

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 4, 2021

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 notified you a remedy was imposed. On January 15, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 8, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective November 24, 2020 be discontinued as of January 8, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 15, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 24, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 4, 2021

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

Re: Reinspection Results

Event ID: LMG312

Dear Administrator:

On January 15, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on October 16, 2020 and December 4, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Paig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 28, 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 of imposed enforcement remedies.

On December 4, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. {Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On December 4, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of G.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 24, 2020, will remain in effect.
- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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.

As we notified you in our letter of October 15, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 24, 2020.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded

by an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office 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

Office: (507) 206-2727 Mobile: (507) 461-9125

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

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

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/ 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 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.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. This

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 01/11/2021 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245409	B. WING				C 04/2020
	PROVIDER OR SUPPLIER	R		1875 19 ⁻	ADDRESS, CITY, STATE, ZIP CODE TH STREET NORTHWEST ESTER, MN 55901	1 12/	04/2020
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E 000	was conducted on at your facility by th Health to determine Preparedness regulacility was IN full of Because you are ensignature is not required, it is required, it is required, it is required, it is required, in the required, it is required in the complete comple	nrolled in ePOC, your uired at the bottom of the first 567 form. Sugh no plan of correction is red that the facility of of the electronic documents.	F O		DEFICIENCY)		
	(IJ) at F880 when the implement infection and/or minimize a f COVID-19. The IJ to facility failed to implement when covid positive from their roommat	d in an Immediate Jeopardy the facility failed to promptly a control practices to prevent acility wide outbreak of began on 11/22/20, when the lement cohorting strategies e residents were not separated tes.					
ABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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

Electronically Signed

(X6) DATE

01/07/2021

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

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F 000	of correction. The following compsubstantiated: H54009077C. Defir F686 H54009078C. Defir H54009079C.	plemented an appropriate plan plaints were found to be ciencies issued at F684, F698, ciency issued at F880. Ciency issued at F561. If correction (POC) will serve of compliance upon the optance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with 1)-(3)(8) ermination. The right to and the facility must atte resident self-determination resident choice, including but ghts specified in paragraphs (f)	F 0			1/8/21

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F 561	choices about asp facility that are sign selections with members of the community activiting facility. §483.10(f)(8) The participate in other religious, and community activiting facility. This REQUIREMED by: Based on observative review, the facility (R18) reviewed was according to her periodical form. R18 was interviewd 1:47 p.m. R18 was room, her hair was appearing texture getting bathed." Rhad a chair bath. I cannot do shower [recliner]. I need to a week I am lucky with wash cloth do she has seborric of itchy and she had stated, "They told"	_	F 50	" R18 had her bathing prefereviewed, and care planned to preference of receiving showe week and hair washed four timeweek. " All residents have the pote affected if their self-determine preferences is not followed. The whole house review of bathing preferences will be completed resident preferences are inclurespective plans of care and in Kardex. " All nursing staff will be eding in portance of resident self-de as it relates to bathing, and fol those preferences in the resid of care. " Bathing preferences will be in care conferences to ensure preferences are being reviewed.	einclude her rs twice a nes per ential to be of bathing nerefore, a to ensure ded in their ndividual exarted on termination lowing ent s plan e reviewed resident		

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				R	OCHESTER, MN 55901		
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F 561	her skin, takes pregood. R18's quarterly Minassessment dated required physical had intact cogmental score of 15 understood and uncomprehension. R18's bath schedule of the week to have the bath schedule of the week to have the week to have the bathing; assist of Wednesday AM (not R18's hair washing included, "[R18] with [Tuesday], TH [The beauty shop with had alon for specified R18's bathing care included, "Behavioral history of refusing the peri-wand to Staff will continued to staff will continue to staff will continue to staff will staff w	nimum Data Set (MDS) 11/19/20; identified R18 nelp in part of bathing activity mber providing physical assist nition with a brief interview s. R18 had clear speech, was nderstands with clear lle indicated she was to be saday and Sunday mornings. It did not indicate two other days he her hair washed. ide Kardex report utilized by to provide cares, indicated to the saday and to provide cares, indicated to the saday and	F 5	661	updated per resident choice. "Weekly bathing audits will be conducted for four weeks, monthly months, and periodically as needed on audit findings. "Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determina adherence and the need for audit continuation. "DON/Designee is responsible fensuring compliance.	tion	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 561	nterviewed three neurit and they could regarding R18's bar interviewed three neurit and they could regarding R18's bar interviewed R18 and bath in her recliner bath for two weeks R18 asked her if the showers because or reassured R18 that The DON also state getting her hair was DON stated her exphave her shower two washed four times about a month ago list so no matter who weed each wing healthing for all of the R18 not getting shounacceptable. Durin 12/4/20, at 8:27 a.m. updated the bath so shampoo days on the stated she would be shampoo days on the stated she sham	mentation was reviewed from and revealed R18 had a bath /15/20 during the time period es were reviewed from 11/1/20 was one progress note dated aded resident refused shower	F 5	561			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
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F 561	"Documentation: Do shower/bath was co	olicy revised 2/26/20 included, ocument in Point of Care that omplete, and the level of	F 5	61		
	shower/bath was complete, and the level of assistance. Reporting: 1. Notify the nurse if resident refuses the shower/tub bath" Geometric Complete and the level of assistance. Reporting: 1. Notify the nurse if resident refuses the shower/tub bath" Geometric Complete and the level of assistance. Reporting: 1. Notify the nurse if resident refuses the shower/tub bath" Geometric Complete and the level of assistance. Reporting: 1. Notify the nurse if resident refuses the shower/tub bath" Geometric Complete and the level of assistance. Reporting: 1. Notify the nurse if resident refuses the shower/tub bath"		F 6	84		1/8/21
	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and assess signs and symptoms of hypo/hyperglycemia (low/high blood sugars) and failed to notify the physician according to physician orders for 2 of 3 residents (R7, R8) reviewed for diabetic management, however the failures had the potential to effect all 15 diabetic residents who resided in the facility. Findings include R7 Admission Record provided by the facility on 12/3/2020, included diagnosis of diabetes type 2 and schizophreniform disorder.			" The facility completed a diaber review on all residents with a diaber diagnosis to ensure blood sugar parameter orders were in place. The includes residents R7 and R8. " All licensed nursing staff will be educated on diabetic monitoring at assessing signs and symptoms of hypo/hyperglycemia, including noti providers if blood sugars are outsit ordered parameters. " Upon admission blood sugar parameter orders will be obtained the physician and entered into PCC " Weekly audits for diabetic management and provider notifical will be conducted weekly for four weekly sugar to the provider of the provide	etic his e hd fying de of from C.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY PLETED
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F 684	10/13/2020, did no and required insular R7's diabetic care to give R7 diabeted monitor/document effectiveness. The monitor/document symptoms of hyporal R7's physician or clantus (long actimorning (start dat 10/1/2020) Lantus 80 units of 10/1/2020, stop delantus 90 units of 10/15/2020 Novolog (rapid actimorning, 12 units (16/12/12) at ever 9/22/2020) Novolog insulin 2 stop date 10/1/2020, stop date 10/1/2020, stop date 10/1/2020, stop date 10/2/2020, stop date 11/6/2020, stop date 11/6	ot have cognitive impairment lin. In plan dated 6/11/2019, directed as medications as ordered and at for side effects and a care plan also directed staff to a care plan also directed staff to a care plan and hyperglycemia. It is included the following and insulin and property of the state	F 6	mo as " mo dia au	onthly for two months, and per needed based on audit finding. Audit results to be reviewed onthly QAPI to evaluate effect abetic management and the redit continuation. DON/Designee is responsible as uring compliance.	ngs. d at tiveness of need for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		` IDENTIFICATION NUMBER.		PLE CONSTRUCTION G	(,	(X3) DATE SURVEY COMPLETED	
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F 684	> 100. During an observa 12/2/2020, at 11:06 (LPN)-A stated R7 units at lunch time to 26 units, walked sugar which was 1 a short acting insuldirected to take with R7's insulin at 11:1 blood sugars were could not articulate when she was symweek R7 reported sugar was around the provider. R7 reapproximately 30 radministration between the provider of approximately 30 radministration between th	tion and interview on 3 a.m. licensed practical nurse received Novolog insulin 26 LPN-A dialed R7's insulin pen to R7's room, took R7's blood 94. LPN-A stated Novolog was lin and the label on the pen th meals. LPN-A administered 2 a.m. R7 stated when her low she got the chills, but what her blood sugars were aptomatic. LPN-A indicated last symptoms however, her blood "125ish" and she had notified ceived her lunch tray between ninutes after insulin ween 11:45-11:50 a.m. ecords and nursing progress m 9/1/2020 to 12/2/2020, high blood sugars without oriate interventions, monitoring,	F 68	4			
	at 4:09 p.m. blood	record identified on 9/28/2020, sugar was 463; record did not til the next scheduled check at					

STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	243403	B: ******		STREET ADDRESS, CITY, STATE, ZIP CODE	12/0	04/2020
	OOK OF ROCHESTE	R		1	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 PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 684	9:29 p.m. at which R7's record lacked monitoring and ass hyperglycemiaR7's blood sugar rat 9:05 p.m. R7's blood sugar rat 9:05 p.m. R7's brecorded the next record lacked evide monitoring and ass symptoms of hyper-On 10/15/2020, at note and blood sugar of 52. blood sugar was not scheduled check at medication administered 26 un blood sugar of 52. interventions, assessigns and symptom-On 11/9/2020, at note indicated R7's to low blood sugar" 3:30 p.m. was 80 a next ordered check lacked evidence of assessment for sig hypoglycemia -On 11/19/2020, at note indicated R7's because R7 refuse at 12:12 p.m. was a monitored for signs hypoglycemia or if I offered snacks to n levels between mea	time blood sugar was 445. physician notification, essment for symptoms of ecord identified on 9/29/2020, lood sugar was 465; next norning at 7:14 a.m. R7's ence of physician notification, essment for signs and glycemia. 11:55 a.m. nursing progress ar record identified R7 had a The record identified R7 had a The rechecked until the next at:448 p.m. According to R7's extration record, R7 was its of Novolog insulin despite a The record lacked evidence essment, and monitoring for its of hypoglycemia. :04 p.m. nursing progress Novolog insulin was held "due at 9:19 p.m. The record monitoring, intervention, and has and symptoms of 12:12 p.m. nursing progress Novolog insulin was held d lunch; recorded blood sugar was not and symptoms of R7 was provided and or naintain safe blood sugar	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245409	B. WING _		12	/04/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	stated the physicia right away when the mg/dl for correction lacked evidence of signs/symptom of lacked documentate physician/family not and effectiveness, protocol, and signs hypo/hyperglycemia. During an interview certified nurse practive supposed to hypoglycemia and symptomatic and for corrections.	n should have been notified e blood sugars were over 400 n orders. DON verified record monitoring and evaluation of hypo/hyperglycemia. DON ion should include otification, interventions used blood sugar rechecks per s/symptoms of	F 68	4			
	9/3/2020, identified had moderate cogninsulin administration R8's diabetic care the following "diabet doctor. Monitor/doceffectiveness." and as needed signs an hypo/hyperglycemic R8's current physic -Novolin NPH insuling with breakfast) and	plan dated 7/28/15, directed of etes medication as ordered by cument for side effects and it to monitor/document/report and symptoms of a. cian orders included: lin 60 units in the morning (give it hold doses if not eating and					

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE	
F 684	for blood glucose 400 next working requires treatment protocol notify imn Facility Post-Acute Orders dated 6/8/r orders for diabete -Notify clinician if 2 readings < 70 and -If finger stick glucy give glucose/carbo -If patient become 70, give glucose/c Notify clinician. Co glucose and treat > 100. Physician visit not note some signific do not see in reco attention to provid Novolin 70/30 30 v in the evening hole and nursing to not than 100 or greate unless symptomat protocol. R8's blood sugar in nursing progress in	NP (certified nurse practitioner) less than 100 or greater than day; unless symptomatic, or t for hypoglycemia per facility nediately. e and Long Term Care Standing 18, included the following s: 2 consecutive blood glucose lor >=400. cose < 70 and asymptomatic, ohydrate orally is symptomatic and glucose is < arbohydrate and protein orally. Intinue to monitor finger stick every 15 minutes until glucose et at dated 12/1/2020, included "I stantly low blood glucose levels, and that this has been brought to er." The physician gave orders, units in the morning and 5 units in the morning and 5 units dif blood sugar is less than 90 iffy provider if blood sugar less er than 350 next working day, tic or per facility hypoglycemic record (BSR) in correlation with notes from 10/1/2020 to	F6	584			
	12/2/2020.??the of The blood sugar reglucose readings of per deciliter) without notification per phregard lacked evice.	order above was given 12/2/20? ecord identified 41 blood of under 100 mg/dl (milligrams out evidence of physician sysician orders. In addition, the dence appropriate interventions R8, the lacked evidence of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 684	monitoring and ass symptoms of hypogare some examples last 30 days where physician, lacked e interventions and massessment for sig -BSR 11/30/2020 At 8:07 a.m. BS wa At 9:44 a.m. BS wa At 12:17 p.m. BS wa At 12:17 p.m. BS wa At 12:17 p.m. BS wa At 3:18 a.m. BS wa -BSR 11/28/2020 At 11:43 a.m. BS wa medication adminis not held per order. At 7:52 p.m. BS wa -BSR on 11/27/202 mg/dl -BSR on 11/27/202 mg/dl -BSR on 11/23/2020 mg/dl -BSR on 11/23/2020 mg/dl -BSR on 11/23/2020 mg/dl -BSR on 11/23/2020 mg/dl, next recorde until the next morni 139.0 mg/dl. Corres 11/23/2020, at 8:54 low BS"BSR on 11/21/2020 mg/dl, at 3:13 p.mBSR on 11/20/2020 next check at 11:15 checked at 4:38 p.r check at 7:18 p.m. 11/20/2020, at 4:39 held due to low blood	essment for signs and glycemia. All of the following is (not all inclusive) within the the facility failed to notify the vidence of appropriate nonitoring, and lacked ns/symptoms of hypoglycemia: as 82.0 mg/dl as 97.0 mg/dl as 97.0 mg/dl as 69.0 mg/dl as 69.0 mg/dl as 62.0 mg/dl as 85.0 mg/dl as 97.0 mg/dl as 97.0 mg/dl as 97.0 mg/dl as 97.0 mg/dl as 85.0 mg/dl as 85.0 mg/dl as 85.0 mg/dl as 97.0 mg/dl as	F	684				

