Electronically delivered

November 9, 2020

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

RE: CCN: 245409
Cycle Start Date: October 2, 2020

Dear Administrator:

On October 15, 2020, we informed you that we may impose enforcement remedies.

On October 16, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 24, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 24, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 24, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 24, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Edenbrook Of Rochester will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 24, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 2, 2021 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 10/15/2020 and 10/16/2020 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5409074C, with a deficiencies cited at F684, F686, and F773. The following complaint was found NOT to be substantiated H5409073C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=G	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	F 684		11/18/20

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

Electronically Signed | 11/13/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 1 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to appropriately monitor, implement physician orders for laboratory monitoring and notify physician with a change in health status for 1 of 1 residents (R1) recently discharged from the hospital with stage 3 chronic renal disease (mild to moderate damage to the kidneys) and osteomyelitis (infection in the bone). R1 sustained harm when his condition deteriorated resulting in re-hospitalization, with diagnoses of acute renal failure, hypotension (low blood pressure), urinary tract infection, and septic shock. Findings include: R1's admission Minimum Data Set (MDS) assessment dated 10/1/2020, indicated R1 had moderate cognitive impairment. R1 required one staff physical assistance and supervision for eating and drinking. The MDS also included R1 was administered antibiotics. R1's Facility Admission record included, diagnoses of acute osteomyelitis of ankle and foot with foot ulcer, diabetes type 2, and stage 3 chronic renal disease. R1's hospital Discharge Summary dated 9/24/2020, indicated R1 was discharged to the facility on 9/24/2020 and included diagnoses of acute osteomyelitis, complicated urinary tract infection, essential hypertension, with a past	F 684	" R1 is no longer a resident at the facility. " Residents in the facility have the potential to be affected by this deficient practice. Current or active residents admitted since August 2020 will have hospital dismissal summary reviewed to ensure orders have been carried out as ordered by the physician. Current resident records will be reviewed for evidence of loose stools, decreased blood pressure, decreased fluid intake, and/or decreased urinary output. Documentation of provider update will be reviewed if any of the above listed changes or combination of changes are noted. If provider has not been updated, notification will be completed at time of audit. " Ongoing, resident records will be reviewed by clinical leadership on a regular basis including vital signs, progress notes, clinical alerts, fluid intake, physician orders, etc. Noted changes will be reviewed for provider notification. " Licensed staff will be provided education regarding follow physician orders documented in dismissal summary from hospital. Notification of change in condition policy will be reviewed with all licensed staff. Signs and symptoms of dehydration and risk of dehydration will be included in education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 2 medical history of chronic renal disease, type 2 diabetes, and mild cognitive impairment. Identified in the section titled, "Active Issues Requiring Follow-up" included the following, lab tests-CBC/BMP (complete blood count/basic metabolic panel) every three days and CRP (The level of C-reactive protein (CRP), which can be measured in your blood, increases when there's inflammation in your body) every three days. R1's physician orders also included: -Encourage resident to drink plenty of water every day and even evening shift (order start date 9/24/2020) -Levofloxacin (antibiotic) 750 milligrams (mg) every other day (start date 9/24/2020) -Flagyl (antibiotic) 500 mg three times a day (start date 9/24/2020) R1's Post Acute and Long Term Care Standing Orders last revised 6/8/18, included orders for change in condition that directed the following; If patient is ill, yet clinically stable: -clear liquids if indicated -Encourage fluids if not on diuretic/digoxin/have fluid restriction. -Monitor vital signs and intake and outputs each shift until symptoms resolved. -If patient has acute dyspnea (shortness of breath) collect vitals and notify clinician if vitals abnormal indicated below, condition unrelieved after 1 hour or if condition declines. -If temperature is >/=100.5, respiratory rate >28, heart rate >110, systolic blood pressure <80 or >200, oxygen saturations <88% from baseline room air/oxygen, notify clinician. R1's record lacked documentation of any follow	F 684	" Dismissal summary orders audit will be completed weekly for 4 weeks, then monthly for 2 months to ensure physician orders are followed. Change of condition audits will be completed weekly for 4 weeks, then monthly for 2 months. Audit will include a review of resident□s medical record including vital signs, progress notes, clinical alerts, fluid intake, physician orders, etc. Noted changes will be reviewed for provider notification. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness and recommendation of audit continuation " Director of nursing will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 3	F 684		

up laboratory testing completed after R1 was admitted to the facility until 10/7/20.

R1's Registered Dietician-Nutrition Assessment dated 9/29/2020, identified R1 was not on a fluid restriction and estimated daily fluid requirements were 1891 milliliters (ml) per day. The assessment indicated R1's average fluid intake at meals was less than 1200 ml; the section "Comments r/t [related to] fluid intake" was left blank.

R1's medication administration record (MAR) included, "encourage plenty of water" marked with nurses initials indicating completed. R1's MAR did not include the amount of water consumed by the nurse's initials. Although, R1's fluid intake was recorded in Point of Care (health record system for documentation used by nursing assistants) and identified R1's 24 hour daily totals as:
-On 10/1/2020 intake was 900 ml
-On 10/2/2020, intake 320 ml
-On 10/3/ 2020 intake 640 ml
-On 10/4/2020 intake 640 ml
-On 10/5/2020, intake 800 ml
-On 10/6/2020, intake 680 ml according to R1's record, R1 was not meeting daily fluid recommendations.

