DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 16, 2021

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

RE: CCN: 245409
Cycle Start Date: November 10, 2021

Dear Administrator:

On December 14, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
November 24, 2021

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

RE: CCN: 245409
Cycle Start Date: November 10, 2021

Dear Administrator:

On November 10, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by February 10, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 10, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 11/10/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/09/21 and 11/10/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H540900C (MN00078158), with deficiencies cited at F580 and F684. AND The following complaints were found to be UNSUBSTANTIATED:. H5409091C (MN00070079) H5409092C (MN00069610) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		12/10/21

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

Electronically Signed | 12/02/2021

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F 580	Continued From page 1 results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct	F 580		

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F 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to notify a physician in a timely manner that 1 of 1 residents (R1) was refusing needed medications, including insulin. Findings include: R1's significant change Minimum Data Set (MDS) dated 11/4/21, identified cognitively intact, had a diagnosis of diabetes and did not refuse cares. R1's July-November 2021 Medication Administration Records (MAR) showed R1 refused an ordered Glargine insulin (long lasting insulin) once in July, 18 doses in August, 25 doses in September, 22 doses in October and 17 doses in November. A review of R1's MAR's showed the following pattern of refusing medications: -Vitamin B12 100 mg daily starting date 10/29/21 (helps prevent anemia and works with the nervous system), in October, one of two doses was refused, and in November 3/10 doses were refused. -Bisacodyl tablet 5 mg give 2 tabs daily for constipation, start date 11/01/21. Of 17 doses offered, six were refused. -Polyethylene glycol powder 17 Gm, give one scoop two times daily for constipation, start date 9/25/21 through 10/29/21, four of 10 doses were refused in September; in October 30/57 doses were refused and an additional 8 doses were not given for a variety of reasons. Medication was	F 580	• R1 provider was notified on 11/10/2021 related to her refusals for her mediations. • All residents have the potential to be affected. Residents reviewed to determine if any have refused medications. Any residents to have been found to routinely refuse medications will have provider notification made. • Licensed nurses and TMA staff educated on the need to notify provider when a resident is routinely refusing medication. • Weekly audits of medication refusals and provider notifications will be completed for one month. • Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. • DON/Designee is responsible for ensuring compliance.	

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F 580	Continued From page 3	F 580		

restarted after a one day hospital admission: start date 11/1/21. Of 17 doses, 14 were refused.
-Tylenol Extra Strength 500 mg give 2 tabs three times daily for pain, starting date 10/29/21. Of 7 doses in October, 5 were refused. Of 29 doses, 19 were refused in November.

R1's medical record and physician visit notes failed to identify the physician had been made aware R1 had been refusing the insulin or any of the other medications at all.

When interviewed on 11/10/21, at 10:01 a.m. registered nurse (RN)-A stated, if the resident continues to refuse medications, "day after day," it should be reported to the physician. In the case of insulin,

When interviewed on 11/10/21, at 10: 03 a.m. licensed practical nurse (LPN)-B, a nurse manager, stated a nurse should attempt to talk the resident into taking their medications, and if they continued to refuse, make out an SBAR (an electronic form to notify the physician) or call the physician directly. LPN-B said missed doses of insulin should also be followed by an additional blood-sugar check.

When interviewed on 11/10/21, at 10:08 a.m. the director of nursing (DON) and assistant director of nursing (ADON) both stated an SBAR should be filled out when medications are refused. DON said generally they would wait until the second refusal. DON stated she would know if an SBAR had been filled out in the EHR as it would flow over to a report they check routinely, but confirmed she had not seen any SBAR regarding the refusal of medications.

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When interviewed on 11/10/21, at 11:42 a.m. R1's physician (MD) stated it was facility practice to send an SBAR if a resident was refusing their medication regime, and stated an expectation to be notified "right away" of refused medications. MD confirmed no SBAR had been received. MD stated she was concerned to hear R1 was refusing her insulin.

The facility Policy & Procedure Care of the Diabetic Resident, dated 7/28/15 and revised 8/12/21, identified the purpose was as follows: "To assist the resident to establish a balance between diet, exercise, and insulin; prevent recurrence of hyperglycemia/hypoglycemia; recognize, assist and document the treatment of complications commonly associated with diabetes; and individualize teaching according to carefully assessed resident and family needs. Diabetes Mellitus is a chronic, hereditary, or developmental disorder is which there is relative or absolute lack of insulin characterized by glucose intolerance." The policy included, "follow the resident's individual hyperglycemic protocol, if ordered by physician. If parameters are not in place update the physician as needed based on assessment and blood glucose reading."