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F 684	-BSR on 11/11/202 mg/dl. During an interview director of nursing (stated the physiciar right away when the orders. DON verifiemonitoring and evanypo/hypoglycemia should include physinterventions used a rechecks per protochypo/hyperglycemia. During an interview certified nurse practive supposed to enhypoglycemia and record. During an interview assistant (PA)-A record did not identified the facility that report mg/dl. PA-A stated multiple blood sugal facility should have parameters. PA-A swas low evaluate for notify the physician intervention and record.	on 12/3/2020, at 8:19 a.m. (DON) reviewed R8's record, a should have been notified be blood sugars per physicians d record lacked evidence of luation of signs/symptom of . DON stated documentation sician/family notification, and effectiveness, blood sugar col, and signs/symptoms of	F6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
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F 684	6/11/20, included tresidents for signs hyperglycemia and indicated. Diabetic signs/symptoms of assessed and trea facility protocol as 2. Upon presentati nurse should chec accucheck. a. If an accucheck above 300 mg/dl o orders, hyperglyce b. If any signs/symcondition are ident resident's condition Hyperglycemic pro 1) Administer hypoper individual phys 2) Offer 16-24 oun beverage over two contraindicated. 3) Recheck blood 4) Report findings Facility policy Hypo 6/11/2020, include residents for signs hypoglycemia and indicated. Diabetic signs/symptoms of assessed and trea facility protocol as 2) Upon presentati nurse should chec accucheck. A) if ar sugar below 70 mg suspected. i. Should signs hypoglyced. i. Should signs hypoglyced. i. Should suspected. i. Should suspected. i. Should suspected. i. Should signs hypoglyced. i. Should suspected. i. Should	he purpose as "To monitor and symptoms of I treat the symptoms as residents presenting with f hyperglycemia will be further ted in accordance with the follows: on of symptoms, the licensed k the blood glucose level via an reveals a blood glucose level r level identified per individual mia should be suspected. ptoms, or other abnormal ified, reprt the diabetic to the physician immediately. tocol: glycemic agents and/or insulin ician orders. ces of water or sugar free hours unless clinically glucose level to the physician orders con the physician orders ces of water or sugar free hours unless clinically glucose level to the physician orders con the physician orders and symptoms of treat the symptoms as residents presenting with f hypoglycemia will be further ted in accordance with the	F 68	34		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	physician immedia symptoms listed of identified, report of immediately. 3) Follow the reside protocol, if ordered protocol is ordered on clinical assess. Hypoglycemic Treinconsistent with process of fast-acting carbon than 70 mg/dl. B. licensed nurse if the treatment, per physician 3) Repeat the accephysician 3) Repeat the profiglucose level remarks are port findings to the indentification.	ately or call 911. B. If any or other abnormal condition are condition the physician dent's individual hypoglycemic d by a physician. If no individual d, update the physician based ment and current blood sugar. Catment protocol was chysician standing orders. The emia promptly with 15-20 grams onlydrates for blood sugar less and given by the patient cannot ingest a sugar visician orders. Sucheck and report findings to stocol only once if the blood the east than 70 mg/dl and	F 68			1/8/21
SS=D	§483.25(I) Dialysis The facility must e require dialysis re- with professional s comprehensive pe the residents' goa This REQUIREME by: Based on observa review the facility monitor dialysis ac symptoms of infec	ensure that residents who ceive such services, consistent standards of practice, the erson-centered care plan, and its and preferences. ENT is not met as evidenced eation, interview, and document failed to accurately identify and excess port for signs and ction, and complete daily weight f 1 resident (R20) reviewed for		" All residents receiving dialysis services were reviewed to ensure are in place for identifying and more dialysis access ports for signs and symptoms of infection, and complete daily weight monitoring. This including resident R20.	orders nitoring I eting	

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F 698	Findings include R20's Admission on 12/4/2020, increnal disease, me and left leg below type 2, and heart R20's admission 11/12/2020, indication impairment, and obehaviors. MDS is assistance from the dressing, one starthygiene, and deptransfers. The MI frequently incontinuity incontinuity in the disease of	Record provided by the facility luded diagnoses of end stage etabolic encephalopathy, right the knee amputation, diabetes failure. Minimum Data Set (MDS) dated ated R20 did not have cognitive did not have rejections of care dentified R20 required extensive wo or more staff members for ff extensive assistance for endent on two or more staff for DS also indicated R20 was nent of urine and required are plan upon admission quired dialysis. R20's are plan for dialysis dated ded: facility will have ongoing and collaboration with the dialysis dered, monitor right tunneled site for bleeding and of infection, update dialysis in condition that may affect	F 69	" All nursing staff will be the importance of identifying monitoring dialysis access and symptoms of infection, completing daily weight mo " Upon admission orders and monitoring dialysis port symptoms of infection as weight monitoring will be obtine physician and entered in " Audits for dialysis care completed weekly for four of two months, and periodic needed based on audit find will include identifying and redialysis access ports for significant symptoms of infection, noting provider if infection is noted conducting daily weight mo " Audit results will be reveat QAPI to evaluate the effect dialysis care management of a for audit continuation. " DON/Designee is responsible to the provider of	g and ports for signs and nitoring. s for identifying ts for signs and rell as daily otained from nto PCC. will be weeks, monthly ically as lings. Audits monitoring gns and fication to I, and nitoring. riewed monthly ectiveness of and the need	

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F 698	R20's physician ord-Dialysis shunt mor shunt in left abdom pulse, or buzzing so fingers over the fist thrill, the blood is floand your fistula is won thrill/bruit present 11/5/2020 stop date -Dialysis, Central Pall dressing changes Nursing to monitor remains clean/dry/ifurther direction of dressing changes et 11/5/2020, -Monitor dialysis for signs/sy including bleeding, around the site. No concerns. Schedule returned Monday, which was the sident has cather implanted, right che-Admission and for 2 weekly for 3 weeks otherwise ordered e-Weigh daily processes before breakfast, pmD of weight gain over a 2 day period date 11/25/2020)	ders included the following: hitoring: Check thrill/bruit of en. Feel the thrill, strong ensation, by placing your hidagraft. If you can feel the bowing through the blood vessel working. Notify MD if weak or hit every shift. (Start date e 12/3/2020) ort: Dialysis Unit to complete es during dialysis appointment. hite to assure dressing htact. Contact dialysis for any concerns or needed every shift. (Start date excess site upon return from exmptoms of complications pain, redness, and edema hite provider and dialysis unit of e on dialysis days and time excess and edema hite provider and dialysis unit of e on dialysis days and time except and dialysis unit of except and dialysis except and dia		98			
	dialysis (Start date	shift four times a day for 11/16/2020) shift for dialysis (start date					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
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OVIDER OR SUPPLIER OK OF ROCHESTE			STREET ADDRESS, CITY, STATE, ZIP C 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		. V 11 - V - V	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
R20's hospital disciples of the medication and record lacked evidentiates and/or inquired primary care proposed of the medication and record lacked evidentiates and/or inquired primary care proposed of the medication and the medication are the medication are the medication per medication	harge summary dated identify any fluid restrictions daily fluid intake goals. R20's ence the facility completed a t to determine adequate fluid ries with the dialysis providers ovider until 12/1/2020. d did not reflect daily weight sician orders; between 4/2020 only 4 weights were of 246 lbs. (pounds) to f 251 lbs. of 114 kg. of 112.3 kg. (dialysis post a records, R20 did not have a fit abdomen, however according administration records (MAR) to 12/3/2020, the boxes had es that indicated nurses found shunt that was not there. The liphysician order for R20's had check marks indicating completed, however no other taining to the integrity of the the record.	F 6	98			
	CORRECTION CONTIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From particles of the medication and the medication are the medication and the medication and the medication are the medication and	CORRECTION 245409 DIVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 R20's hospital discharge summary dated 1/5/2020, did not identify any fluid restrictions ind/or direction on daily fluid intake goals. R20's ecord lacked evidence the facility completed a ietary assessment to determine adequate fluid intake and/or inquiries with the dialysis providers in primary care provider until 12/1/2020. R20's weight record did not reflect daily weight monitoring per physician orders; between 1/5/2020 and 12/4/2020 only 4 weights were ecorded. 1/5/2020, weight of 246 lbs. (pounds) 1/23/2020, weight of 114 kg. 2/2/2020 weight of 112.3 kg. (dialysis post	DENTIFICATION NUMBER: 245409 B. WING DVIDER OR SUPPLIER OK OF ROCHESTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 R20's hospital discharge summary dated 1/5/2020, did not identify any fluid restrictions nd/or direction on daily fluid intake goals. R20's ecord lacked evidence the facility completed a ietary assessment to determine adequate fluid hake and/or inquiries with the dialysis providers or primary care provider until 12/1/2020. R20's weight record did not reflect daily weight nonitoring per physician orders; between 1/5/2020 and 12/4/2020 only 4 weights were ecorded. 1/5/2020, weight of 254 lbs. (pounds) 1/23/2020, weight of 251 lbs. 2/2/2020 weight of 112.3 kg. (dialysis post weight) A. BUILDII B. WING DRAFT TAG F 69 R20's hospital discharge summary dated 1/5/2020, did not identify any fluid restrictions nd/or direction on daily fluid intake goals. R20's ecord action and the determine adequate fluid hake and/or inquiries with the dialysis providers or primary care provider until 12/1/2020. R20's weight record did not reflect daily weight nonitoring per physician orders; between 1/5/2020 weight of 251 lbs. 2/2/2020, weight of 114 kg. 2/2/2020 weight of 112.3 kg. (dialysis post weight) According to R20's records, R20 did not have a ialysis shunt in left abdomen, however according the medication administration records (MAR) etween 11/5/2020 to 12/3/2020, the boxes had heck marked boxes that indicated nurses found ruit and thrill on a shunt that was not there. The AR also identified physician order for R20's entral port; boxes had check marks indicating ne task had been completed, however no other ocumentation pertaining to the integrity of the ite was evident in the record. R20's progress note dated 11/20/2020 at 10:55 .m. included, "Received a call from [name of urse] at dialysis, stating resident is being taken of ED [emergency department] d/f [due to] rainage from his dialysis catheter. R2	DOUBT OR SUPPLIER 245409 245409 245409 245409 245409 245409 245409 245409 245409 245409 245409 2570ER OR SUPPLIER 2570ER OR OF ROCHESTER 2570ER OR OF ROCHESTER, MN 55901 2570ER OR USC DENTIFYING INFORMATION) 2570ER OR USC DENTIFYING INFORMATION 2570ER OR USC DENTIFY OR USC DENTIFY 2570ER OR USC	DIMIDER OR SUPPLIER 245409 DEVIDER OR SUPPLIER DK OF ROCHESTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DOINTINUED From page 17 Continued From page 17 F 698 Continued From page 17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
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F 698	included, "[R20] wa [hemodialysis dialy 11/20 in the setting Noted purulence, resite. Resident was R20's hospital Afte 11/24/2020, indicat hospital on 11/20, a facility on 11/24/20 was infection cather The AVS included purulence at the ca concern for cather presenting for replatemodialysis cather included he present and hypotension downs noted to have right chest wall tun with surrounding endifferent intravenout to oral antibiotics. In "weigh patient daily dialysis." During an interview assistant director of dialysis access was stated the order ab error, nurses shoul DON stated R20 w from dialysis becautone of the line port.	as transferred from HD sis] to [name of hospital] on of AMS [sic], hypotension. edness around his catheter admitted to [name of hospital]. It Visit Summary dated the R20 was admitted to the and discharged back to the 20. Reason for hospitalization eter peripheral insertion central. It male admitted for atheter insertion site with earlier insertion site with earlier. The summary also atted with altered mental status uring hemodialysis session. He purulent drainage from the neled dialysis catheter exit site rythema. R20 received two antibiotics and transitioned Discharge orders included a per facility protocol Daily for a for 12/2/2020, at 2:39 p.m. If nursing (ADON) stated R7's son his right chest wall. DON dominal site was entered in d not have been documenting, as admitted to the hospital use R7 central line had blood in	F6	98		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING	-	COM	E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVI CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 698	abnormalities it word progress note. LPN site morning; there around the insertion not looked at the sidialysis around lund there was blood uninsertion site. During an interview dialysis charge nurs 11/20/2020 she was central line site. DR arriving to the clinic indicated any changform. DRN stated with the line had thick puthe catheter line frod dressing, more purd dressing. DRN statel lot of drainage on it the insertion site was drainage was very been missed if som indicated that could couple of hours. Drave a fistula in his times dialysis paties since R20 was sor monitoring how mudialysis run to detern necessary or if nee stated another reas hospital on 11/20/2 hypotensive. DRN sweigh residents whommunicate weigh also expected staff	Ild be documented in a -A stated she looked at R7's was a little bit of dried blood in site. LPN-A stated she had the after R7 had returned from the time and was not aware der the dressing around the on 12/3/2020, at 2:49 a.m.	F 6	98			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE	
F 698	and immediately concentrated in the reading and immediately concentrated in the reading and immediately concentrated in the reading and immediately and immedi	age 20 ontact dialysis clinic. y on 12/3/2020, at 4:16 p.m. derstood the central line was ecked only before and after not recall observing the line rior to R20 going to the hospital e usually worked the night shift. is residents are supposed to and confirmed R20 had not 0 got weighed at dialysis three N-A stated dialysis patients are tored for intake and output, rdration and fluid overload. y on 12/4/2020, at 9:37 a.m. t (PA)-A checking dialysis andard of practice and nurses be checking the site "Obviously PA-A confirmed R20 did not I shunt; stated nurses should by what they are checking off off and was concerning for as were just checked off. PA-A sysician notes and discharge dicated the type of access tified, the staff should have alysis clinic or physician. PA-A a fluid restriction that was spital and if it was noted, then a that restriction if there was a ror use the standard 2 liters. standard and important to uid intake and output, as well weight monitoring and expected we the orders and facility.	F 6	98				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245409	B. WING_		12	C / 04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 698	dated 1/3/2020, incomplete the needs of the reare met by both the center. Resident in transported routine Communication is -Facility will provide resident's condition complications before treatment received Facility will have on collaboration with topical possible condition, such as injury and appropried appropried terms of the condition, such as injury and appropried appropried terms of the condition of the co	cluded: Purpose: To ensure esident receiving hemodialysis er facility and the dialysis eceiving hemodialysis are ely out of the facility. essential for continuity of care, er ongoing assessment of the nand will monitor for one and after each dialysis facility, agoing communication and the dialysis facility. Ould be made aware of on that may affect their overall increased risk for pressure ate interventions. It ken so the external catheter is about the bedside ations. He dialysis facility at the bedside ations. He external catheter is about the bedside ations. He external catheter is a should be kept at the bedside ations. He external catheter is a should be kept at the bedside ations. He external catheter is a should be kept at the bedside ations. He external catheter is a should be kept at the bedside ations. He external catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations and apply new sterile between the catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside ations. He catheter is a should be kept at the bedside at the bedside ations. He catheter is a should be kept at the bedside at the	F 69	98		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245409	B. WING _			C / 04/2020
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 698	-Alteration in skin ir	ntegrity ocedures/Pharmacist/Records	F 69			1/8/21
	§483.45 Pharmacy The facility must prodrugs and biologica them under an agre §483.70(g). The fa personnel to admin permits, but only ur a licensed nurse. §483.45(a) Procedu pharmaceutical ser that assure the acc dispensing, and ad	, , , ,				
	must employ or obt pharmacist who-	Consultation. The facility ain the services of a licensed				
		ides consultation on all ision of pharmacy services in				
		olishes a system of records of tion of all controlled drugs in nable an accurate				
	order and that an a is maintained and p This REQUIREMED by:	rmines that drug records are in count of all controlled drugs periodically reconciled. NT is not met as evidenced		" The facility completed a	diabatic ard -	
	based on observa	tion, interview, and document		" The facility completed a	มลมยนติ 01001	