R1's October MAR identified a decrease in urine output when daily totals were added.
-On 10/1/2020, output 1675 ml
-On 10/2/2020, output 1320 ml
-On 10/3/2020, output 1250 ml
-On 10/4/2020, output 300 ml (no output documented for evening and overnight shift)
-On 10/5/2020, output 850 ml

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 4 -On 10/6/2020, output 400 ml R1's blood pressure record on 10/1/2020, at 10:10 p.m. was 88/57 R1's blood pressure record on 10/2/2020, did not identify a blood pressure was taken. R1's progress note dated 10/3/2020, at 3:38 p.m. indicated R1's blood pressure was 98/48. R1's progress note dated 10/4/2020, at 3:38 p.m. indicated R1's blood pressure was 88/47. R1's progress note dated 10/5/2020, at 6:51 a.m. indicated R1's blood pressure was 87/54 and included, "Loose stools this shift. Resident febrile 100.8 short duration with sustained 100.1 t/o [sic]." R1 was shivering and extra blankets were effective. "Resident worried about loose stools; Imodium {antidiarrheal] was not administered d/t abx [do to antibiotics]" The note indicated the physician was notified. A subsequent note at 10:26 a.m. indicated R1 had "multiple loose stools and R1's blood pressure was 88/47. R1's blood pressure record on 10/6/2020, at 1:03 p.m. was 102/57 and at 11:33 p.m. was 70/50. Although R1 had a decrease in urinary output, had a decrease in fluid intake with low blood pressures from 10/1 through 10/5/2020, there was not evidence the physician was notified until 10/5/2020 when the Covid (a mild to severe respiratory illness that is caused by a coronavirus) and C-Diff (Clostridioides difficile is a bacterium that causes diarrhea and colitis (an inflammation of the colon) testing was ordered. However the record did not include a response from the physician in relation to input/output and low blood pressures. In addition, the record lacked evidence of R1 being monitored and assessed to correct low blood pressures or loose	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 5 stools. R1's physician note dated 10/7/2020, indicated on 9/25/20 R1's labs included creatinine (Cr) (A test reveals important information about your kidneys) was 1.1, BUN [bun urea nitrogen] 13, GFR >60 and sodium 137, but today (10/7/20) Cr 2.2, BUN 37, and GFR 29 and noted acute kidney injury with today's results. Resident is fatigued, hypotensive (low BP). The note also indicated the physician had given a verbal order for R1 to be sent to the emergency department. R1's progress note was dated 10/7/2020, at 2:38 p.m. included "Resident today had a low BP of 55/39. A call from NP [nurse practitioner] to update nursing that residents labs showed signs of acute kidney injury disease and stated she had attempted to make contact with family but was unable. NP stated she had called [name of hospital] to update on resident status and to send resident to [hospital] ED [emergency department] During an interview on 10/15/2020, at 1:46 p.m. director of nursing (DON) stated nurses were supposed to be tracking and monitoring fluid intake as well as the nursing assistants. DON stated diarrhea could cause dehydration, and low blood pressures could be a symptom of dehydration. DON indicated the focus and concern was COVID symptoms and in hind sight should have completed dehydration assessment. DON indicated when the physician was notified of the loose stools on 10/5/2020, a COVID and C-DIFF labs were ordered. DON further indicated that adequate fluid intake was important when residents had chronic kidney disease and antibiotics were hard on kidneys. DON indicated	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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	F 684		

the facility did not currently have a system in place to track fluid intake, however, it would be a standard of nursing practice and something a physician would not specifically order.

During an interview on 10/15/2020, at 2:58 p.m. R1's family member (FM)-1 stated once R1 arrived at the emergency room physicians were concerned of septic shock and his kidneys were shutting down. R1 had very low blood pressure, and normally R1 had high blood pressure. FM-1 stated the emergency room had a difficult time starting a IV (intravenous catheter) because of low blood pressure, and R1 received 5 bags of fluids and an IV medication to increase his blood pressure. FM-1 stated R1 was then transferred to another hospital, admitted to the intensive care unit (ICU) where they gave him 2 more bags of fluids.

During an interview on 10/15/2020, at 4:09 p.m. nurse practitioner (NP)-A confirmed R1's diagnosis of stage 3 renal disease. NP-A reviewed R1's lab records; stated labs were not completed per the hospital discharge summary, stated an unawareness of why they were not completed and they should have been. NP-A stated the facility should have been monitoring and evaluating R1's fluid balance, it was a standard of practice. NP-A stated the facility should have identified and reported the decrease in intake/output in conjunction with the presence of low blood pressures, and was not provided that information. R1's recorded fluid intake and outputs were reviewed with NP-A, NP-A stated "fluid intake and output is very low."

During an interview on 10/15/2020, at 4:38 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 7	F 684		

registered nurse (RN)-A reviewed R1's fluid intakes and outputs; stated the physician should have been notified about the decrease and further assessment of dehydration should have been completed. RN-A indicated staff were supposed to encourage fluid intake with encounters, however the amount and/or refusals were not documented.

During an interview on 10/15/2020, at 5:16 p.m. NA-C thought she remembered R1 having loose stools prior to going to the hospital. NA-C stated she would encourage R1 to take a drink when she took care of him, however she did not record the amount.

