; orders are discontinued. Licensed nurses have been educated to ensure that residents who have wounds have wound care orders and that the orders are completed and signed out accurately in the medical record. Licensed nurses have been educated to date and initial dressings when applied. Licensed nurses have been educated to reach out to the provider to discontinue the order for wound care if the wound is closed. Licensed nurses have been educated to only sign out treatments that are completed in the medical record. The DON or designee will audit 3 patients with wounds weekly for one month, then 3 patients with wounds every 2 weeks for a month, then 3 patients with wounds for a month to ensure that patients with wounds have wound care orders, that the wound care is provided as ordered, the treatments have dates and initials, and that if the wound has closed, the orders are discontinued. The results of these audits will be brought to the facility QAPI committee for follow up and recommendations.	

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F 684	Continued From page 2	F 684		

indicated his front right lateral lower leg wound was improving. It measured 2.04 centimeters (cm) length by 1.16 cm width. There was no evidence of infection, it had moderate serous exudate define.

R3's Wound Evaluation Form dated 10/15/24 indicated his front right lateral lower leg wound was improving. It measured 1.67 cm length by 1.11cm width. There were no signs of infection. There were no other descriptive details documented about the wound.

R3's October treatment administration record (TAR) had the following documentation:
-Licensed practical nurse (LPN)-C documented she completed wound care on 10/10/24 and 10/11/24.
-Registered nurse (RN)-A was scheduled the evening of 10/12/24. The 10/12/24 box was left blank. RN-A documented she completed wound care on 10/13/24
-RN-B documented he completed wound care on 10/14/24.

On 10/14/24 at 10:30 a.m., R3 was observed. The date on R3's dressing was 10/10/24. R3 stated the skin tear was from being scraped a few times while being in the shower chair. He stated the last time the dressing was changed was on 10/10/24.

On 10/15/24 at 8:43 a.m., R3 was interviewed again. R3 stated he did not receive wound care on the evening of 10/14/24. The bandage was observed to have a date of 10/10/24 on it.

On 10/15/24 at 8:55 a.m., director of nursing (DON)-A and DON-B entered the room to provide

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F 684	Continued From page 3 R3 repositioning and an incontinent brief change. When asked if there were a date or time on the dressing, DON-A verified the dressing had a date of 10/10/24 which indicated it was last changed on 10/10/24. DON-A stated she would have to look at the TAR and ask the nurses what had happened with the wound care. On 10/15/24 at 11:22 a.m., RN-A stated R3 told her the wound care was only supposed to be done once every three days, because the order had recently changed. RN-A stated staff must follow what the resident says if the order was different from the order in the computer. She was not sure who was responsible for managing wound care orders. She left the administration record for the wound care blank on 10/12/24 because there was an issue with the computer, but she did provide the wound care. She was not sure who was responsible for managing wound care orders once the wound was resolved. On 10/15/24 at 11:32 a.m., the medical director (MD) was interviewed. The MD was also responsible for completing wound rounds for R3 and prescribing wound care orders. She stated she had just been to R3's room to assess his wound after the wound care had not been completed for 4 days. R3's wound had continued to improve, it had reduced in size and showed no signs of infection despite wound care treatments not being given. Not following orders was not acceptable. When asked if she had concerns about nurses documenting that wound care orders were completed for wounds that had been resolved, she stated she was honestly not sure what to say. On 10/15/24 at 11:56 a.m., RN-B stated when he	F 684		

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F 684	Continued From page 4	F 684		

charted R3's wound care as being completed when it wasn't, it was an oversight on his part, and he took the blame for it. When a resident had a resolved wound, the nurse should call the physician to discontinue the order, they should not document it as given.

R4
R4's annual MDS dated 9/20/24, indicated R4 was moderately cognitively impaired, and was independent with activities of daily living.

R4's Physician Orders dated 8/6/24 directed wound care - right lateral foot: Cleanse with wound cleanser, pat dry, apply antiseptic, cover with foam dressing, once daily.

R4's Wound Evaluation Form dated 10/2/24 indicated the wound was surgical and had healed.