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245409	B. WING	i		12/0)4/2020
	PROVIDER OR SUPPLIER	R		1	TREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST ROCHESTER, MN 55901	1 12/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	review the facility fatimely implementat to administration of reviewed for medic. Finding include: R7 Admission Recc. 12/3/2020, included and schizophrenifo. During an observat a.m. licensed pract received Novolog in LPN-A dialed R7's to R7's room, took 194. LPN-A stated insulin and the labe with meals. LPN-A 11:12 a.m. R7 state were low she got that articulate what her was symptomatic. I reported symptoms was around "125ish provider. R7's diabetic care provided to give R7 diabetes monitor/document reflectiveness. R7's endocrinology current orders for in breakfast, 12 units meal (8/24/2020). I noted also included	ailed to ensure a system of ion of physician orders related insulin for 1 of 3 (R7) ation administration. Ord provided by the facility on diagnosis of diabetes type 2 rm disorder. Ion on 12/2/2020, at 11:08 ical nurse (LPN)-A stated R7 isulin 26 units at lunch time. insulin pen to 26 units, walked R7's blood sugar which was Novolog was a short acting on the pen directed to take administered R7's insulin at ied when her blood sugars ie chills, but could not blood sugars were when she LPN-A indicated last week R7 is however, her blood sugar in and she had notified the olan dated 6/11/2019, directed in medications as ordered and	F7	755	review on all residents with a diabed diagnosis to ensure short acting insorders included correct directions for in conjunction with meal times. This includes residents R7. "All licensed nursing staff will be educated on importance of following prescribed orders for short-acting in conjunction with meal times. "Audits for diabetic managements be completed weekly for four week monthly for two months, and period as needed based on audit findings audits will include monitoring that short-acting insulins are being administered as prescribed in conjuith meal times. "Audit results will be reviewed in at QAPI to evaluate the effectiveness insulin administration and the needed audit continuation. "DON designee is responsible for ensuring compliance	sulin or used s e ig nsulins nt will s, dically These unction nonthly ess of	

Please update the medication list."

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		LE CONSTRUCTION	COMPLETED		
		245409	B. WING				04/2020
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER				1	STREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST ROCHESTER, MN 55901	121	04/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	HOULD BE COMPLÉTION	
F 755	R7's medication ad identified the new of was not implement received the less wand 9/4/2020. Facility records lach medication errors. R7's endocrinology included "Increase and 16 lunch. Please R7's Medication Adidentified the new obreakfast and 16 unand implemented units for breakfast and implemented units for breakfast and 16 unand implemented units for breakfast and units for bre	ministration record (MAR) order for Lantus 70 units daily ed until 9/5/2020; indicating R7 rong dose of 60 units on 9/3 ked identification of the visit dated 9/17/2020, Novolog to 20 with breakfast se update in med list." Iministration Record (MAR), orders for Novolog 20 units with nits for lunch was not updated ntil 9/22/2020; indicating R7 e lesser wrong dose of 16 and 12 units for lunch from		755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		245409	B. WING _		12	/04/2020	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER				STREET ADDRESS, CITY, STATE, ZIP 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIO DATE		
F 755	10/16/2020; indicate dose of 80 units on Facility records lac medication errors. R7's endocrinology indicated blood sugidentified insulin do appointment and n to 26 units with each of the suppointment and n to 26 units with each of the suppointment and n to 26 units with each of the suppointment and n to 26 units with each of the suppointment and n to 26 units with each of the suppointment and suppointment and suppointment and nor communication for communication supply units and Novolog Label reads: Novol and 16 units with luin system says 22 (10/16/2020). The orders to be faxed The printed SBAR "Recommended do beginning of each insulin label according the correct dose of 11/17/2020.	ted and implemented untiliting R7 received the lesser in 10/16/2020. ked identification of the visit dated 11/6/2020, gars were improving and oses from previous ew orders to increase Novologich meal. Ind/assessment/recommendation tool to health care ed 11/17/2020, identified the nication was for medication note included "EMAR ion administration record] and is not matching" Lantus 90 26 units with meals. Supply og Inject 20 units at breakfast unch and dinner. Recent note units with each meal note requested for current to the facility. had handwritten orders; ose of Novolog 26 units at the meal." Despite the wrong ling to the MAR R7 received insulin from 11/6/2020 to	F 75	55			
	included "Yes, adju some time especia	visit dated 11/24/2020, ustment to euglycemia will take lly if patient keeps eating to nd "Always important when					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		I \ /	(X3) DATE SURVEY COMPLETED	
		245409	B. WING _		12	/ 04/2020	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETI DATE		
F 755	symptomatic to chabove 90 to reassito hypoglycemia" R7's endocrinology included "blood sunumbers are still some Novolog to 30 units update the med lissed R7's MAR identifies units with evening implemented until received the lessed 11/30/2020 to 12/22. Facility records lack medication errors. During an interview regional nurse condursing (DON) stands given within 15 mind a substantial snack had not identified to the medication error and error report should have between the MAR immediately and conducting an interview certified nurse praywas overseen by emanagement, and	eck patients blood sugar and if ure that symptoms are not due y visit dated 11/30/2020, gars are improving. Bedtime uboptimal most days. Increase is with evening meal. Please t." d the new order for Novolog 30 meal was not updated and 12/3/2020; indicating R7 r dose of 26 units from	F 75				
	insulin. CNP-A sta identified the wron	ted nurses should have g discrepancy between the pen tely had the nurses been doing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	l' '	(X3) DATE SURVEY COMPLETED	
		245409	B. WING			C / 04/2020	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER				STREET ADDRESS, CITY, STATE, ZIP COE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
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F 755		on checks prior to riously this was not being done. ovolog should be given after ypoglycemia. n & Control	F 7			1/8/21	
	§483.80 Infection C The facility must es infection prevention designed to provide comfortable enviro development and to diseases and infection §483.80(a) Infection	Control stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable					
		stablish an infection prevention m (IPCP) that must include, at lowing elements:					
	identifying, reportin infections and com residents, staff, vol individuals providin arrangement based	stem for preventing, g, investigating, and controlling municable diseases for all unteers, visitors, and other g services under a contractual d upon the facility assessment ng to §483.70(e) and following standards;					
	procedures for the but are not limited (i) A system of surv possible communic infections before the persons in the facil	veillance designed to identify cable diseases or spread to other					