During an interview on 10/15/2020, at 5:42 p.m. hospital-1 registered nurse (H1-RN) stated R1 arrived at the ED on 10/7/2020, at 2:40 p.m. H1-RN stated R1 had been diagnosed with urinary tract infection and septic shock. H1-RN stated when R1 arrived at the hospital blood pressure was 77/41, a central line was attempted however, it didn't work. H1-RN stated R1 was administered a bolus of fluid, two IV antibiotics, and a norepinephrine drip. H1-RN confirmed R1 received fluids continuously over the course of 5 hours he was at hospital-1. H1-RN indicated R1's labs were indicative of sepsis and dehydration; and renal function and sodium levels had slightly improved after fluid administration. H1-RN stated R1 was transferred to hospital-2 at 8:23 p.m.

During an interview on 10/15/2020, at 7:04 p.m. hospital-2 registered nurse (H2-RN) confirmed R1 arrived at hospital-2 and was admitted to the ICU. H2-RN indicated R1 was administered fluids. H2-RN stated dehydration could cause

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 8 acute renal failure. Facility policy Change in Condition 12/19/2018, included: The physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference in usual sign/symptoms and/or the signs/symptoms are unrelieved by measures already prescribed: Specific information that requires prompt notification include, but is not limited to: Significant change or instability of vital signs; Prolonged/unresolved emesis/diarrhea A significant change in the resident's physical/psychosocial/mental condition A need to alter the resident's medical treatment significantly Nurse will complete assessment and document findings in resident record including but not limited to vital signs, pain, respiratory status as applicable, cardiac status as applicable, etc. Notification of medical professional and resident representative will be documented in medical record. Facility Hydration Policy that was undated included: It is critical that each resident at risk for hydration deficit or imbalance ...be identified and assessed to determine appropriate interventions. The resident may experience a decline in appetite or have difficulty eating or swallowing. Upon admission, each resident will be assessed by the R.D. to determine estimated fluid needs and risk for dehydration. Fluid needs and risk for dehydration will be documented in the Registered Dietician Nutritional assessment. Upon admission, Nursing will also assess physical status, including, but not limited to skin	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 9 turgor, mucous membranes, urinary status, and vitals to determine if resident has adequate hydration or risk factors are presents. Residents who already reside in the building will be assessed for risk or symptoms of dehydration on a quarterly basis, or as needed if risk increases or symptoms are present. Conditions that contribute to increased risk of dehydration include, but are not limited to the following: increased fluid losses; included diarrhea, acute illness or fever, poor fluid intake, presence of an infection. If resident is at elevated risk of dehydration or symptoms of fluid deficit/dehydration are present, resident will be immediately referred to the I-team and/or MD for further review and assessment Symptoms of dehydration include, but are not limited to: orthostatic hypotension, dry mucous membranes decreased urine output or concentrated urine, change in lab values If resident is at elevated risk of dehydration or symptoms of fluid deficit or dehydration are present, any or all of the following interventions will be implemented and the care plan will be updated. MD notification, PUSH fluids order, Daily weights, Basic metabolic panel or other labs, IV hydration, Alert staff of increased fluid needs, Monitor vitals per protocol, Start resident on Hydration Program, Daily Intake and Output monitoring.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		11/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 686	Continued From page 10 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure weekly assessments were completed to identify and prevent deterioration of the pressure ulcers for 1 of 2 residents (R2) reviewed for pressure ulcers. Findings included: R2's Admission Minimum Data Set (MDS) assessment dated 9/23/2020, indicated R2 did not have cognitive impairment and R2 required extensive assist of one person for bed mobility, toileting, and personal hygiene. R2 required extensive assist from two or more staff members for transfers. The MDS further identified R2 was at risk for pressure ulcers, had one unstageable ulcer and two venous or arterial ulcers. The MDS did not identify R2 had a stage 2 pressure ulcer upon admission. R2's Admission Record, included diagnoses of Stage 3 pressure ulcer of sacral region, unstageable pressure ulcer of the right hip, Stage 3 pressure ulcer of the right buttock, lumbar spina bifida, peripheral vascular disease, and congestive heart failure.	F 686	" R2 wounds will be assessed weekly to identify and prevent possible deterioration of pressure ulcers. " Residents with wounds have the potential to be affected by deficient practice. Residents with active wounds including pressure ulcers will be reviewed to ensure weekly assessments are completed. Wounds with evidence of deterioration or not healing will be reviewed to ensure physician/NP has been updated per policy. " Licensed staff will be provided education regarding the facility wound care policy including the weekly assessment of wounds including pressure ulcers. Wounds will be assessed for presence of healing or deterioration. MD/NP will be updated for wounds that are deteriorating or have not improved in a period of 2 weeks. " Wound management system will be audited once a week for 4 weeks, then monthly for 2 months. Audit will include assessment of wounds weekly, status of wound, and proper physician notification per policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 686	Continued From page 11 R2's skin care plan revised on 9/29/2020, included R2 had alteration in skin integrity related to unstageable pressure ulcer to right buttock, 2-stage 3 pressure ulcers, 2 vascular ulcers. R2's skin goals included, "My alterations in skin integrity will show signs of improvement in healing by the review date." Associated interventions of care included: encourage offloading (initiated 9/29/2020), pressure reducing mattress and chair cushion (initiated 9/29/2020), administer skin treatments as ordered, assess/monitor the alteration in my skin integrity and document status weekly (initiated 9/16/2020) . R2's physician orders dated 9/16/20 included, right buttock, right ischium (forms the lower and back part of the hip bone), right hip: apply half Plurogel (unique burn and wound dressing that is 100% water-soluble, bio-compatible, cell-friendly, and non-ionic It aids in the creation of an optimal moist wound healing environment that helps to protect healthy tissue and soften wound debris) and half silvadene (used with other treatments to help prevent and treat wound infections) cream on wounds. To be applied daily and covered with abdominal pads daily and as needed. During an observation on 10/16/2020, at 11:45 a.m. R2 laid in bed. Director of nursing (DON), licensed practical nurse (LPN)-A, and registered nurse (RN)-C were also in the room to complete dressing changes. RN-C removed dressing to R2's lower right buttock, measured the wound-3.0 centimeters (cm) x 1.8 cm x 0.2 cm. LPN-A informed R2 that the wound had increased in size since the last time she had measured it on 9/29/2020. LPN-A indicated the wound was right	F 686	" Audit results to be reviewed at monthly QAPI to evaluate the effectiveness and recommendation of audit continuation " Director of nursing will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 686	Continued From page 12 under the incontinent brief and discussed with R2 about removing that side of the pad, R2 agree. RN-C completed the dressing change per physician order. R2's paper wound record dated 9/29/2020, R2 had a stage 2 pressure ulcer on right lower buttock that measured 1.2 cm (centimeters) x 0.8 cm x0.1 cm in depth. The note on the paper included, "100% granulation with light bleeding". R2's facility record did not identify reference to this wound prior to 9/29/2020. Although the physician orders included treatments for the wounds R2 had been admitted to the facility when the facility failed to identify/revise the treatment orders and care plan to include the newly developed stage 2 pressure ulcer on the lower right buttock that was first identified on 9/29/2020. R2's physician visit notes dated 9/24/2020 and 10/7/2020 were reviewed and did not identify the presence of stage II ulcer on the lower right buttock. R2's progress note dated 10/16/2020, included 4 Right lower buttock stage 2 present on admission (record lacked previous assessments/measurements of this wound prior to 9/29/2020). Measurements: 3.0 cm x 1.8 cm x 0.2 cm depth. Status: deteriorating, possible causative factor is incontinence brief and location of wound. Intervention: while in bed remove right side of brief straps to prevent friction and rubbing. Wound bed: skin tear flap, (islands of epithelial tissue 30%) granulation tissue 70%). Peri wound: rolled edges, intact skin, normal	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 686	Continued From page 13	F 686		