R4's October TAR indicated wound care was provided from 10/2/24 through 10/14/24 with the exception on the box being blank on 10/12/24.

On 10/14/24 at 1:25 p.m., R4 stated there was no bandage on her right foot. R4 took her sock off, and no dressing or open areas were visible.

On 10/15/24 at 9:12 a.m., DON-A assessed R4's foot and verified the surgical incision was healed.

R5
R5's quarterly MDS dated 7/31/24, indicated she was cognitively intact, and had no skin conditions.

R5's Physician Orders dated 8/16/24 directed skin tear left arm: cleanse area with generic wound cleanser, pat dry, apply oil emulsion, cover with dry dressing. Complete one time a day every

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F 684	Continued From page 5 3 days. R5's October TAR indicated the left arm skin tear wound care was completed on 10/1/24, 10/4/24, 10/7/24, 10/10/24, and 10/14/24. R5's Physician Orders dated 9/24/24 directed skin tear left lower leg: cleanse with wound cleanser, pat dry, apply oil emulsion dressing. Cover with dry dressing. One time a day every Monday, Wednesday and Friday. R5's October administration record indicated the left leg skin tear wound care was completed on 10/2/24, 10/4/24, 10/7/24, 10/11/24, and 10/14/24. R5's Physician Orders dated 9/17/24, directed skin tear to left forearm: cleanse area with generic wound cleanser, pat dry. Apply oil emulsion dressing and cover with dry dressing. Change 3 times per week one time a day. R5's October administration record indicated the left forearm skin tear wound care was completed On 10/2/24, 10/4/24, 10/7/24, 10/9/24, 10/11/24, and 10/14/24. On 10/14/24 at 1:34 p.m., R5 stated all of her skin tears have been healed for a long time, she was unable to remember for how long. On 10/15/24 at 9:16 a.m., DON-A verified all three of R5's skin tears were healed. She thought staff were not feeling empowered to discontinue the wound care orders if the wounds were resolved. Nurses could also reach out to her or DON-B to tell them wounds have been resolved, and they could discontinue orders. Nurses should	F 684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 not sign out wound care was completed when it was not. The facility policy Pressure Injury Prevention and Wound Care Management last revised 3/4/24, directed residents who have a pressure injury or wound will receive care and services to promote healing.	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		11/15/24

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	245275	A. BUILDING _____ B. WING _____	C 10/15/2024

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F 880	Continued From page 7 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 880	R3 is receiving care with appropriate	

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F 880	Continued From page 8 review, the facility failed to utilize enhanced barrier precautions (EBP) for 2 of 5 residents (R3) observed for personal cares and wound care treatments. Findings include: Per the Centers for Disease Control (CDC) dated 6/28/24: EBP are indicated during high contact care activities for residents with infection or colonization with a CDC targeted multi-drug resistant organisms (MDRO) (when contact precautions do not apply) or for any resident who has a chronic wound and/or indwelling medical device. High-contact resident care activities include dressing, bathing/showering, transferring, toileting, providing hygiene, changing linens or briefs, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care: generally, for residents with a chronic wound(s), not skin breaks or tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing. R3's Face Sheet indicated R5 had diagnoses of paraplegia (paralysis caused by spinal injury or disease), peripheral vascular disease (abnormal narrowing of arteries other than those that supply the heart or brain), and methicillin resistant staphylococcus aureus infection (MRSA, a type of bacteria that has developed resistance to antibiotics). R3's quarterly Minimum Data Set (MDS) dated 9/5/24 indicated R3 was cognitively intact, and required the assist of two staff for toileting, transfers, and bed mobility.	F 880	enhanced barrier precautions and hand hygiene. Residents who require enhanced barrier precautions receive care with precautions as indicated and hand hygiene. Nursing staff have been educated on the use of enhanced barrier precautions and hand hygiene. The DON or designee will audit 3 patients that require enhanced barrier precautions and hand hygiene weekly for one month, then 3 patients every 2 weeks for a month, then 3 patients monthly to ensure that nursing staff use appropriate enhanced barrier precautions and hand hygiene. The results of these audits will be brought to the facility QAPI committee for follow up an recommendations.	