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	1		
	C 12/04/2020		
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	020		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	OULD BE COMPLETION		
Continued From page 28 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with resident contact. §483.80(a)(A) A system for recording incidents identified under the facility. §483.80(b) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility full conduct an annual review of its IPCP and the corrective and the corrective and the corrective and transport linens so as to prevent t			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		SURVEY PLETED
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EDENBR	OOK OF ROCHESTE	=K		R	OCHESTER, MN 55901		
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F 880	(R1, R2, R5, R6) is separate and quar from negative residealed to ensure proprocedures were famitigate the risk of This deficient praceall 41 residents residents residents all 41 residents resident to when the facility faminection control propression of the spread of COV identified on 12/3/2 nurse consultant (Inursing (DON) well is peopardy at 3:19 purple party was remarked at the long, isolated scope tharm that is not improved infection control construction. The facility did not residents were pla from COVID negation of the potential causal facility and causal facility and developed infection control conservations and the comprehensive rise exposures and/or investigation of the potential causal facility and quarkets.	when the facility failed to antine covid positive residents dent roommates. The facility oper infection control ollowed to prevent and/or an outbreak of COVID-19. tice had the potential to affect siding in the facility and staff or contracting COVID-19. In pardy began on 11/22/20, illed to implement appropriate factices to mitigate or reduce (ID-19 in the facility, the IJ was 20. The administrator, regional RNC) and the director of the notified of the immediate and implemented an allowever, noncompliance wer scope and severity level of and severity, which indicated and severity, which indicated and implemented and implemented and severity, which indicated and severity, which indicated and implemented in general several properties of the facility lacked evidence of k analysis of potential transmission to other residents, alliness, and identification of ctors of disease transmission.	F8	380	room. Recovered from Covid in Ju 2020. R5 had positive results of Covid and hospitalized on 11/25/20 and remain the hospital at this time R6 had positive POC results and we placed in Covid Unit room. Has sin recovered and no longer resides in specific Covid room. Residents with COVID-19 exposure positive COVID-19 test results are a for alleged deficient practices. The facility has identified specific robe used for Covid Positive & Presult Covid Positive residents. This will inthose residents with presumed Covid Positive residents. This will inthose residents with presumed Covid Positive residents. All recommental Positive will be available in these room These will be for a single resident of The facility has developed a log of residents who have previously recommon Covid, what room they reside what room they were relocated to will be kept current by facility IDT To The log will be audited 3 times a week Months, then weekly x 3months. Rewill be analyzed and reported to QA Committee to determine if further a required. Infection Control policies related to COVID-19 have been reviewed and updated as needed. Education of staff regarding cohortic residents with like infections was completed by 1/8/2021. Use of designated Infection Rooms for the procuracy and fo	d was ns in as ice a a and at risk boms to mptive nclude rid sitive ded s. only. overed in and The log eam. eek x 3 esults API ction is	
		ensus reports, R1 and R2			presumed/active symptoms and/or	าลร	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
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NAME OF F	DOVIDED OF CURRUES	245409	D. WING		TREET ADDRESS CITY STATE ZID CODE	12/0	04/2020
NAIVIE OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 375 19TH STREET NORTHWEST		
EDENBR	OOK OF ROCHESTE	R					
					OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	admitted to the faci included Non-Hodg asthma, adult failur R1's admission Mir assessment dated intact cognition. R1's progress note "COVID PCR [polyt completed as part of COVID positive staresults." R1's progress note p.m. included, "11/confirmed as positi initiated." R1's progress note p.m. included, "Res [complaints of] pair signs] remain WNL sounds] clear. Goodiarrhea this evenir replacement." R1's progress note a.m. included, "oca [nonproductive] coubreath], denies pair night."	cord, indicated R1 was lity 9/28/20. R1's diagnosis kin Lymphoma, unspecified e to thrive and anemia. nimum Data Set (MDS) 10/5/20 indicated R1 had dated 11/17/20 included, merase chain reaction] test of house wide testing due to tus in the building. Will await dated 11/22/2020, at 12:59 16/2020 COVID-19 test result ve. Droplet Precautions dated 11/24/2020, at 11:13 sident doing well, no c/on, dyspnea, cough. VS [vital within normal limits], LS [lung diappetite and output. Someing. Encouraging fluids for dated 11/25/2020, at 4:31 ss [occasional] loose non produgh. denies SOB [shortness of the mass been asleep most of the side of t	F 8	380	used the Minnesota /Principles for Cohorting Covid 19 in Long Term Of Facilities for educating staff. The Interdisciplinary Team will comaudits of Hand Hygiene, Donning a Doffing of PPE 3 times per Week x Month then Weekly x 2 months. Reresident placement related to COV symptoms, exposure and testing w completed daily at the IDT stand-up meeting and by the Nurse on week in collaboration with Manager on Dissues will be addressed as they aridentified during the audits. Audit rewill be analyzed and reported to QA Committee to determine if further a required.	aplete nd 11 21 21 21 21 21 21 21 21 21 21 21 21	
	R2's Admission Re	cord, indicated R2 was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245409	B. WING				04/2020
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	admitted to the faci included unspecifie disturbance and co R2's quarterly Minit assessment dated had long and shortwas independent with daily living. R2's progress note p.m. included, "CO reaction] test compt testing due to COV building. Will await R2's progress note 5:31p.m., included, positive for COVID-19 positive instituted" R2's progress note p.m. included, "CO antigen test compleresults. COVID PC test was also comphouse wide testing of the building. Will R2's progress note p.m. included, "Res COVID-like sympto antigen test which was a confirmatory PCF test. Will await results. Will await results. Will await results.	lity 1/20/20. R1's diagnosis and dementia without behavioral gnitive communication deficit. mum Data Set (MDS) 10/17/20, indicated R2 -term memory problems and with decision-making skills for dated 11/17/2020, at 7:31 VID PCR [polymerase chain leted as part of house wide ID positive status of the results." dated 11/22/2020, at "[R2]'s roommate tested 19. Although her result came R2] will be treated as Droplet precautions will be dated 11/23/2020, at 9:02 VID POC [point of care] eted today with negative R [polymerase chain reaction] eleted and sent to lab as part of due to COVID positive status await results." dated 11/30/2020, at 2:47 sident noted to have some ems. Completed point of care was negative. Also completed R [polymerase chain reaction]	F8	80			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245409	B. WING			12/	04/2020
	PROVIDER OR SUPPLIER	R		1	STREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	testing on 11/17/20 positive COVID lab asymptomatic. R1 moved to the COVICOVID tests result was moved to the Considered her to be sharing a room with positive in July 202 have symptoms of undigested food, R discomfort in umbil after emesis. Docu was waiting for result R2 was tested for Contigen testing on that time, R2 was runit and was placed precautions. During an interview regional nurse conshave been kept in herecautions and the positive should have unit to separate the previously positive COVID. According to the corresided in the same R5 R5's Admission Results.	The facility received R1's results on 11/22/20. R1 was and roommate R2, were D unit on 11/22/20. R2's were negative however, R2 COVID unit because the facility of presumptive positive from R1. R2 had been COVID O. On 11/30/20, R2 started to two medium emesis of 2 complained of abdominal icus region and headache mentation indicated the facility ults of R2's PCR testing, and COVID via the point of care 12/3/20 which was negative. At noved to a room off the COVID of on 14-day droplet on 12/2/20, at 1:40 p.m. the sultant (RNC) stated R2 should her room, placed on 14-day to roommate (R1) that was been moved to the COVID of m. RNC stated R2 had been and had recovered from the covid indicated R5 was cord, indicated R5 was	F	380			
	included Type 2 dia neuropathy, end sta	lity on 9/14/20. R5's diagnoses abetes with diabetic age renal disease, all dialysis and major					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245409	B. WING _		12	/04/2020
	PROVIDER OR SUPPLIER	ER .	1	STREET ADDRESS, CITY, STATE, ZIP COI 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	depressive disorder R5's quarterly Minited assessment dated intact cognition. R5's progress noted p.m., included, "C0 antigen test completed a.m., included, "2L [oxygen] started du 90% (88%)." R5's progress noted a.m. included, "Choobservations, evaluate: Baseline statu Provider Feedback	mum Data Set (MDS) 10/26/20 indicated R5 had dated 11/23/2020, at 8:57 OVID POC [point of care] eted today with positive results. dated 11/24/2020, at 2:37 [liters] supplemental O2 ue to sats [saturations] below dated 11/25/2020, at 11:22 ange of conditionNursing uations and recommendations s but increased. Primary Care a A. Recommendations: Send vider ordered R5 to sent to	F 88	,		
	admitted to the factincluded chronic produced chronic pro	ecord, indicated R6 was ility 6/28/2017. R6's diagnosis ulmonary obstructive disease, pplemental oxygen, major er, recurrent, moderate and especified. mum Data Set (MDS) 8/28/20, indicated R6 had edated 11/17/2020, at 7:17 eVID PCR [polymerase chain pleted as part of house wide ID positive status of the				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		C (X3) DATE SURVEY			
		245409	B. WING_		12	/04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	R6's progress note p.m. included, "CC antigen test compl results. COVID PC test was also complouse wide testing of the building. Wil results were negated to the p.m. included, "CC reaction] testing complete testing testing complete testing test	e dated 11/23/2020, at 9:03 DVID POC [point of care] eted today with negative ER [polymerase chain reaction] Deleted and sent to lab as part of due to COVID positive status I await results." R6's test ive. dated 11/30/2020, at 2:56 DVID PCR [polymerase chain ompleted. Will await results." dated 12/2/2020, at 2:11 p.m. de tested positive for COVID this implaints of] not feeling well, inp [temperature] of 102.2. ine." dated 12/3/2020, at 6:07 a.m. ins: BP [blood pressure] T, T [temperature] 96.6, RR 2 [oxygen saturations] 95% cannula]. Active COVID in malaise, fatigue, SOB, fever, taste/smell, GI sx imptoms]): non-productive reased sleepiness ADL[ving]/functional declines or no changes- in bed all night. social Concerns: none.	F 88	30		
	bedside. Current in rest, encourage flu R5's onset of sympoccuring on 11/23/	intake: sleeping, water at nterventions and effectiveness: iids." otoms was identified as 20, when documentation cose stools. On 11/23/20, the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED C	
		245409	B. WING _		12	/04/2020
	PROVIDER OR SUPPLIER	iR		STREET ADDRESS, CITY, STATE, ZIP COD 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	facility completed F positive. R5 shared shared was on the R5 and R6 shared R5 was hospitalize the room they shar requested to be mo On 12/2/2020, R6 headache, tempera complaints of not for completed and res moved back to the During an observation. In the COVID had mask on) enter building. RN-B walked the plastic barrier in unit). RN-B came of shield on walked the gown. RN-B stated was appropriate. The doffing/donning by During an interview RNC stated R6 had until R5 was hospit refused to move rooms. During an interview RNC stated the facility did not have to move rooms. During an interview RNC stated the facility did not compoutbreak had concontrolled the facility outbreak had concontrolled for contact tracing had a plan to compoutbreak had concontrolled for contact the facility outbreak had concontrolled for contact the facility of contact the facility outbreak had concontrolled for co	POC testing and results were d a room with R6. The room COVID unit created 11/22/20. a room on the COVID unit until d on 11/25/20. R6 remained in ed on the COVID unit until R6 oved off the unit on 11/28/20. displayed symptoms ature 102.2 and had eeling well. A POC test was ults were positive. R6 was COVID unit. Ition on 12/2/2020, at 11:45 unit, RN-B and resident (who red from the exit door of the only N95 donned- no other up the length of hallway thru nto the nurse breakroom (in out of the breakroom with face arough barrier and then donned she did not think the set up here should be a	F 88			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		245409	B. WING_		12	/04/2020
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CO 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	common denominaresidents that could spread. She stated was completing the however, going for be expanding the aexposure to reside other staff they had exposures out of w. During an interview certified nurse pract not aware the facilities residents were being CNP-A stated the spositive residents as same rooms as resident not have symptom the facility's COVII included, "Policy: Teducation, surveillar prevention strategic transmission of CC changing and fluid will monitor, follow, recommendations with the Centers for Prevention (CDC), (WHO), CMS [Center and the State Department of the country of the immediate jeon 11/22/2020, was rep.m., when it could	ators between staff and d be a potential link to possible I for positive staff, the facility e staff risk assessments ward the facility was going to analysis to include any potential nts they had cared for and d worked with and any potential rork. You on 12/4/2020, at 9:16 a.m. etitioner (CNP)-A stated was ty had not been aware ng inappropriately cohorted. Symptomatic and/or COVID should absolutely not be in the sidents that are negative and/or oms. D-19 policy revised 10/19/20 The facility will conduct ance and infection control and set to reduce the risk of OVID-19. Due to the constantly nature of the virus; the facility	F 8	30		

NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 37 precautions strategies, had initiated risk assessments for residents, and had provided staff education. EDENBROOK OF ROCHESTER STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 37 precautions strategies, had initiated risk assessments for residents, and had provided staff education.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 37 precautions strategies, had initiated risk assessments for residents, and had provided			245409	B. WING _			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 37 precautions strategies, had initiated risk assessments for residents, and had provided			R		1875 19TH STREET NORTHWEST		0.11.2020
precautions strategies, had initiated risk assessments for residents, and had provided	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE
	F 880	precautions strateg	ies, had initiated risk	F 88	30		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 28, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: LMG311

Dear Administrator:

The above facility was surveyed on December 2, 2020 through December 4, 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

Edenbrook Of Rochester December 28, 2020 Page 2

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, RN, Unit Supervisor Rochester District Office 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

Office: (507) 206-2727 Mobile: (507) 461-9125

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.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00916	B. WING		12/0	; 4/2020
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 12/0	
EDENBR	ROOK OF ROCHESTE	R	I STREET N TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the matter of th	nether a violation has been				
	When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ns several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	survey was conduct with State Licensure NOT in compliance Please indicate in y correction that you	rs:) and 12/4/20, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				

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

01/07/21 **Electronically Signed**

TITLE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
72 . 2	o. oo.u.20o		A. BUILDING:			
		00916	B. WING		12/0	4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBR	OOK OF ROCHESTE	R	HSTREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: H54009077C with II S4658.0520 Subp. H54009078C with a S4658.0800 Subp. H54009079C with a S144.651 Subd. 10 The facility is enroll signature is not req page of state form.	icensing orders issed at 1 and S4658.1320 Subp.1545 a licensing order issued at 4 a licensing order issued at ed in ePOC and therefore a uired at the bottom of the first				
2 830	Proper Nursing Car	O Subp. 1 Adequate and re; General general. A resident must	2 830			1/8/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from to	e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
	by: Based on observati review the facility fa signs and symptom (low/high blood sug physician according	ent is not met as evidenced on, interview and document alled to monitor and assess as of hypo/hyperglycemia ars) and failed to notify the g to physician orders for 2 of 3 reviewed for diabetic		Acknowledged		

Minnesota Department of Health

STATE FORM 6899 LMG311 If continuation sheet 2 of 36

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING:		,	,
		00916	B. WING		12/0)4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBR	ROOK OF ROCHESTE	R	H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	potential to effect a resided in the facility Findings include R7 Admission Reconstruction 12/3/2020, included and schizophrenifo 10/13/2020, did not and required insuling R7's diabetic care put to give R7 diabetes monitor/document effectiveness. The monitor/document/symptoms of hypograms of hypograms (long acting to give R7's physician order-Lantus (long acting the facility of	ord provided by the facility on d diagnosis of diabetes type 2 rm disorder. mum Data Set (MDS) dated thave cognitive impairment n. plan dated 6/11/2019, directed a medications as ordered and for side effects and care plan also directed staff to report as needed any signs or glycemia and hyperglycemia. ers included the following g insulin) 70 units daily in the				
	10/1/2020) -Lantus 80 units da 10/1/2020, stop dai -Lantus 90 units da 10/15/2020 -Novolog (rapid act morning, 12 units a (16/12/12) at eveni 9/22/2020) -Novolog insulin 20 stop date 10/1/2020 -Novolog insulin 22 date 10/2/2020, sto -Novolog insulin 26 date 11/6/2020, sto	sily in the morning (start date sing insulin) 16 units in the st lunch, and 12 units ng meal (8/24/2020, end date 1/16/16 (start date 9/22/2020, 0) 2 units daily with meals (start op date 11/6/2020) 3 units daily with meals (start op date daily with meals (start date daily with meals daily with meals (start date daily with meals daily with meals (start date daily with meals daily with meals daily with meals (start date daily with meals daily with meals daily with meals daily with meals (start date daily with meals				

Minnesota Department of Health

STATE FORM 6899 LMG311 If continuation sheet 3 of 36

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		00916	B. WING			4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBR	ROOK OF ROCHESTE	R		ORTHWEST		
	0.0000000000000000000000000000000000000		TER, MN 55		1011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	orders for diabetes -Notify clinician if 2 readings < 70 and/o -If finger stick gluco give glucose/carbo -If patient becomes 70, give glucose/ca Notify clinician. Cor glucose and treat e > 100.	consecutive blood glucose or >=400. use < 70 and asymptomatic, hydrate orally symptomatic and glucose is urbohydrate and protein orally. utinue to monitor finger stick very 15 minutes until glucose 				
	12/2/2020, at 11:08 (LPN)-A stated R7 units at lunch time. to 26 units, walked sugar which was 19 a short acting insuli directed to take witl R7's insulin at 11:1 blood sugars were could not articulate when she was sym week R7 reported sugar was around "the provider. R7 recapproximately 30 m	ion and interview on a.m. licensed practical nurse received Novolog insulin 26 LPN-A dialed R7's insulin pen to R7's room, took R7's blood 24. LPN-A stated Novolog was in and the label on the pen in meals. LPN-A administered 2 a.m. R7 stated when her low she got the chills, but what her blood sugars were ptomatic. LPN-A indicated last symptoms however, her blood 125ish" and she had notified beived her lunch tray between iniutes after insulin teen 11:45-11:50 a.m.				
	notes reviewed fror identified low and h evidence of approp and physician notification 9/23/2020, at 1 note included "Resithis evening and shinsulin on the MAR	ecords and nursing progress in 9/1/2020 to 12/2/2020, igh blood sugars without riate interventions, monitoring, cations. 0:09 p.m. nursing progress idents blood sugar was high the no longer has scheduled [medication administration raged her to increase water]				