color. Drainage: dressing was removed prior to assessment, serous fluid and scant bleeding after cleansing no signs and symptoms of infection, no odor. Treatment: Slivadene/plurogel to wound base cover with Mepilex (foam absorbent dressing).

During an interview on 10/16/2020, at 2:05 p.m. LPN-A reviewed R2's record, stated the lower right buttock pressure ulcer had not been present upon admission, the wound was identified on 9/29/2020, and that was the last time the wound was assessed. LPN-A stated weekly skin assessment had not been completed as they should have been.. LPN-A indicated although the pressure ulcer had increased in size and slightly in depth the wound continued to be a stage II pressure ulcer. LPN-A stated had the skin assessments been completed, the increase in size and depth could have been prevented. LPN-A stated the wound physician viewed the wounds remotely during a telehealth appointment and instructed the same dressing changes as the other pressure ulcer wound on the buttocks, and indicated she had not renewed the order in the electronic health record. LPN-A indicated she should had documented in a progress note.

During an interview on 10/15/2020, at 1:46 p.m. DON reviewed R2's record, stated wound assessments were not completed weekly and should have been. DON indicated the facility's wound policies should be followed.

Facility's Pressure Injury Prevention and Wound Care Management policy dated 6/30/2020, included:
-Purpose: To identify factors that places the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 686	Continued From page 14 residents at risk for the development of pressure injuries and to implement appropriate interventions to prevent the development of clinically avoidable wounds. To promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. To promote healing of existing pressure injuries and wounds. -The facility will ensure that a resident who is admitted without a pressure injury does not develop a pressure injury, unless clinically unavoidable. -A resident who has a pressure injury will receive care and services to promote healing and to prevent additional ulcers. -A complete assessment is essential to an effective pressure injury prevention and treatment program. A comprehensive assessment helps the facility to identify residents at risk of developing pressure ulcers, as well as the level and nature of their risks. 5. Resident's skin will be monitored daily during cares by nursing assistant and skin check will be completed weekly by licensed nurse. -Skin impairments, including pressure injuries, non-pressure injury wounds, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the Wound Nurse, or designee, using the PCC Weekly Wound Assessment. a.) Weekly documentation will include pertinent characteristics of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues, and a description of any drainage, eschar, necrosis, odor, tunneling, or undermining. -Documentation of the wound characteristics will	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 686	Continued From page 15 be completed in PCC using the PCC Skin and Wound Assessment. This assessment is started in the mobile application. If a device is not available or in need of service, the documentation will be completed in the resident's electronic medical record. Consent for photography will be obtained in the admission packet. -Daily, the clinicians responsible for caring for the Resident will assess the status of the dressing if present, (intact, soiled, leaking), and evaluate for complications such as infection and/or uncontrolled pain -Nursing staff should update the attending physician immediately of wounds that have developed complications and/or not healing as anticipated. The attending physician will also be updated upon assessment if a wound has not improved in 2 weeks.	F 686		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on document review and interview the	F 773	" R1 is no longer a resident at the	11/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 773	Continued From page 16 facility failed to ensure laboratory tests were completed according to the hospital discharge summary for 1 of 2 (R1) residents Reviewed. Findings included: R1's hospital discharge summary dated 9/24/2020, indicated R1 was hospitalized for urinary tract infection and osteomyelitis, with a history of chronic kidney disease, diabetes, and hypertension. The discharge summary also included a section titled "Active Issues Requiring Follow-up" which included the following lab tests-CBC/BMP (complete blood count/basic metabolic panel) every three days and CRP (C-reactive protein) every three days. R1's record lacked evidence the labs were completed per physician order. R1's physician note dated 10/7/2020, included "CMP today showed acute kidney injury, creatinine was 1.1, BUN [bun urea nitrogen] 13, GFR >60 on 9/25/2020 but today Cr 2.2, BUN 37, and GFR 29. He also has hyponatremia; sodium was 137 on 9/25/2002, today 128. Resident is fatigued, hypotensive." The note also indicated the physician had given a verbal order for R1 to be sent to the emergency department During an interview on 10/15/2020, at 4:09 p.m. nurse practitioner (NP)-A reviewed R1's record, indicated the discharge plan for follow-up labs had not been completed, stated an unawareness as to why they were not completed, and indicated they should have been done. Facility policy requested and not received	F 773	facility. " Residents in the facility have the potential to be affected by this deficient practice. Current or active residents admitted since August 2020 will have dismissal summary reviewed to ensure orders have been carried out as ordered by the physician. " Licensed staff will be provided education in regard to follow physician orders documented in dismissal summary from hospital. " Dismissal summary orders audit will be completed weekly for 4 weeks, then monthly for 2 months to ensure physician orders are followed. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness and recommendation of audit continuation " Director of nursing will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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

Electronically delivered
November 9, 2020

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: FS1T11

Dear Administrator:

The above facility was surveyed on October 15, 2020 through October 16, 2020 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:

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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.