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F 880	Continued From page 9	F 880		

R3's care plan dated 10/14/24, indicated R3 had a history of MRSA and required EBP.

R3's Physician Orders dated 9/12/24, directed wound care on left lower leg: Cleanse with normal saline and pat dry. Apply a nickel thick Santyl (ointment that removes dead skin) to the wound bed over slough, and cover with foam dressing. Change daily on evening shift and as needed.

On 10/14/24 at 10:16 a.m., licensed practical nurse (LPN)-A entered R3's room to administer a suppository and reposition him. LPN-A donned gloves, but did not donn a gown. R3's door had a sign indicating he required EBP and directed to wear personal protective equipment for high contact care activities.

On 10/14/24 at 10:22 a.m., LPN-A stated she went into R3's room to administer a scheduled suppository and repositioned him. LPN-A verified she didn't wear a gown. When asked about the EBP sign on R3's door, LPN-A stated she doesn't wear a gown unless a resident has an active infection, and stated the director of nursing (DON) could answer questions about it.

On 10/15/24 at 9:43 a.m., LPN-B was observed wearing a gown and gloves, and providing wound care for R3. LPN-B removed R3's soiled dressing. She cleansed the wound with normal saline, patted it with a sterile dressing, opened the tube of Santyl ointment and applied it to the wound. She touched the trash can and removed the first set of gloves, and was wearing another set of gloves underneath the top set. DON-B entered the room to take a picture of the wound. LPN-B removed the second set of gloves, and without performing hand hygiene, applied a clean

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F 880	Continued From page 10 dressing without gloves. Outside of R3's room, LPN-B used a hand wipe to cleanse her hands. On 10/15/24 at 10:48 a.m., LPN-B stated hand hygiene should only be completed before and after wound care. LPN-B stated she used double gloves occasionally because she didn't know what to expect, and it was nice to just take the top set of gloves off. On 10/15/24 at 11:14 a.m., DON-B stated hand hygiene should be completed before putting gloves on, when changing gloves, and after soiled items have been touched. Double gloving was not an acceptable practice. On 10/15/24 at 11:22 a.m., registered nurse (RN)-A stated hand hygiene should only be completed before and after wound care was completed. She used double gloves when providing wound care because it was easier than taking gloves on and off. On 10/15/24 at 11:32 a.m., the medical director (MD) stated hand hygiene should be completed when going from dirty to clean, and during every glove change. Double gloving was not an acceptable practice because the second set of gloves would be considered dirty. Staff should follow the EBP signs on the doors, and should be using EBP properly. On 10/15/24 at 1:04 p.m., DON-A stated double gloves were not acceptable and staff had been recently trained in infection control. Hand hygiene should be completed before going into the resident room, when putting new gloves on and removing soiled dressings. Staff had been trained on EBP and should be following policy for wearing	F 880		

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F 880	Continued From page 11 gowns. The facility policy Enhanced Barrier Precautions dated 3/26/24 directed EBP will be implemented during high-contact resident care activities when caring for a resident with chronic open wound requiring a dressing or residents with an infection or colonization with and MDRO. The facility policy Pressure Injury Prevention and Wound Care Management last revised 3/4/24, directed to refer to the dressing change policy for detailed policy and procedure for dressing changes. Clean technique for wound and dressing changes are indicated. A policy pertaining to infection control during wound care was requested but not provided.	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/14/24 through 10/15/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52759455C (MN00107308) H52759456C (MN00107310) H52759393C (MN00107306) A licensing order was issued at 4658.0800 Subp. 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to utilize enhanced barrier precautions (EBP) for 2 of 5 residents (R3) observed for personal cares and wound care treatments. Findings include: Per the Centers for Disease Control (CDC) dated 6/28/24: EBP are indicated during high contact care activities for residents with infection or colonization with a CDC targeted multi-drug resistant organisms (MDRO) (when contact precautions do not apply) or for any resident who has a chronic wound and/or indwelling medical device. High-contact resident care activities include dressing, bathing/showering, transferring,	21375	Acknowledged and corrected.	11/15/24