Minnesota Department of Health

STATE FORM 6899 LMG311 If continuation sheet 4 of 36

NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				7 ti BoileBiirto.		С	
EDENBROOK OF ROCHESTER 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			00916	B. WING		1	
EDENBROOK OF ROCHESTER ROCHESTER, MN 55901	NAME OF PROV	ROVIDER OR SUPPLIER	SUPPLIER STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ROCHESTER, MN 55901	EDENBROO	OOK OF ROCHESTE	CHESTER				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			ROCHES				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		(EACH DEFICIENC)	DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETE DATE
2 830 Continued From page 4 2 830	2 830 Co	Continued From pa	From page 4	2 830			
and walk. Resident did this." According to the blood sugar record R7's blood sugar was 412; according to the record R7's blood sugar was not rechecked until the next morning at 7:36 a.m. R7's record lacked evidence of assessment and monitoring for signs/symptoms of hyperglycemiaR7's blood sugar record identified on 9/28/2020, at 4:09 p.m. blood sugar was 463; record did not identify recheck until the next scheduled check at 9:29 p.m. at which time blood sugar was 445. R7's record lacked physician notification, monitoring and assessment for symptoms of hyperglycemiaR7's blood sugar record identified on 9/29/2020, at 9:05 p.m. R7's blood sugar was 465; next recorded the next morning at 7:14 a.m. R7's record lacked evidence of physician notification, monitoring and assessment for signs and symptoms of hyperglycemiaOn 10/15/2020, at 11:55 a.m. nursing progress note and blood sugar record identified R7's blood sugar was not rechecked until the next scheduled check at 4:48 p.m. According to R7's medication administration record, R7 was administered 26 units of Novolog insulin despite a blood sugar of 52. The record lacked evidence interventions, assessment, and monitoring for signs and symptoms of hypoglycemiaOn 11/19/2020, at 4:04 p.m. nursing progress note indicated R7's Novolog insulin was held "due to low blood sugar"; recorded blood sugar was at 3:30 p.m. was 80 and was not rechecked until the next ordered check at 9:19 p.m. The record lacked evidence of monitoring, intervention, and assessment for signs and symptoms of hypoglycemiaOn 11/19/2020, at 2:12 p.m. nursing progress note indicated R7's Novolog insulin was held "due to low blood sugar"; recorded blood sugar was at 3:30 p.m. was 80 and was not rechecked until the next ordered check at 9:19 p.m. The record lacked evidence of monitoring, intervention, and assessment for signs and symptoms of hypoglycemiaOn 11/19/2020, at 2:12 p.m. nursing progress note indicated R7's Novolog insulin was held	an blo ac rec R7 mo -R at ide 9:2 R7 mo hy -R at rec rec mo sy -O no blo sc mo ad blo int sig -O no to 3:3 nec as hy -O	and walk. Resident blood sugar record according to the recrechecked until the R7's record lacked monitoring for signs-R7's blood sugar rat 4:09 p.m. blood sidentify recheck un 9:29 p.m. at which R7's record lacked monitoring and ass hyperglycemiaR7's blood sugar rat 9:05 p.m. R7's brecorded the next record lacked evide monitoring and ass symptoms of hyper-On 10/15/2020, at note and blood sugar was not scheduled check at medication administered 26 un blood sugar of 52. Interventions, assessigns and symptom-On 11/9/2020, at 4 note indicated R7's to low blood sugar" 3:30 p.m. was 80 a next ordered check lacked evidence of assessment for sig hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar" 3:30 p.m. was 80 a next ordered check lacked evidence of assessment for sig hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar" 3:30 p.m. was 80 a next ordered check lacked evidence of assessment for sig hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar" 3:30 p.m. was 80 a next ordered check lacked evidence of assessment for sig hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar" 3:30 p.m. was 80 a next ordered check lacked evidence of assessment for sig hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar" 3:30 p.m. was 80 a next ordered check lacked evidence of assessment for sig hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar" 3:30 p.m. was 80 a next ordered check lacked evidence of assessment for sig hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar hypoglycemia -On 11/19/2020, at 4 note indicated R7's to low blood sugar hypoglycemia -On 11/19/2020, at 4 note indicated R7's to lo	Resident did this." According to the ar record R7's blood sugar was 412; to the record R7's blood sugar was not until the next morning at 7:36 a.m. d lacked evidence of assessment and for signs/symptoms of hyperglycemia. d sugar record identified on 9/28/2020, n. blood sugar was 463; record did not check until the next scheduled check at at which time blood sugar was 445. d lacked physician notification, and assessment for symptoms of emia. d sugar record identified on 9/29/2020, n. R7's blood sugar was 465; next he next morning at 7:14 a.m. R7's ked evidence of physician notification, and assessment for signs and of hyperglycemia. 1/2020, at 11:55 a.m. nursing progress alood sugar record identified R7 had a far of 52. The record identified R7's ar was not rechecked until the next check at 4:48 p.m. According to R7's an administration record, R7 was red 26 units of Novolog insulin despite a far of 52. The record lacked evidence ans, assessment, and monitoring for symptoms of hypoglycemia. 1/2020, at 4:04 p.m. nursing progress and R7's Novolog insulin was held "due to sugar"; recorded blood sugar was at was 80 and was not rechecked until the ed check at 9:19 p.m. The record dence of monitoring, intervention, and not for signs and symptoms of mia 1/2020, at 12:12 p.m. nursing progress				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
ı					С	
		00916	B. WING		12/0	4/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDENBR	OOK OF ROCHESTE	R	ISTREET N FER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	monitored for signs hypoglycemia or if offered snacks to nevels between measured buring an interview director of nursing stated the physicial right away when the mg/dl for correction lacked evidence of signs/symptom of histated documentati physician/family no and effectiveness, protocol, and signs hypo/hyperglycemia and symptomatic and for CNP-A stated this strecord. R8 R8's quarterly Mining 9/3/2020, identified had moderate cogninsulin administration. R8's diabetic care in the following "diabet doctor. Monitor/doctor.	109 and blood sugar was not and symptoms of R7 was provided and or naintain safe blood sugar als. 2 on 12/3/2020, at 8:19 a.m. (DON) reviewed R7's record, a should have been notified blood sugars were over 400 a orders. DON verified record monitoring and evaluation of hypo/hyperglycemia. DON on should include tification, interventions used blood sugar rechecks per /symptoms of a. 2 on 12/4/2020, at 9:16 a.m. stitioner (CNP)-A stated nurses evaluate for signs/symptoms of notify us if residents are blow the facility protocol. Should be documented in the mum Data Set (MDS) dated R8 had diagnosis of diabetes, nitive impairment and required on. Data dated 7/28/15, directed of stes medication as ordered by sument for side effects and to monitor/document/report	2 830			

Minnesota Department of Health

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00916	B. WING		12/0)4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBR	OOK OF ROCHESTE	R	I STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 6	2 830			
	-Novolin NPH insul with breakfast) and with evening meal) blood sugar (BS) urblood glucose che bedtime. Notify CN for blood glucose le 400 next working d requires treatment protocol notify imm Facility Post-Acute Orders dated 6/8/10 orders for diabetes -Notify clinician if 2 readings < 70 and/orlef finger stick glucogive glucose/carborlef patient becomes 70, give glucose/carNotify clinician. Cor	cks before meals and at P (certified nurse practitioner) ess than 100 or greater than ay; unless symptomatic, or for hypoglycemia per facility ediately. and Long Term Care Standing 8, included the following: consecutive blood glucose or >=400. ose < 70 and asymptomatic,				
	note some signification do not see in recordattention to provide Novolin 70/30 30 up in the evening hold and nursing to notifithan 100 or greater	dated 12/1/2020, included "I antly low blood glucose levels, d that this has been brought to r." The physician gave orders, nits in the morning and 5 units if blood sugar is less than 90 ty provider if blood sugar less than 350 next working day, c or per facility hypoglycemic				
	R8's blood sugar re	ecord (BSR) in correlation with otes from 10/1/2020 to der above was given 12/2/20?				

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winnesc	<u>ita Department of He</u>					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00916	B. WING		1	
		00916			12/0	4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1875 19T	H STREET N	ORTHWEST		
EDENBR	OOK OF ROCHESTE	R	TER, MN 559			
	0.0000000000000000000000000000000000000				~	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
		·		DEFICIENCY)		
0.000	0 " 1=		0.000			
2 830	Continued From pa	ge 7	2 830			
	The blood sugar re	cord identified 41 blood				
		f under 100 mg/dl (milligrams				
		it evidence of physician				
		sician orders. In addition, the				
		ence appropriate interventions				
		8, the lacked evidence of				
		essment for signs and				
		llycemia. All of the following				
		s (not all inclusive) within the				
		the facility failed to notify the				
		vidence of appropriate				
		nonitoring, and lacked				
		ns/symptoms of hypoglycemia:				
	-BSR 11/30/2020					
	At 8:07 a.m. BS wa					
	At 9:44 a.m. BS wa					
	At 12:17 p.m. BS w					
	At 4:38 p.m. BS wa					
	At 8:18 a.m. BS wa	s 131.0 mg/dl				
	-BSR 11/28/2020					
	At 11:43 a.m. BS w					
		s 85.0 mg/dl-according to				
	medication adminis	tration record R7's insulin was				
	not held per order.					
	At 7:52 p.m. BS wa	s 95.0 mg/dl				
	-BSR on 11/27/202	0, at 7:22 a.m. BS was 92.0				
	mg/dl					
	-BSR on 11/25/202	0, at 3:30 p.m. BS was 98.0				
	mg/dl					
	-BSR on 11/23/202	0, at 8:54 p.m. BS was 38.0				
	mg/dl, next recorde	d BS check was not recorded				
		ng at 11:29 p.m. BS was				
		sponding progress note on				
		only included, "OJ give due to				
	low BS".					
		0, at 7:52 a.m. BS was 98.0				
	mg/dl, at 3:13 p.m.					
		0, at 7:09 a.m. BS was 87,				
		5 a.m. BS was 90.0 mg/dl, next				
		n. 63.0 mg/dl, next recorded				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		I	C 04/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBF	ROOK OF ROCHESTE	R	H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	11/20/2020, at 4:39 held due to low blod -BSR on 11/18/202 mg/dl -BSR on 11/11/202 mg/dl.	85 mg/dl. Progress note dated p.m. only included, "Insulin od sugar. OJ given." 0, at 6:58 a.m. BS was 86.0 0, at 3:12 p.m. BS was 80				
	director of nursing (stated the physiciar right away when the orders. DON verifie monitoring and eva hypo/hypoglycemia should include phys interventions used a	(DON) reviewed R8's record, in should have been notified be blood sugars per physicians and record lacked evidence of luation of signs/symptom of a DON stated documentation sician/family notification, and effectiveness, blood sugar col, and signs/symptoms of				
	certified nurse prac were supposed to e hypoglycemia and r symptomatic and for	on 12/4/2020, at 9:16 a.m. titioner (CNP)-A stated nurses evaluate for signs/symptoms of notify us if residents are ollow the facility protocol. should be documented in the				
	assistant (PA)-A rerectord did not idented the facility that reports mg/dl. PA-A stated multiple blood sugated facility should have parameters. PA-A swas low evaluate for notify the physician intervention and rectangled.	on 12/4/2020, physician viewed R8's record, stated the ify any communication from orted blood sugars under 100 an unawareness of the ars under 100 mg/dl; stated the notified per the ordered stated when the blood sugar or signs of hypoglycemia and into providing the correct check the blood sugars every fe level. PA-A stated all the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
		00916	B. WING		12/0	2 4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	<u>,</u>	
EDENDE	DOOK OF BOCHESTE	1875 19TF	STREET N			
EDENBR	ROOK OF ROCHESTE	ROCHES1	TER, MN 559	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	information should be documented in the medical record.					
	6/11/20, included the residents for signs: hyperglycemia and indicated. Diabetic signs/symptoms of assessed and treat facility protocol as f 2. Upon presentation nurse should check accucheck. a. If an accucheck above 300 mg/dl or orders, hyperglycer b. If any signs/symptomation are identificated resident's condition Hyperglycemic prot 1) Administer hypogper individual physic 2) Offer 16-24 our beverage over two contraindicated. 3) Recheck blood g 4) Report findings to Facility policy Hypoglycemia and to indicated. Diabetic signs/symptoms of assessed and treat facility protocol as f 2) Upon presentation urse should check	treat the symptoms as residents presenting with hyperglycemia will be further ed in accordance with the ollows: on of symptoms, the licensed of the blood glucose level via an reveals a blood glucose level level identified per individual nia should be suspected. Otoms, or other abnormal fied, reprt the diabetic to the physician immediately. Occol: glycemic agents and/or insulincian orders. See of water or sugar free shours unless clinically lucose level to the physician orders. In the physician orders and symptoms of reat the symptoms as residents presenting with hypoglycemia will be further ed in accordance with the				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00916	B. WING		12/0	; 4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENDE	OOK OF BOOLIESTE	1875 19Ti	H STREET N	ORTHWEST		
EDENDA	OOK OF ROCHESTE	ROCHES.	TER, MN 559	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
2 830	sugar below 70 mg, suspected. i. Should life-threatening sigrice physician immediate symptoms listed or identified, report commediately. 3) Follow the reside protocol, if ordered protocol, if ordered protocol is ordered, on clinical assessmed Hypoglycemic Treatinconsistent with pheating the protocol of fast-acting carbothan 70 mg/dl. B. Golicensed nurse if the treatment, per physician 3) Repeat the accurphysician 3) Repeat the protocollice level remains report findings to the Based on observation review the facility farmonitor dialysis accomplying services. Findings include R20's Admission Roon 12/4/2020, include the pelow the treatment of the pelow the p	/dl, hypoglycemia should be d evidence of severe, or as/symptoms exist contact the ely or call 911. B. If any other abnormal condition are ndition the physician ent's individual hypoglycemic by a physician. If no individual update the physician based ent and current blood sugar. It the protocol was a promptly with 15-20 grams hydrates for blood sugar less lucagon 1 mg is given by a patient cannot ingest a sugar ician orders. The check and report findings to colonly once if the blood ans less than 70 mg/dl and a physician. on, interview, and document alled to accurately identify and the physician. on, interview, and document alled to accurately identify and the physician. on, and complete daily weight 1 resident (R20) reviewed for the knee amputation, diabetes ilure.				
	renal disease, meta and left leg below th type 2, and heart fa R20's admission Mi	abolic encephalopathy, right ne knee amputation, diabetes				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00916	B. WING		12/0) 4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE	•	
		1875 19TI	STREET N			
EDENBR	ROOK OF ROCHESTE	ROCHEST	TER, MN 559	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	behaviors. MDS ide assistance from two dressing, one staff hygiene, and deper transfers. The MDS	I not have rejections of care entified R20 required extensive or more staff members for extensive assistance for ident on two or more staff for also indicated R20 was ent of urine and required				
	identified R20 requi comprehensive car 11/18/2020, include communication and center, fluid as orde dialysis catheter sits signs/symptoms of	e plan for dialysis dated ed: facility will have ongoing I collaboration with the dialysis ered, monitor right tunneled e for bleeding and infection, update dialysis n condition that may affect				
	12/2/2020, at 3:12 p stated his dialysis a chest and never ha R20 pulled down his secured and covered had a dime size am insertion site and lig	ion and interview on p.m. R20 laid in his bed. R20 laccess was on his right upper d anything in his stomach. Is shirt, the central line was ed with a clear dressing that lount of blood around the light yellow/purplish bruising anding up to the shoulder.				
	-Dialysis shunt mor shunt in left abdom- pulse, or buzzing se fingers over the fist thrill, the blood is flo and your fistula is w no thrill/bruit preser 11/5/2020 stop date	lers included the following: nitoring: Check thrill/bruit of en. Feel the thrill, strong ensation, by placing your ula/graft. If you can feel the owing through the blood vessel vorking. Notify MD if weak or nit every shift. (Start date e 12/3/2020) ort: Dialysis Unit to complete				