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/15/2020 and 10/16/2020, a survey was conducted to determine compliance with state licensure. The following correction order(s) are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 In addition, a complaint investigations were also completed at the time of the licensing survey. The following complaint was/were found to be substantiated: H#549074C. Correction orders were issued The following complaint were found unsubstantiated: H#5409073C.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to appropriately monitor, implement physician orders for laboratory monitoring and notify physician with a change in health status for 1 of 1 residents (R1) recently discharged from the hospital with stage 3 chronic renal disease (mild to moderate damage to the kidneys) and	2 830	Acknowledged	11/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 2 osteomyelitis (infection in the bone). R1 sustained harm when his condition deteriorated resulting in re-hospitalization, with diagnoses of acute renal failure, hypotension (low blood pressure), urinary tract infection, and septic shock. Findings include: R1's admission Minimum Data Set (MDS) assessment dated 10/1/2020, indicated R1 had moderate cognitive impairment. R1 required one staff physical assistance and supervision for eating and drinking. The MDS also included R1 was administered antibiotics. R1's Facility Admission record included, diagnoses of acute osteomyelitis of ankle and foot with foot ulcer, diabetes type 2, and stage 3 chronic renal disease. R1's hospital Discharge Summary dated 9/24/2020, indicated R1 was discharged to the facility on 9/24/2020 and included diagnoses of acute osteomyelitis, complicated urinary tract infection, essential hypertension, with a past medical history of chronic renal disease, type 2 diabetes, and mild cognitive impairment. Identified in the section titled, "Active Issues Requiring Follow-up" included the following, lab tests-CBC/BMP (complete blood count/basic metabolic panel) every three days and CRP (The level of C-reactive protein (CRP), which can be measured in your blood, increases when there's inflammation in your body) every three days. R1's physician orders also included: -Encourage resident to drink plenty of water every day and even evening shift (order start date 9/24/2020) -Levofloxacin (antibiotic) 750 milligrams (mg) every other day (start date 9/24/2020) -Flagyl (antibiotic) 500 mg three times a day (start date 9/24/2020)	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 R1's Post Acute and Long Term Care Standing Orders last revised 6/8/18, included orders for change in condition that directed the following; If patient is ill, yet clinically stable: -clear liquids if indicated -Encourage fluids if not on diuretic/digoxin/have fluid restriction. -Monitor vital signs and intake and outputs each shift until symptoms resolved. -If patient has acute dyspnea (shortness of breath) collect vitals and notify clinician if vitals abnormal indicated below, condition unrelieved after 1 hour or if condition declines. -If temperature is >/=100.5, respiratory rate >28, heart rate >110, systolic blood pressure <80 or >200, oxygen saturations <88% from baseline room air/oxygen, notify clinician. R1's record lacked documentation of any follow up laboratory testing completed after R1 was admitted to the facility until 10/7/20. R1's Registered Dietician-Nutrition Assessment dated 9/29/2020, identified R1 was not on a fluid restriction and estimated daily fluid requirements were 1891 milliliters (ml) per day. The assessment indicated R1's average fluid intake at meals was less than 1200 ml; the section "Comments r/t [related to] fluid intake" was left blank. R1's medication administration record (MAR) included, "encourage plenty of water" marked with nurses initials indicating completed. R1's MAR did not include the amount of water consumed by the nurse's initials. Although, R1's fluid intake was recorded in Point of Care (health record system for documentation used by nursing assistants) and identified R1's 24 hour daily totals as: -On 10/1/2020 intake was 900 ml -On 10/2/2020, intake 320 ml	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 -On 10/3/ 2020 intake 640 ml -On 10/4/2020 intake 640 ml -On 10/5/2020, intake 800 ml -On 10/6/2020, intake 680 ml according to R1's record, R1 was not meeting daily fluid recommendations. R1's October MAR identified a decrease in urine output when daily totals were added. -On 10/1/2020, output 1675 ml -On 10/2/2020, output 1320 ml -On 10/3/2020, output 1250 ml -On 10/4/2020, output 300 ml (no output documented for evening and overnight shift) -On 10/5/2020, output 850 ml -On 10/6/2020, output 400 ml R1's blood pressure record on 10/1/2020, at 10:10 p.m. was 88/57 R1's blood pressure record on 10/2/2020, did not identify a blood pressure was taken. R1's progress note dated 10/3/2020, at 3:38 p.m. indicated R1's blood pressure was 98/48. R1's progress note dated 10/4/2020, at 3:38 p.m. indicated R1's blood pressure was 88/47. R1's progress note dated 10/5/2020, at 6:51 a.m. indicated R1's blood pressure was 87/54 and included, "Loose stools this shift. Resident febrile 100.8 short duration with sustained 100.1 t/o [sic]." R1 was shivering and extra blankets were effective. "Resident worried about loose stools; Imodium {antidiarrheal] was not administered d/t abx [do to antibiotics]" The note indicated the physician was notified. A subsequent note at 10:26 a.m. indicated R1 had "multiple loose stools and R1's blood pressure was 88/47. R1's blood pressure record on 10/6/2020, at 1:03 