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21375	Continued From page 3 toileting, providing hygiene, changing linens or briefs, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care: generally, for residents with a chronic wound(s), not skin breaks or tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing. R3's Face Sheet indicated R5 had diagnoses of paraplegia (paralysis caused by spinal injury or disease), peripheral vascular disease (abnormal narrowing of arteries other than those that supply the heart or brain), and methicillin resistant staphylococcus aureus infection (MRSA, a type of bacteria that has developed resistance to antibiotics). R3's quarterly Minimum Data Set (MDS) dated 9/5/24 indicated R3 was cognitively intact, and required the assist of two staff for toileting, transfers, and bed mobility. R3's care plan dated 10/14/24, indicated R3 had a history of MRSA and required EBP. R3's Physician Orders dated 9/12/24, directed wound care on left lower leg: Cleanse with normal saline and pat dry. Apply a nickel thick Santyl (ointment that removes dead skin) to the wound bed over slough, and cover with foam dressing. Change daily on evening shift and as needed. On 10/14/24 at 10:16 a.m., licensed practical nurse (LPN)-A entered R3's room to administer a suppository and reposition him. LPN-A donned gloves, but did not donn a gown. R3's door had a sign indicating he required EBP and directed to wear personal protective equipment for high contact care activities.	21375		

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21375	Continued From page 4 On 10/14/24 at 10:22 a.m., LPN-A stated she went into R3's room to administer a scheduled suppository and repositioned him. LPN-A verified she didn't wear a gown. When asked about the EBP sign on R3's door, LPN-A stated she doesn't wear a gown unless a resident has an active infection, and stated the director of nursing (DON) could answer questions about it. On 10/15/24 at 9:43 a.m., LPN-B was observed wearing a gown and gloves, and providing wound care for R3. LPN-B removed R3's soiled dressing. She cleansed the wound with normal saline, patted it with a sterile dressing, opened the tube of Santyl ointment and applied it to the wound. She touched the trash can and removed the first set of gloves, and was wearing another set of gloves underneath the top set. DON-B entered the room to take a picture of the wound. LPN-B removed the second set of gloves, and without performing hand hygiene, applied a clean dressing without gloves. Outside of R3's room, LPN-B used a hand wipe to cleanse her hands. On 10/15/24 at 10:48 a.m., LPN-B stated hand hygiene should only be completed before and after wound care. LPN-B stated she used double gloves occasionally because she didn't know what to expect, and it was nice to just take the top set of gloves off. On 10/15/24 at 11:14 a.m., DON-B stated hand hygiene should be completed before putting gloves on, when changing gloves, and after soiled items have been touched. Double gloving was not an acceptable practice. On 10/15/24 at 11:22 a.m., registered nurse (RN)-A stated hand hygiene should only be completed before and after wound care was	21375		

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21375	Continued From page 5 completed. She used double gloves when providing wound care because it was easier than taking gloves on and off. On 10/15/24 at 11:32 a.m., the medical director (MD) stated hand hygiene should be completed when going from dirty to clean, and during every glove change. Double gloving was not an acceptable practice because the second set of gloves would be considered dirty. Staff should follow the EBP signs on the doors, and should be using EBP properly. On 10/15/24 at 1:04 p.m., DON-A stated double gloves were not acceptable and staff had been recently trained in infection control. Hand hygiene should be completed before going into the resident room, when putting new gloves on and removing soiled dressings. Staff had been trained on EBP and should be following policy for wearing gowns. The facility policy Enhanced Barrier Precautions dated 3/26/24 directed EBP will be implemented during high-contact resident care activities when caring for a resident with chronic open wound requiring a dressing or residents with an infection or colonization with and MDRO. The facility policy Pressure Injury Prevention and Wound Care Management last revised 3/4/24, directed to refer to the dressing change policy for detailed policy and procedure for dressing changes. Clean technique for wound and dressing changes are indicated. A policy pertaining to infection control during wound care was requested but not provided. SUGGESTED METHOD OF CORRECTION: The	21375		

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21375	Continued From page 6 director of nursing (DON) or designee person could review policies and procedures on infection control. The DON or designee could educate staff on these policies and procedures. The DON or designee could conduct audits to ensure compliance, and bring the results of these audits to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21375		