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Millieso	ta Department of He	alli	Γ			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						•
		00916	B. WING		1	4/2020
		1 000.0			12/0	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBB	OOK OF ROCHESTE	B 1875 19TH	I STREET N	ORTHWEST		
EDENDA	OOK OF ROCHESTE	ROCHEST	TER, MN 55	901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON NC	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
2 830	Continued From pa	ge 12	2 830			
	all dressing change	es during dialysis appointment.				
		site to assure dressing				
	remains clean/dry/ii	ntact. Contact dialysis for				
	further direction of a	any concerns or needed				
		every shift. (Start date				
	11/5/2020,	- '				
	-Monitor dialysis ac	cess site upon return from				
	dialysis for signs/sy	mptoms of complications				
	including bleeding,	pain, redness, and edema				
	around the site. No	tify provider and dialysis unit of				
	concerns. Schedule	e on dialysis days and time				
	returned Monday, V	Vednesday, Friday (start date				
	11/5/2020, stop dat	e 12/3/2020)				
	-Resident has cathe	eter permanent tunneled				
	implanted, right che	est wall (Start date 11/24/2020)				
	-Admission weight	procedure: weigh upon				
	admission and for 2	2 days after admission then				
	weekly for 3 weeks	, then monthly for unless				
	otherwise ordered ((start date 11/5/2020)				
	-Weigh daily proces	ss for weight, every morning				
	before breakfast, pe	erform in same manner, notify				
	MD of weight gain of	of 2-3 lbs. or more per day				
	over a 2 day period	or 5 pounds in a week (Start				
	date 11/25/2020)					
	-Fluid intake every	shift four times a day for				
	dialysis (Start date	11/16/2020)				
	-Urine output every	shift for dialysis (start date				
	11/16/2020)					
		narge summary dated				
		dentify any fluid restrictions				
		daily fluid intake goals. R20's				
		ence the facility completed a				
		t to determine adequate fluid				
		ies with the dialysis providers				
	or primary care pro	vider until 12/1/2020.				
	D201aa:1-4					
		d did not reflect daily weight				
		sician orders; between				
	11/3/2020 and 12/4	/2020 only 4 weights were				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		l l	C 04/2020
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
EDENB	ROOK OF ROCHESTE	R	H STREET NO FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	recorded. 11/5/2020, weight of 11/23/2020, weight of 12/2/2020 weight of weight) According to R20's dialysis shunt in left to the medication a between 11/5/2020 check marked boxe bruit and thrill on a TAR also identified central port; boxes the task had been of documentation perfisite was evident in R20's progress not a.m. included, "Reconurse] at dialysis, sto ED [emergency of drainage from his of dated 11/20, did not assessed or that the of infection. A substincluded, "[R20] was included, "R20's hospital After 11/24/2020, indicated 11/24/202	of 246 lbs. (pounds) of 251 lbs. of 114 kg. of 112.3 kg. (dialysis post records, R20 did not have a a abdomen, however according dministration records (MAR) to 12/3/2020, the boxes had es that indicated nurses found shunt that was not there. The physician order for R20's had check marks indicating completed, however no other raining to the integrity of the	2 830			

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	:	
00916 B. WING 12/04	C 12/04/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
1875 19TH STREET NORTHWEST		
EDENBROOK OF ROCHESTER ROCHESTER, MN 55901		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
concern for catheter infection post removal, now presenting for replacement of the tunneled hemodialysis catheter." The summary also included he presented with altered mental status and hypotension during hemodialysis session. He was noted to have purulent drainage from the right chest wall tunneled dialysis catheter exit site with surrounding erythema. R20 received two different intravenous antibiotics and transitioned to oral antibiotics. Discharge orders included "weigh patient daily per facility protocol Daily for dialysis." During an interview on 12/2/2020, at 2:39 p.m. assistant director of nursing (ADON) stated R7's dialysis access was on his right chest wall. DON stated the order abdominal site was entered in error, nurses should not have been documenting. DON stated R20 was admitted to the hospital from dialysis because R7 central line had blood in one of the line ports. During an interview on 12/2/2020, at 5:40 p.m. licensed practical nurse (LPN)-A stated the dialysis site was supposed to be checked before and after dialysis and if there was any abnormalities it would be documented in a progress note. LPN-A stated she looked at R7's site morning; there was a little bit of dried blood around the insertion site. LPN-A stated she had not looked at the site after R7 had returned from dialysis around lunch time and was not aware there was blood under the dressing around the insertion site. During an interview on 12/3/2020, at 2:49 a.m. dialysis charge nurse (DRN) stated on 11/20/2020 she was the one who observed the central line site. DRN stated prior to the R20 arriving to the clinic the facility had not called or		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: C 12/04/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMEN						
00916 B. WING 12/04/2020							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			00916	B. WING		_	
	NAME OF F	F PROVIDER OR SUPPLIER	FR STREET AD	DRESS CITY S	STATE ZIP CODE		
1875 19TH STREET NORTHWEST			1875 19TI				
EDENBROOK OF ROCHESTER ROCHESTER, MN 55901	EDENBR	BROOK OF ROCHESTE	TFR				
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENC)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
indicated any changes on the communication form. DRN stated when she went to hook R20 up, the line had thick purulent drainage dripping down the catheter line from undermeath the clear dressing, more purulent drainage underneath the dressing. DRN stated she took the dressing off, a lot of drainage on it, cleaned the area and noted the insertion site was quite red. DRN stated the drainage was very evident and could not have been missed if someone was looking at it. DRN indicated that could not have happened within a couple of hours. DRN confirmed R20 did not have a fistula in his abdomen. DRN stated most times dialysis patients are on fluid restrictions but since R20 was so new to dialysis they were monitoring how much fluid was removed each dialysis run to determine if a restriction was necessary or if needed to increase fluid. DRN stated another reason she sent him to the hospital on 11/20/20, was because he was hypotensive. DRN stated expectation facility staff weigh residents who are on dialysis daily and communicate weight gains as appropriate, she also expected staff to monitor the appropriate dialysis site for signs and symptoms of infection and immediately contact dialysis clinic. During an interview on 12/3/2020, at 4:16 p.m. RN-A stated he understood the central line was supposed to be checked only before and after dialysis and the did not recall observing the line when he worked prior to R20 going to the hospital on 11/20, stated he usually worked the night shift. RN-A stated dialysis residents are supposed to be weighted daily and confirmed R20 had not been, however R20 got weighed at dialysis patients are supposed to be the checked only before and after dimes per week. RN-A stated dialysis patients are supposed to be until the state of the state of the supposed to be weighted at dialysis patients are supposed to not the supposed be monitored for intake and output,	2 830	indicated any change form. DRN stated withe line had thick puthe catheter line frod dressing, more purious dressing. DRN stated to of drainage on it the insertion site was drainage was very been missed if som indicated that could couple of hours. Drawe a fistula in his times dialysis paties since R20 was som monitoring how mudialysis run to deter necessary or if neestated another reast hospital on 11/20/2 hypotensive. DRN sweigh residents who communicate weigh also expected staff dialysis site for sign and immediately composed to be chedialysis and he did when he worked pron 11/20, stated he RN-A stated dialysis be weighted daily a been, however R20 times per week. RN-RI drawer week. RN-A stated dialysis be weighted daily a been, however R20 times per week. RN-RI drawer week. RN-RI	anges on the communication d when she went to hook R20 up, purulent drainage dripping down from underneath the clear urulent drainage underneath the tated she took the dressing off, a noit, cleaned the area and noted was quite red. DRN stated the ry evident and could not have omeone was looking at it. DRN uld not have happened within a DRN confirmed R20 did not his abdomen. DRN stated most tients are on fluid restrictions but onew to dialysis they were much fluid was removed each termine if a restriction was eeded to increase fluid. DRN eason she sent him to the b/20, was because he was N stated expectation facility staff who are on dialysis daily and eight gains as appropriate, she aff to monitor the appropriate igns and symptoms of infection contact dialysis clinic. Sew on 12/3/2020, at 4:16 p.m. understood the central line was checked only before and after id not recall observing the line prior to R20 going to the hospital he usually worked the night shift. The prior to R20 going to the hospital he usually worked at dialysis three RN-A stated dialysis patients are RN-A stated dialysis patients are	2 830	DEFICIENCY		

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		7. BOILBII10.				
		00916	B. WING		1	4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDENBR	OOK OF ROCHESTE	R	ISTREET N ER, MN 559	ORTHWEST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
	physician assistant access sites are stawere supposed to be it was not caught." have an abdominal be reading and known to just to check it opotential other task reviewed R20's physummaries and indivasn't clearly identicalled either the diastated if there was used during the hos she would continue not a specific order PA-A stated it was monitor/evaluate fluas following daily w	on 12/4/2020, at 9:37 a.m. (PA)-A checking dialysis and ard of practice and nurses be checking the site "Obviously PA-A confirmed R20 did not shunt; stated nurses should by what they are checking off off and was concerning for swere just checked off. PA-A visician notes and discharge icated the type of access ified, the staff should have allysis clinic or physician. PA-A a fluid restriction that was spital and if it was noted, then that restriction if there was or use the standard 2 liters. standard and important to uid intake and output, as well eight monitoring and expected by the orders and facility				
	dated 1/3/2020, inc the needs of the re- are met by both the center. Resident re- transported routine Communication is e- Facility will provide resident's condition complications before treatment received Facility will have on collaboration with the -Dialysis center sho changes in condition	essential for continuity of care. e ongoing assessment of the and will monitor for re and after each dialysis at a certified dialysis facility. going communication and ne dialysis facility. build be made aware of on that may affect their overall ncreased risk for pressure				

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				С		
		00916	B. WING		12/0	4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBR	OOK OF ROCHESTE	R		ORTHWEST		
			ER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 17	2 830			
	not pinched poked, -A smooth clamp si for emergency situa -Avoid getting cathor may cover with plas -Replace the dress wet. Cleanse the a Betadine swab or h dressing. The coordinated, princlude: -Monitor for complis -Frequency of mon distress, chest pain -Potential for bleed -Care of the access -Potential for infect -Nutritional/fluid ma documentation of w	ken so the external catheter is bent or pulled. hould be kept at the bedside ations. eter wet during bathing. You stic wrap during bathing ing if it comes off or becomes area with cleanser such as dibiclens and apply new sterile erson-centered care plan will cations itoring vital signs, respiratory a, headache, seizure, etc. ing s site ion anagement including weights, resident compliance ictions and provision of meals or after dialysis.				
	director of nursing of review policies and dialysis management could develop and staff pertaining to sinterventions/monit diabetic and dialysis DON/designee could an auditing system assurance program compliance.	ld then develop and implement as part of facility's quality n to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
						С	
		00916	B. WING		12/0	4/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EDENBR	OOK OF ROCHESTE	R		ORTHWEST			
040.15	CLIMANA DV CTA		ER, MN 55		ON	0.(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
	MN Rule 4658.0520 Proper Nursing Car Subp. 2. Criteria for proper care. The cradequate and proper care adequate and proper care and proper care are the cradequate and proper care and proper care and proper care are the cradequate and proper care and proper care are the cradequate are the cr	O Subp. 2 C Adequate and re; Shampoo r determining adequate and riteria for determining	2 845		PRIATE	1/8/21	
	assessment dated required physical he from one staff mem and had intact cogr mental score of 15.	imum Data Set (MDS) 11/19/20; identified R18 elp in part of bathing activity ber providing physical assist iition with a brief interview R18 had clear speech, was derstands with clear					

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		= 11m1=		C	
	00916	B. WING		12/0	4/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDENBROOK OF ROCHESTE	1875 19TH	STREET N	ORTHWEST		
EBENBROOK OF ROOMESTE	ROCHEST	ER, MN 559	901		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
2 845 Continued From pa	ge 19	2 845			
comprehension. R18's bath schedul bathed on Wednes The bath schedule of the week to have R18's Visual/Bedsic nursing assistants to Bathing; assist of 1 Wednesday AM (m. R18's hair washing included, "[R18] wo [Tuesday], TH [Thu beauty shop with he Intervention included salon for specified of R18's bathing care included, "Behavior a history of refusing then complaining to being bathed. Intervention included salon for specified requested indicate what they were shower/bathing." R18's bathing docu 11/11/20 to 12/2/20 on 11/12/20 and 11 reviewed. R18's progress not to 12/3/2020. There 11/8/2020 that including the time peri During an interview the director of nursi interviewed three in unit and they could regarding R18's bar	e indicated she was to be day and Sunday mornings. did not indicate two other days her hair washed. de Kardex report utilized by to provide cares, indicated , bath Sunday and orning). care plan revised 6/27/19 uld like her hair washed T rsday], Sat [Saturday] in the er specific shampoo." dd, Staff will offer the beauty dates to wash [R18's] hair. plan revised 11/25/19; refusing to bathe. [R18] has go to bathe when offered and o staff that she is allegedly not ventions included, "Resident assist with personal hygiene. To offer [R18] her showers at a times. Staff will [did not would do] if [R18] refuses her mentation was reviewed from and revealed R18 had a bath /15/20 during the time period es were reviewed from 11/1/20 es was one progress note dated aded resident refused shower	2 845			