p.m. was 102/57 and at 11:33 p.m. was 70/50. Although R1 had a decrease in urinary output, had a decrease in fluid intake with low blood pressures from 10/1 through 10/5/2020, there	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 was not evidence the physician was notified until 10/5/2020 when the Covid (a mild to severe respiratory illness that is caused by a coronavirus) and C-Diff (Clostridioides difficile is a bacterium that causes diarrhea and colitis (an inflammation of the colon) testing was ordered. However the record did not include a response from the physician in relation to input/output and low blood pressures. In addition, the record lacked evidence of R1 being monitored and assessed to correct low blood pressures or loose stools. R1's physician note dated 10/7/2020, indicated on 9/25/20 R1's labs included creatinine (Cr) (A test reveals important information about your kidneys) was 1.1, BUN [bun urea nitrogen] 13, GFR >60 and sodium 137, but today (10/7/20) Cr 2.2, BUN 37, and GFR 29 and noted acute kidney injury with today's results. Resident is fatigued, hypotensive (low BP). The note also indicated the physician had given a verbal order for R1 to be sent to the emergency department. R1's progress note was dated 10/7/2020, at 2:38 p.m. included "Resident today had a low BP of 55/39. A call from NP [nurse practitioner] to update nursing that residents labs showed signs of acute kidney injury disease and stated she had attempted to make contact with family but was unable. NP stated she had called [name of hospital] to update on resident status and to send resident to [hospital] ED [emergency department] During an interview on 10/15/2020, at 1:46 p.m. director of nursing (DON) stated nurses were supposed to be tracking and monitoring fluid intake as well as the nursing assistants. DON stated diarrhea could cause dehydration, and low blood pressures could be a symptom of dehydration. DON indicated the focus and concern was COVID symptoms and in hind sight	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 should have completed dehydration assessment. DON indicated when the physician was notified of the loose stools on 10/5/2020, a COVID and C-DIFF labs were ordered. DON further indicated that adequate fluid intake was important when residents had chronic kidney disease and antibiotics were hard on kidneys. DON indicated the facility did not currently have a system in place to track fluid intake, however, it would be a standard of nursing practice and something a physician would not specifically order. During an interview on 10/15/2020, at 2:58 p.m. R1's family member (FM)-1 stated once R1 arrived at the emergency room physicians were concerned of septic shock and his kidneys were shutting down. R1 had very low blood pressure, and normally R1 had high blood pressure. FM-1 stated the emergency room had a difficult time starting a IV (intravenous catheter) because of low blood pressure, and R1 received 5 bags of fluids and an IV medication to increase his blood pressure. FM-1 stated R1 was then transferred to another hospital, admitted to the intensive care unit (ICU) where they gave him 2 more bags of fluids. During an interview on 10/15/2020, at 4:09 p.m. nurse practitioner (NP)-A confirmed R1's diagnosis of stage 3 renal disease. NP-A reviewed R1's lab records; stated labs were not completed per the hospital discharge summary, stated an unawareness of why they were not completed and they should have been. NP-A stated the facility should have been monitoring and evaluating R1's fluid balance, it was a standard of practice. NP-A stated the facility should have identified and reported the decrease in intake/output in conjunction with the presence of low blood pressures, and was not provided that information. R1's recorded fluid intake and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 outputs were reviewed with NP-A, NP-A stated "fluid intake and output is very low." During an interview on 10/15/2020, at 4:38 p.m. registered nurse (RN)-A reviewed R1's fluid intakes and outputs; stated the physician should have been notified about the decrease and further assessment of dehydration should have been completed. RN-A indicated staff were supposed to encourage fluid intake with encounters, however the amount and/or refusals were not documented. During an interview on 10/15/2020, at 5:16 p.m. NA-C thought she remembered R1 having loose stools prior to going to the hospital. NA-C stated she would encourage R1 to take a drink when she took care of him, however she did not record the amount. During an interview on 10/15/2020, at 5:42 p.m. hospital-1 registered nurse (H1-RN) stated R1 arrived at the ED on 10/7/2020, at 2:40 p.m. H1-RN stated R1 had been diagnosed with urinary tract infection and septic shock. H1-RN stated when R1 arrived at the hospital blood pressure was 77/41, a central line was attempted however, it didn't work. H1-RN stated R1 was administered a bolus of fluid, two IV antibiotics, and a norepinephrine drip. H1-RN confirmed R1 received fluids continuously over the course of 5 hours he was at hospital-1. H1-RN indicated R1's labs were indicative of sepsis and dehydration; and renal function and sodium levels had slightly improved after fluid administration. H1-RN stated R1 was transferred to hospital-2 at 8:23 p.m. During an interview on 10/15/2020, at 7:04 p.m. hospital-2 registered nurse (H2-RN) confirmed R1 arrived at hospital-2 and was admitted to the ICU. H2-RN indicated R1 was administered fluids. H2-RN stated dehydration could cause acute renal failure.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 Facility policy Change in Condition 12/19/2018, included: The physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference in usual sign/symptoms and/or the signs/symptoms are unrelieved by measures already prescribed: Specific information that requires prompt notification include, but is not limited to: Significant change or instability of vital signs; Prolonged/unresolved emesis/diarrhea A significant change in the resident's physical/psychosocial/mental condition A need to alter the resident's medical treatment significantly Nurse will complete assessment and document findings in resident record including but not limited to vital signs, pain, respiratory status as applicable, cardiac status as applicable, etc. Notification of medical professional and resident representative will be documented in medical record. Facility Hydration Policy that was undated included: It is critical that each resident at risk for hydration deficit or imbalance ...be identified and assessed to determine appropriate interventions. The resident may experience a decline in appetite or have difficulty eating or swallowing. Upon admission, each resident will be assessed by the R.D. to determine estimated fluid needs and risk for dehydration. Fluid needs and risk for dehydration will be documented in the Registered Dietician Nutritional assessment. Upon admission, Nursing will also assess physical status, including, but not limited to skin turgor, mucous membranes, urinary status, and vitals to determine if resident has adequate hydration or risk factors are presents. Residents who already reside in the building will	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 be assessed for risk or symptoms of dehydration on a quarterly basis, or as needed if risk increases or symptoms are present. Conditions that contribute to increased risk of dehydration include, but are not limited to the following: increased fluid losses; included diarrhea, acute illness or fever, poor fluid intake, presence of an infection. If resident is at elevated risk of dehydration or symptoms of fluid deficit/dehydration are present, resident will be immediately referred to the I-team and/or MD for further review and assessment Symptoms of dehydration include, but are not limited to: orthostatic hypotension, dry mucous membranes decreased urine output or concentrated urine, change in lab values If resident is at elevated risk of dehydration or symptoms of fluid deficit or dehydration are present, any or all of the following interventions will be implemented and the care plan will be updated. MD notification, PUSH fluids order, Daily weights, Basic metabolic panel or other labs, IV hydration, Alert staff of increased fluid needs, Monitor vitals per protocol, Start resident on Hydration Program, Daily Intake and Output monitoring. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON)/designee could review the facility's dehydration policy/procedure. DON/designee could develop education on signs/symptoms/monitoring of dehydration and intervetnions to nursing staff. DON/designee could then develop compentency testing, in addition to an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 10	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure weekly assessments were completed to identify and prevent deterioration of the pressure ulcers for 1 of 2 residents (R2) reviewed for pressure ulcers. Findings included: R2's Admission Minimum Data Set (MDS) assessment dated 9/23/2020, indicated R2 did not have cognitive impairment and R2 required extensive assist of one person for bed mobility, toileting, and personal hygiene. R2 required extensive assist from two or more staff members for transfers. The MDS further identified R2 was at risk for pressure ulcers, had one unstageable	2 900	Acknowledged	11/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 11 ulcer and two venous or arterial ulcers. The MDS did not identify R2 had a stage 2 pressure ulcer upon admission. R2's Admission Record, included diagnoses of Stage 3 pressure ulcer of sacral region, unstageable pressure ulcer of the right hip, Stage 3 pressure ulcer of the right buttock, lumbar spina bifida, peripheral vascular disease, and congestive heart failure. R2's skin care plan revised on 9/29/2020, included R2 had alteration in skin integrity related to unstageable pressure ulcer to right buttock, 2-stage 3 pressure ulcers, 2 vascular ulcers. R2's skin goals included, "My alterations in skin integrity will show signs of improvement in healing by the review date." Associated interventions of care included: encourage offloading (initiated 9/29/2020), pressure reducing mattress and chair cushion (initiated 9/29/2020), administer skin treatments as ordered, assess/monitor the alteration in my skin integrity and document status weekly (initiated 9/16/2020) . R2's physician orders dated 9/16/20 included, right buttock, right ischium (forms the lower and back part of the hip bone), right hip: apply half Plurogel (unique burn and wound dressing that is 100% water-soluble, bio-compatible, cell-friendly, and non-ionic It aids in the creation of an optimal moist wound healing environment that helps to protect healthy tissue and soften wound debris) and half silvadene (used with other treatments to help prevent and treat wound infections) cream on wounds. To be applied daily and covered with abdominal pads daily and as needed.