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Minneso	<u>ta Department of He</u>	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			D 14/11/0			
		00916	B. WING		12/0	4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENDE	OOK OF BOCHESTE	B 1875 19TH	I STREET N	ORTHWEST		
EDENDA	OOK OF ROCHESTE	ROCHEST	TER, MN 55	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 845	Continued From pa	ge 20	2 845			
	R18 asked her if the showers because of reassured R18 that The DON also stated getting her hair was DON stated her explayed her shower two washed four times about a month agolist so no matter who moved each wing healthing for all of the R18 not getting shound acceptable. During 12/4/20, at 8:27 a.m. updated the bath so shampoo days on the stated she would be document shampoof the DON. The Bath/Shower possible to be assistance. Reporting resident refuses the SUGGESTED MET director of nursing of in-service staff on the orders for resident's monitor for compliant.	before that. The DON stated ey were not able to have of COVID. The DON stated she she could have a shower. She at the she could have a week. The country of the residents as the she was to she week. The DON stated we created a master shower have they (the residents) are had the master schedule for the residents. The DON stated owers and hair washed was and a subsequent interview on the DON stated she chedule to include R18's the bath schedule. The DON the developing a form to constant in Point of Care that complete, and the level of the shower/tub bath" THOD OF CORRECTION: The correct of the shower/tub bath" THOD OF CORRECTION: The correct of the shair to be shampooed. Also noce. R CORRECTION: Twenty-one				
21390		Subp. 4 A-I Infection Control	21390			1/8/21
Ī	Subn / Policies	and procedures. The infection				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00916	B. WING		12/0	2 4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBR	ROOK OF ROCHESTE	R	H STREET N FER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service en prevention and con E. a resident he immunization progredefined in part 465 procedures of resident the prevention and F. the development of the prevention and F. the development of the procedures of resident of the prevention and F. the development of the procedures of the prevention and F. the development of the procedures of the proce	ust include policies and provide for the following: based on systematic data a nosocomial infections in a detection, investigation, and so of infectious diseases; disprecautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of policies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and cts; and	21390			
	This MN Requirement by: Based on observation review, the facility for the comment of the comment	maintaining awareness of of practice in infection control. ent is not met as evidenced on, interview and document ailed to implement CDC se Control) and CMS (Centers edicare Services) andations for 4 of 4 residents when the facility failed to antine covid positive residents ent roommates. The facility per infection control		Acknowledged		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 21390 Continued From page 22 21390 Continued From page 22	STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) CROSS-REFERENCED TO THE APPROPRIATE DATE	l		00916	B. WING		1	
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ROCHESTER, MN 55901 Complete the control of t	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	EDENB	ROOK OF ROCHESTE	R				
21390 Continued From page 22 21390	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
procedures were followed to prevent and/or mitigate the risk of an outbreak of COVID-19. This deficient practice had the potential to affect all 41 residents residing in the facility and staff who were at risk for contracting COVID-19. The immediate jeopardy began on 11/22/20, when the facility failed to implement appropriate infection control practices to mitigate or reduce the spread of COVID-19 in the facility, the IJ was identified on 12/3/20. The administrator, regional nurse consultant (RNC) and the director of nursing (DON) were notified of the immediate jeopardy at 3:19 p.m. on 12/3/20. The immediate jeopardy was removed on 12/4/20, when the facility had developed and implemented an acceptable plan. However, noncompliance remained at the lower scope and severity level of G, isolated scope and severity, which indicated harm that is not immediate jeopardy. Findings Include: The facility did not ensure COVID positive residents were placed in quarantine separate from COVID negative residents, In addition, infection control concerns were observed during observations and the facility lacked evidence of comprehensive risk analysis of potential exposures and/or transmission to other residents, investigation of the illness, and identification of potential causal factors of disease transmission. According to the census reports, R1 and R2 resided in the same room on the COVID unit. R1 R1's Admission Record, indicated R1 was admitted to the facility 9/28/20. R1's diagnosis included Non-Hodgkin Lymphoma, unspecified	21390	procedures were for mitigate the risk of This deficient pract all 41 residents resi who were at risk for The immediate jeon when the facility fail infection control prathe spread of COVI identified on 12/3/2 nurse consultant (Roursing (DON) were jeopardy at 3:19 p.r. jeopardy was remosfacility had develop acceptable plan. He remained at the low G, isolated scope a harm that is not immediate were placed from COVID negation infection control concobservations and the comprehensive risk exposures and/or to the potential causal factor of the potential causal factor of the same R1 R1's Admission Relation and R1 R1's Admission Relation R1 R1's Admission R1 R1's Admission R1 R1's Admission R1 R1's Admission R2 R1 R1's R1's R1's R1's R1's R1's R1's R	ollowed to prevent and/or an outbreak of COVID-19. ice had the potential to affect iding in the facility and staff or contracting COVID-19. Deardy began on 11/22/20, led to implement appropriate actices to mitigate or reduce ID-19 in the facility, the IJ was 0. The administrator, regional RNC) and the director of the notified of the immediate m. on 12/3/20. The immediate end on 12/4/20, when the led and implemented an owever, noncompliance wer scope and severity level of and severity, which indicated mediate jeopardy. Densure COVID positive red in quarantine separate we residents. In addition, incerns were observed during the facility lacked evidence of analysis of potential ransmission to other residents, illness, and identification of the form of disease transmission. Densure reports, R1 and R2 aroom on the COVID unit.	21390			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00916	B. WING			C 04/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
L EDENBROOK OF ROCHESTER			H STREET N FER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 23	21390			
	asthma, adult failur	e to thrive and anemia.				
		nimum Data Set (MDS) 10/5/20 indicated R1 had				
	"COVID PCR [polyr completed as part of	dated 11/17/20 included, merase chain reaction] test of house wide testing due to tus in the building. Will await				
	p.m. included, "11/1	dated 11/22/2020, at 12:59 16/2020 COVID-19 test result ve. Droplet Precautions				
	p.m. included, "Res [complaints of] pain signs] remain WNL sounds] clear. Good	dated 11/24/2020, at 11:13 sident doing well, no c/o n, dyspnea, cough. VS [vital [within normal limits], LS [lung d appetite and output. Some ng. Encouraging fluids for				
	a.m. included, "oca [nonproductive] cou	dated 11/25/2020, at 4:31 ss [occasional] loose non produgh. denies SOB [shortness of the has been asleep most of the				
	R2					
	admitted to the faci included unspecifie	cord, indicated R2 was lity 1/20/20. R1's diagnosis d dementia without behavioral gnitive communication deficit.				
		num Data Set (MDS) 10/17/20, indicated R2				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		00916	B. WING			C 04/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	·	
EDENBR	ROOK OF ROCHESTE	R	H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 24	21390			
		term memory problems and ith decision-making skills for				
	p.m. included, "CO' reaction] test comp	dated 11/17/2020, at 7:31 VID PCR [polymerase chain leted as part of house wide ID positive status of the results."				
	5:31p.m., included, positive for COVID- back undetected, [F	dated 11/22/2020, at "[R2]'s roommate tested 19. Although her result came R2] will be treated as Droplet precautions will be				
	p.m. included, "CO" antigen test comple results. COVID PCI test was also comp	dated 11/23/2020, at 9:02 VID POC [point of care] eted today with negative R [polymerase chain reaction] leted and sent to lab as part of due to COVID positive status await results."				
	p.m. included, "Res COVID-like sympto antigen test which v	dated 11/30/2020, at 2:47 sident noted to have some ms. Completed point of care was negative. Also completed [polymerase chain reaction] alts from the lab."				
	testing on 11/17/20 positive COVID lab asymptomatic. R1 a moved to the COVI COVID tests results was moved to the C	COVID during the facility wide . The facility received R1's results on 11/22/20. R1 was and roommate R2, were D unit on 11/22/20. R2's s were negative however, R2 COVID unit because the facility the presumptive positive from				

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			:
00916			B. WING			4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDENBR	OOK OF ROCHESTE	R	ISTREET N ER, MN 559	ORTHWEST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21390	Continued From pa	ge 25	21390			
	sharing a room with positive in July 202 have symptoms of undigested food, R discomfort in umbil after emesis. Docu was waiting for rest R2 was tested for C antigen testing on that time, R2 was nuit and was placed precautions. During an interview regional nurse conshave been kept in herecautions and the positive should havunit to separate the	n R1. R2 had been COVID 0. On 11/30/20, R2 started to two medium emesis of 2 complained of abdominal icus region and headache mentation indicated the facility ults of R2's PCR testing, and COVID via the point of care 12/3/20 which was negative. At noved to a room off the COVID				
		ensus reports, R5 and R6 had				
	resided in the same	e room on the COVID unit.				
	R5					
	admitted to the faci included Type 2 dia neuropathy, end sta	age renal disease, al dialysis and major				
		mum Data Set (MDS) 10/26/20 indicated R5 had				
		dated 11/23/2020, at 8:57 VID POC [point of care]				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00916	B. WING			C 04/2020
	PROVIDER OR SUPPLIER	R 1875 19TH		STATE, ZIP CODE ORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21390	antigen test completed. R5's progress note a.m., included, "2L [oxygen] started du 90% (88%)." R5's progress note a.m. included, "Chaobservations, evaluare: Baseline status Provider Feedback for admission (Provhospital for admission Readmitted to the faci included chronic pudependence on supdepressive disorder anxiety disorder unsersessment dated intact cognition. R6's quarterly Minimassessment dated intact cognition. R6's progress note p.m. included, "COV reaction] test completesting due to COV building. Will await R6's progress note p.m. included, "COV antigen test completest was also comphouse wide testing	eted today with positive results. dated 11/24/2020, at 2:37 [liters] supplemental O2 e to sats [saturations] below dated 11/25/2020, at 11:22 ange of conditionNursing lations and recommendations but increased. Primary Care A. Recommendations: Send vider ordered R5 to sent to ion)" cord, indicated R6 was lity 6/28/2017. R6's diagnosis elimonary obstructive disease, oplemental oxygen, major r, recurrent, moderate and specified. mum Data Set (MDS) 8/28/20, indicated R6 had dated 11/17/2020, at 7:17 VID PCR [polymerase chain leted as part of house wide ID positive status of the results." dated 11/23/2020, at 9:03 VID POC [point of care] eted today with negative R [polymerase chain reaction] leted and sent to lab as part of due to COVID positive status await results." R6's test	21390			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		00916	B. WING			4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBR	ROOK OF ROCHESTE	R	I STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Continued From pa	age 27	21390			
	p.m. included, "CO reaction] testing co	dated 11/30/2020, at 2:56 VID PCR [polymerase chain mpleted. Will await results."				
	included, "Residen afternoon. C/O [coi	dated 12/2/2020, at 2:11 p.m. t tested positive for COVID this mplaints of] not feeling well, up [temperature] of 102.2. ie."				
	included, "Vital Sig 110/58, P [pulse] 7 [respirations]19, O2 2LNC [liters nasal of Symptoms (cough, headache, loss of t [gastrointestinal sycough, fatigue, increactivities of daily liverecent falls noted: in Emotional/Psychose Appetite and Fluid	mptoms]): non-productive reased sleepiness ADL[ring]/functional declines or no changes- in bed all night. social Concerns: none. intake: sleeping, water at terventions and effectiveness:				
	occuring on 11/23/2 indicated R5 had lo facility completed F positive. R5 shared shared was on the R5 and R6 shared R5 was hospitalize the room they shar requested to be mo On 12/2/2020, R6 of headache, temperation of the R5 was hospitalize the room they shar requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room that they are the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room they shared was not requested to be more than the room the room the room the room they shared was not requested to be more than the room	otoms was identified as 20, when documentation cose stools. On 11/23/20, the POC testing and results were a room with R6. The room COVID unit created 11/22/20. a room on the COVID unit until d on 11/25/20. R6 remained in ed on the COVID unit until R6 oved off the unit on 11/28/20. displayed symptoms ature 102.2 and had beeling well. A POC test was				

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NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER Major Major	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
SUMMARY STATEMENT OF DEFICIENCIES TAG			00916	B. WING			_
CX4 D SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY CACH DEFICIENCY MUST BE PRECEDED BY FULL PEFEIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL PEFEIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL PEFEIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL PEFEIX TAG CACH DEFICIENCY CACH DEFICIENCY CACH DEFICIENCY CACH DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 21390 Continued From page 28 Completed and results were positive. R6 was moved back to the COVID unit. RN-B and resident (who had mask on) entered from the exit door of the building. RN-B had only N95 donned-no other PPE. RN-B walked up the length of hallway thru the plastic barrier into the nurse breakroom (in unit), RN-B stated she did not think the set up was appropriate. There should be a doffing/donning by the exit door. During an interview on 12/2/20, at 1:56 p.m. the RNC stated R6 had remained in the room with R5 until R5 was hospitalized as he initially had refused to move rooms. The RNC verified the facility did not have documentation of R6's refusal to move rooms. During an interview on 12/3/2020, at 10:21 a.m. RNC stated the facility had nothing documented for contact tracing at this time for residents, but had a plan to complete an analysis once the outbreak had concluded. RN-C stated going forward the facility planned to review residents that were newly positive to identify if there are any common denominators between staff and residents that could be a potential link to possible spread. She stated for positive staff, the facility was completing the staff risk assessments	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	· · · · · ·	
(A4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (CROSS-REFERENCED TO THE APPROPRIATE DATE) 21390 Continued From page 28 completed and results were positive. R6 was moved back to the COVID unit. During an observation on 12/2/2020, at 11:45 a.m. in the COVID unit, RN-B and resident (who had mask on) entered from the exit door of the building. RN-B had only N95 donned- no other PPE. RN-B walked up the length of hallway thru the plastic barrier into the nurse breakroom (in unit). RN-B cane out of the breakroom with face shield on walked through barrier and then donned gown. RN-B stated she did not think the set up was appropriate. There should be a doffing/donning by the exit door. During an interview on 12/2/20, at 1:56 p.m. the RNC stated R6 had remained in the room with R5 until R6 was hospitalized as he initially had refused to move rooms. The RNC verified the facility did not have documentation of R6's refusal to move rooms. During an interview on 12/3/2020, at 10:21 a.m. RNC stated the facility had nothing documented for contact tracing at this time for residents, but had a plan to complete an analysis once the outbreak had concluded. RN-C stated going forward the facility planned to review residents that were newly positive to identify if there are any common denominators between staff and residents that could be a potential link to possible spread. She stated for positive staff, the facility was completing the staff risk assessments	FDFNRF	OOK OF ROCHESTE	R				
ECAH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21390 Continued From page 28 completed and results were positive. R6 was moved back to the COVID unit. During an observation on 12/2/2020, at 11:45 a.m. in the COVID unit, RN-B and resident (who had mask on) entered from the exit door of the building, RN-B had only N95 donned-no other PPE. RN-B walked up the length of hallway thru the plastic barrier into the nurse breakroom (in unit), RN-B came out of the breakroom with face shield on walked through barrier and then donned gown. RN-B stated she did not think the set up was appropriate. There should be a doffing/donning by the exit door. During an interview on 12/2/20, at 1:56 p.m. the RNC stated R6 had remained in the room with R5 until R5 was hospitalized as he initially had refused to move rooms. During an interview on 12/3/2020, at 10:21 a.m. RNC stated the facility had nothing documented for contact tracing at this time for residents, but had a plan to complete an analysis once the outbreak had concluded. RN-C stated going forward the facility planned to review residents that were newly positive to identify if there are any common denominators between staff and residents that could be a potential link to possible spread. She stated for positive staff, the facility was completing the staff risk assessments	LDLINDI	NOOK OF ROOFIEGIE	ROCHES	TER, MN 559	901		
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however, going forward the facility was going to be expanding the analysis to include any potential exposure to residents they had cared for and other staff they had worked with and any potential exposures out of work. During an interview on 12/4/2020, at 9:16 a.m.	21390	completed and resumoved back to the During an observat a.m. in the COVID had mask on) enter building. RN-B had PPE. RN-B walked the plastic barrier in unit). RN-B came oshield on walked the gown. RN-B stated was appropriate. The doffing/donning by During an interview RNC stated R6 had until R5 was hospitarefused to move roofacility did not have to move rooms. During an interview RNC stated the factor contact tracing a had a plan to compoutbreak had concletorward the facility plat were newly postommon denominare sidents that could spread. She stated was completing the however, going for be expanding the alexance out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposures out of well and the staff they had exposured the staff they had they had the staff they had they had the staff they had they h	ults were positive. R6 was COVID unit. ion on 12/2/2020, at 11:45 unit, RN-B and resident (who red from the exit door of the only N95 donned- no other up the length of hallway thru nto the nurse breakroom (in ut of the breakroom with face rough barrier and then donned she did not think the set up here should be a the exit door. I on 12/2/20, at 1:56 p.m. the did remained in the room with R5 alized as he initially had oms. The RNC verified the documentation of R6's refusal of this time for residents, but lete an analysis once the uded. RN-C stated going colanned to review residents sitive to identify if there are any stors between staff and the apotential link to possible for positive staff, the facility is staff risk assessments ward the facility was going to nalysis to include any potential of the core.				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	
		A. BUILDING:			
00916		B. WING		12/0	; 4/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
EDENBROOK OF ROCHESTER		ISTREET NO ER, MN 559	ORTHWEST 901		
PREFIX (EACH DEFICIENCY MUS	MENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
not aware the facility haresidents were being in CNP-A stated the symptoms as resident do not have symptoms. The facility's COVID-19 included, "Policy: The facility's The facility's COVID-19 included, "Policy: The facility and fluid nature will monitor, follow, and recommendations and with the Centers for Distriction (CDC), the Will (WHO), CMS [Centers and the State Department identification and isolatic cases". The immediate jeopard 11/22/2020, was removed their policies, implemented cohorting precautions strategies, assessments for reside staff education. Suggested Method of Cadministrator or designed and procedures to ensurpractices to mitigate or COVID-19 in the facility	oner (CNP)-A stated was ad not been aware happropriately cohorted. ptomatic and/or COVID ald absolutely not be in the ints that are negative and/or so. Popolicy revised 10/19/20 facility will conduct and infection control and to reduce the risk of policy. The facility are of the virus; the facility are of the virus; the facility are in accordance sease Control and World Health Organization for Medicare & Medicaid], and of Health to include the facility had appropriately and transmission based had initiated risk ents, and had provided. Correction: The nee could review policies ure proper infection control reduce the spread of	21390			