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 12 During an observation on 10/16/2020, at 11:45 a.m. R2 laid in bed. Director of nursing (DON), licensed practical nurse (LPN)-A, and registered nurse (RN)-C were also in the room to complete dressing changes. RN-C removed dressing to R2's lower right buttock, measured the wound- 3.0 centimeters (cm) x 1.8 cm x 0.2 cm. LPN-A informed R2 that the wound had increased in size since the last time she had measured it on 9/29/2020. LPN-A indicated the wound was right under the incontinent brief and discussed with R2 about removing that side of the pad, R2 agree. RN-C completed the dressing change per physician order. R2's paper wound record dated 9/29/2020, R2 had a stage 2 pressure ulcer on right lower buttock that measured 1.2 cm (centimeters) x 0.8 cm x0.1 cm in depth. The note on the paper included, "100% granulation with light bleeding". R2's facility record did not identify reference to this wound prior to 9/29/2020. Although the physician orders included treatments for the wounds R2 had been admitted to the facility when the facility failed to identify/revise the treatment orders and care plan to include the newly developed stage 2 pressure ulcer on the lower right buttock that was first identified on 9/29/2020. R2's physician visit notes dated 9/24/2020 and 10/7/2020 were reviewed and did not identify the presence of stage II ulcer on the lower right buttock. R2's progress note dated 10/16/2020, included 4 Right lower buttock stage 2 present on admission (record lacked previous	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 13 assessments/measurements of this wound prior to 9/29/2020). Measurements: 3.0 cm x 1.8 cm x 0.2 cm depth. Status: deteriorating, possible causative factor is incontinence brief and location of wound. Intervention: while in bed remove right side of brief straps to prevent friction and rubbing. Wound bed: skin tear flap, (islands of epithelial tissue 30%) granulation tissue 70%). Peri wound: rolled edges, intact skin, normal color. Drainage: dressing was removed prior to assessment, serous fluid and scant bleeding after cleansing no signs and symptoms of infection, no odor. Treatment: Slivadene/plurogel to wound base cover with Mepilex (foam absorbent dressing). During an interview on 10/16/2020, at 2:05 p.m. LPN-A reviewed R2's record, stated the lower right buttock pressure ulcer had not been present upon admission, the wound was identified on 9/29/2020, and that was the last time the wound was assessed. LPN-A stated weekly skin assessment had not been completed as they should have been.. LPN-A indicated although the pressure ulcer had increased in size and slightly in depth the wound continued to be a stage II pressure ulcer. LPN-A stated had the skin assessments been completed, the increase in size and depth could have been prevented. LPN-A stated the wound physician viewed the wounds remotely during a telehealth appointment and instructed the same dressing changes as the other pressure ulcer wound on the buttocks, and indicated she had not renewed the order in the electronic health record. LPN-A indicated she should had documented in a progress note. During an interview on 10/15/2020, at 1:46 p.m. DON reviewed R2's record, stated wound	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 14 assessments were not completed weekly and should have been. DON indicated the facility's wound policies should be followed. Facility's Pressure Injury Prevention and Wound Care Management policy dated 6/30/2020, included: -Purpose: To identify factors that places the residents at risk for the development of pressure injuries and to implement appropriate interventions to prevent the development of clinically avoidable wounds. To promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. To promote healing of existing pressure injuries and wounds. -The facility will ensure that a resident who is admitted without a pressure injury does not develop a pressure injury, unless clinically unavoidable. -A resident who has a pressure injury will receive care and services to promote healing and to prevent additional ulcers. -A complete assessment is essential to an effective pressure injury prevention and treatment program. A comprehensive assessment helps the facility to identify residents at risk of developing pressure ulcers, as well as the level and nature of their risks. 5. Resident's skin will be monitored daily during cares by nursing assistant and skin check will be completed weekly by licensed nurse. -Skin impairments, including pressure injuries, non-pressure injury wounds, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the Wound Nurse, or designee, using the PCC Weekly Wound Assessment. a.) Weekly documentation will	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 15 include pertinent characteristics of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues, and a description of any drainage, eschar, necrosis, odor, tunneling, or undermining. -Documentation of the wound characteristics will be completed in PCC using the PCC Skin and Wound Assessment. This assessment is started in the mobile application. If a device is not available or in need of service, the documentation will be completed in the resident's electronic medical record. Consent for photography will be obtained in the admission packet. -Daily, the clinicians responsible for caring for the Resident will assess the status of the dressing if present, (intact, soiled, leaking), and evaluate for complications such as infection and/or uncontrolled pain -Nursing staff should update the attending physician immediately of wounds that have developed complications and/or not healing as anticipated. The attending physician will also be updated upon assessment if a wound has not improved in 2 weeks. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		