6899

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
						.
		00916	B. WING			4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1875 19TI	H STREET N	,		
EDENBR	OOK OF ROCHESTE	R	ΓER, MN 55			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
21390	Continued From pa	nge 30	21390			
	Time Period for Co days.	rrection: Twenty one (14)				
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			1/8/21
	Subd. 10. Particip notification of family	pation in planning treatment; y members.				
	in the planning of the includes the opport alternatives with incorportunity to requestare conferences, a family member or oboth. In the event to present, a family mechosen by the resident and the includes a family mechosen by the resident and the includes a family mechosen by the resident and the includes a family mechosen by the resident and the includes a family mechosen by the resident and the includes a family mechosen by the resident and the includes a family mechosen and the includes a family mechonical an	Il have the right to participate neir health care. This right runity to discuss treatment and dividual caregivers, the lest and participate in formal and the right to include a other chosen representative or that the resident cannot be lember or other representative dent may be included in such				
	unconscious or con communicate, the f efforts as required either a family men writing by the reside	who enters a facility is matose or is unable to facility shall make reasonable under paragraph (c) to notify her or a person designated in ent as the person to contact in				
	admitted to the faci family member to p planning, unless the to believe the resident	the resident has been lity. The facility shall allow the participate in treatment e facility knows or has reason ent has an effective advance				
	specified in writing member included ir notifying a family m family member to p planning, the facility	trary or knows the resident has that they do not want a family in treatment planning. After tember but prior to allowing a participate in treatment y must make reasonable				
		with reasonable medical ine if the resident has				

Minnesota Department of Health

STATE FORM 6899 LMG311 If continuation sheet 31 of 36

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 [X41]ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 31 executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (5) inquiring of the physician to whom the resident normally goes for care; and (6) inquiring of the physician to whom the resident normally goes for care; and (6) inquiring of the physician to whom the resident normally goes for care; and (7) inquiring of the physician to whom the resident normally goes for care; and (8) inquiring of the physician to whom the resident normally goes for care; and (1) inquiring of the physician to whom the resident normally goes for care; and (1) inquiring of the physician to whom the resident normally goes for care; and (1) inquiring of the physician to whom the resident normally goes for care; and (1) inquiring of the physician to whom the resident normally goes for care; and (1) inquiring of the physician to whom the resident normally goes for care; and (1) inquiring of the physician to whom the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member or designated emergency contact or the participation of the family member or emergency contact or the participation of the family member or was improper or violated the		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 [X4] ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES BY PLLI (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 31 executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has a physician to whom the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (4) inquiring the medical modern the resident normally goes for care; and (5) inquiring of the physician to whom the resident normally goes for care; and (6) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the	ANDFLAN	TOF CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMP	LLTLD
EDENBROOK OF ROCHESTER 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 (X4) ID PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 31 executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member or emergency contact or the participation of the family member or over emergency contact or the participation of the family member was improper or violated the			00916	B. WING			_
(24) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 31 executed an advance directive relative to the esident in the possession of the facility; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive and whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	EDENBR	ROOK OF ROCHESTE	R				
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executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member or emergency contact or the participation of the family member or violated the	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETE
esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the	21830	Continued From pa	age 31	21830			
(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family	21830	executed an advant esident's health carthis paragraph, "rea (1) examining the resident; (2) examining the resident in the poss (3) inquiring of a family member consuments whether the resident directive and whether the resident normally governments and (4) inquiring of the resident normally governments whether the resident designated emergency entactive. If a facility designated emergency entactive and the motification of the motification of the motification of the mergency contact family member was patient's privacy rigus (c) In making reafamily member or a designated entactive and the medical reapossession of the form the facility shall attempted the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the medical reapossession of the form the facility and the faci	ice directive relative to the re decisions. For purposes of asonable efforts" include: e personal effects of the emedical records of the session of the facility; ny emergency contact or stacted under this section in thas executed an advance for the resident normally goes for the physician to whom the soes for care, if known, in thas executed an advance ty notifies a family member or ency contact or allows a family ate in treatment planning in its paragraph, the facility is not in damages on the grounds that the family member or to or the participation of the improper or violated the phts. It is asonable efforts to notify a designated emergency contact, empt to identify family gnated emergency contact by sonal effects of the resident in the facility. If the facility is unable ember or designated it within 24 hours after the lity shall notify the county is identified and interest and interes	21830			

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00916	B. WING		12/0	2 4/2020
NAME OF	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE	1 12/0	77/2020
NAME OF	PROVIDER OR SUPPLIER			ORTHWEST		
EDENBI	ROOK OF ROCHESTE	R	ER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	county social service enforcement agency identifying and notification designated emerge service agency or lethat assists a facility subdivision is not liad damages on the growthe family member participation of the for violated the patient or viol	te agency and local law by shall assist the facility in rying a family member or ncy contact. A county social bocal law enforcement agency y in implementing this able to the resident for bounds that the notification of or emergency contact or the family member was improper	21830	Acknowledged		

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00916	B. WING			C 04/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
EDENBR	ROOK OF ROCHESTE	R	H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 33	21830			
	assessment dated required physical he from one staff mem and had intact cogr mental score of 15. understood and uncomprehension. R18's bath schedul bathed on Wednes. The bath schedule of the week to have	de Kardex report utilized by o provide cares, indicated , bath Sunday and				
	included, "[R18] wo [Tuesday], TH [Thu beauty shop with he Intervention include salon for specified of R18's bathing care included, "Behavior a history of refusing then complaining to being bathed. Intervention has a peri-wand to Staff will continue to specified requested.	care plan revised 6/27/19 uld like her hair washed T rsday], Sat [Saturday] in the er specific shampoo." ed, Staff will offer the beauty dates to wash [R18's] hair. plan revised 11/25/19 ; refusing to bathe. [R18] has g to bathe when offered and e staff that she is allegedly not ventions included, "Resident assist with personal hygiene. offer [R18] her showers at a times. Staff will [did not vould do] if [R18] refuses her				
	shower/bathing." R18's bathing docu	mentation was reviewed from				

	ta Department of He		1		1	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COIVIE	LLILD
					c	;
		00916	B. WING		12/0	4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TV WIL OT	NOVIDER OR GOLF EIER			ORTHWEST		
EDENBR	OOK OF ROCHESTE	R	TER, MN 55			
()(4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX	_	MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
21830	Continued From pa	ge 34	21830			
	on 11/12/20 and 11	/15/20 during the time period				
	reviewed.	7 13/20 during the time period				
		es were reviewed from 11/1/20				
		was one progress note dated				
	during the time peri	ided resident refused shower				
	during the time pen	od reviewed.				
	During an interview	on 12/3/2020, at 4:05 p.m.				
		ng (DON) stated she had				
		ursing assistants on the covid				
		not answer questions				
		thing. The DON stated she				
		d R18 told her she had a bed yesterday, but had not had a				
		before that. The DON stated				
		ey were not able to have				
		of COVID. The DON stated she				
		she could have a shower.				
		ed R18 shared she was not				
		shed four times a week. The				
		pectation was R18 was to rice a week and her hair				
		a week. The DON stated				
		we created a master shower				
		ere they (the residents) are				
		ad the master schedule for				
		e residents. The DON stated				
		owers and hair washed was				
		ng a subsequent interview on				
		n. the DON stated she chedule to include R18's				
	•	he bath schedule. The DON				
		e developing a form to				
		os, which, will be turned in to				
	the DON.					
		olicy revised 2/26/20 included,				
		ocument in Point of Care that omplete, and the level of				
	Shower/Dath was co	ompiete, and the level of				

Minnesota Department of Health

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00916	B. WING) 4/2020
	PROVIDER OR SUPPLIER	R 1875 19TH		STATE, ZIP CODE ORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21830	assistance. Reporti resident refuses the SUGGESTED MET director of nursing of in-service staff on the requests especially frequency. Also mo	ge 35 ng: 1. Notify the nurse if e shower/tub bath" THOD OF CORRECTION: The per social services could the need to honor resident for choice in bathing nitor for compliance. R CORRECTION: Twenty-one	21830			



Protecting, Maintaining and Improving the Health of All Minnesotans

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

In order to assist with identifying appropriate corrective actions and implementing systemic changes, the facility must contract with an infection control consultant to provide consultation and oversight for infection prevention and control within the facility.

- The consultant shall exercise independent judgement in the performance of all duties under the
 consultant contract. The consultant shall meet the independent judgement requirement if the
 consultant is not presently and has not within a five (5) year period immediately preceding June
 1, 2020 directly or indirectly affiliated with the facility, facility's owner(s),
 agent(s), or employee(s).
 - The consultant shall have completed infection prevention and control training from a recognized source, such as the Centers for Disease Control and Prevention or American Health Care Association.
 - The consultant will be contracted to work with the facility for a minimum of two (2) months.
- The consultant will assist the facility in completing the CMS infection control self-assessment. If this assessment was completed prior to the June 4, 2020 survey, the assessment should be reviewed to determine if it is an accurate reflection of the facility's infection control program. The self-assessment can be found in the CMS publication QSO-20-20-All, Prioritization of Survey Activity.

Infection control consultant responsibilities must include, but are not limited to, the following:

- Work with the facility to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS-2567.
- The facility's Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee, must participate in the completion of the RCA. Information regarding RCAs can be found in the CMS publication Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs).
- Take immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR § 483.80 for the affected residents impacted by the noncompliance identified in the CMS-2567 to include identification of other residents that may have been impacted by the noncompliant practices. This plan must include but is not limited to implementation of procedures to ensure:

Cohorting Residents/Transmission Based Precaution "Isolation"

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing shall complete the following:

- Grouping of residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Dedicate a unit or part of a unit as the care location for residents with disease, including those with or without current symptoms of illness. Anticipate ways to close off units to prevent spread of illness from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents).
- Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask.
- Provide dedicated equipment for areas, as able.

When a resident is placed on transmission-based precautions, the staff should implement the following:

- Clearly identify the type of precautions and the appropriate PPE to be used.
- Place signage in a conspicuous place outside the resident's room (e.g., the door or on the wall next to the door) identifying the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. Ensure that signage also complies with residents' rights to confidentiality and privacy.
- Make PPE readily available near the entrance to the resident's room.
- Don appropriate PPE upon entry into the environment (e.g., room or cubicle) of resident on transmission-based precautions (e.g., contact precautions).
- Use disposable or dedicated noncritical resident-care equipment (e.g., blood pressure cuff, bedside commode). If noncritical equipment is shared between residents, it will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use.
- Clean and disinfect objects and environmental surfaces that are touched frequently (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms).

TRAINING/EDUCATION:

• Provide education to residents (to the degree possible/consistent with the resident's capacity) and their representatives or visitors on the use of transmission-based precautions.

- Refer to CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- Refer to MDH COVID-19 Infection Prevention and Control and Cohorting in Long-term Care. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf
- MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions. https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare

Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC AA refVal=https%3A%2F%2Fwww.cd c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care

Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will verify the placement of each new admission and location and audit for transmission based precautions are being appropriately implemented.
- Conduct a Root Cause Analysis (RCA) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found in the document: Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs)

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Use this for IJ

Item	Checklist: Documents Required
	for Successful Completion of the Directed Plan
1	Consultant name and credentials meeting the criteria outlined above
2	Executed contract with the consultant
3	Documentation demonstrating that the RCA was completed as described above
4	List of facility policies and procedures reviewed by the consultant.
5	Infection control self-assessment
6	Summary of all changes as a result of the RCA and consultant review – to
	include a summary of how staff were notified and trained on the changes
7	Content of the trainings provided to staff to include a Syllabus, outline, or
	agenda as well as any training materials used and provided to staff during the
	training
8	Names and positions of all staff to be trained
9	Staff training sign-in sheets
10	Summary of staff training post-test results, to include facility actions in response
	to any failed post-tests
11	Summary of follow-up employee supervision and work performance appraisal to
	include when employees were observed, what actions were observed, and an
	evaluation of the effectiveness of any new policies and procedures.

In order to speed up our review, identify all submitted documents with the number in the "Item" column.