A facility policy titled Policy & Procedure Change in Condition dated 8/1/15 and most recently revised 7/6/21, included, a purpose of the policy is: "The ensure prompt notification of the resident, the attending physician and Durable Power of Attorney/Responsible Part of changes in the resident's physical, psychosocial and/or mental condition and/or status. The document indicates that the physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset,

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F 580	Continued From page 5 a change that is a marked difference unusual sign/symptom and/or the signs/symptoms are unrelieved by measures already prescribed. The document indicates that a refusal of treatment or medications (i.e. two (2) or more consecutive times) should be reported, and the nurse is to assess and document pertinent findings in the resident record and notify the physician or the Medical Director if the physician cannot be reached.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, facility failed to respond to 1 of 1 resident's (R1) continued refusal of medications which had the potential to result in adverse outcomes such as, but not limited to hyperglycemia (high blood sugar), nutritional deficits and bowel impaction. Findings include: R1's significant change Minimum Data Set (MDS) dated 11/4/21, included cognitively intact with diagnoses including diabetes, and received insulin daily. R1 did not reject cares. R1's	F 684	" R1 was assessed for possible side effects related to refusal of medication including but not limited to hyperglycemia, constipation, and nutritional deficits. Provider was also updated of resident□s refusal of insulin. " All residents have the potential to be affected. Residents reviewed to determine if any have refused medications. Any residents to have been found to refuse medications will be reviewed to ensure that no adverse side effects have occurred. " Licensed nurses educated on the	12/10/21

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F 684	Continued From page 6 admission MDS dated 7/23/21, included moderate cognitive impairment with diagnosis of diabetes, received insulin daily and did not reject cares. R1's care plan included diabetes, however, did not identify R1 had any refusal of insulin. R1's Medication Administration Records (MAR) R1 identified Glargine insulin (long lasting) 300/ml (a concentrated formulary for persons who require high doses of insulin) give 90 units every night at bedtime starting on 7/16/21 through 7/20/21 when the dose was increased to 95 units when R1's blood sugar exceeded 200 each night. On 7/23/21 a dose was not documented as having been given. In August, nurses administered 19 of 31 doses. Eleven doses were listed as "held" and 7 doses were listed as "refused." Twelve nightly bed-time blood sugar levels were not recorded. In September, nurses administered only 5 of 30 doses of R1's Glargine with the remainder marked as refused. Twenty nightly bed-time blood sugar levels were not recorded. In October, nurses administered only 6 of 28 doses, and recorded only 6 nightly bed-time blood sugar levels by 11/09/21. R1's November 2021 MAR, indicated an order was initiated 11/02/21-11/03/21 for Aspart Insulin (fast acting) 100/unit/ml, give 90 units one time daily in the morning, but was not documented as having been given on 11/2/21, and documented as refused by R1 on 11/3/21. On 11/03/21 the order was revised to be given per a sliding scale (dose titrated to R1's blood-sugar level) with each meal. From 11/03/21 until the date of survey, only 4 of 21 doses of the Aspart insulin were given. No additional blood-sugar monitoring was noted on	F 684	need to notify provider when a resident declines medication and to complete additional monitoring as needed related to potential side effects. " Weekly audits of medication refusals, potential side effects of missed medications, and provider notifications will be completed for one month. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. " DON/Designee is responsible for ensuring compliance.	

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F 684	Continued From page 7	F 684		

the dates that R1's Aspart was refused.

A review of R1's MAR's showed the following pattern of refusing medications:
-Vitamin B12 100 mg daily starting date 10/29/21 (helps prevent anemia and works with the nervous system), in October, one of two doses was refused, and in November 3/10 doses were refused.
-Bisacodyl tablet 5 mg give 2 tabs daily for constipation, start date 11/01/21. Of 17 doses offered, six were refused.
-Polyethylene glycol powder 17 Gm, give one scoop two times daily for constipation, start date 9/25/21 through 10/29/21, 4 of 10 doses were refused in September; in October 30/57 doses were refused and an additional 8 doses were not given for a variety of reasons. Medication was restarted after a one day hospital admission: start date 11/1/21. Of 17 doses, 14 were refused.
-Tylenol Extra Strength 500 mg give 2 tabs three times daily for pain, starting date 10/29/21. Of 7 doses in October, 5 were refused. Of 29 doses, 19 were refused in November.

R1's progress notes failed to show nurses reported any of R1's refusals of insulin or of the other medications listed, even when R1's progress note showed she had complained on 9/21/21 that she had not had a bowel movement (BM) in 10 days. Nurse notified provider of no BM, but did not indicate the refusal of bowel medications. Progress notes failed to indicate nurses had done any follow-up assessments related to her refusal of medications or attempted to educate R1 about the risks of not following her ordered medication regime.

When interviewed on 11/9/21, at 2:00 p.m. R1

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stated, the facility did not, "give me my medications like I took them at home." R1 said she did not like to take Tylenol, and she did not believe she needed insulin, or at least not the way it had been ordered at the facility. R1 stated a belief that she did not require insulin if her blood sugars remained below 200, and was unable to state the consequences of refusing insulin. R1 was able to describe her lower legs as feeling almost as if they were paralyzed, and understood this was due to her diabetes, but had no stated insight to correlate the importance of glucose management with the nerve dysfunction that has already occurred. R1 said the nurses told her it was her right to refuse her medications, but had not explained any risks of doing so.

On 11/10/21, 9:59 a.m. a licensed practical nurse (LPN)-A was observed to be leaving R1's room after administering medications. She was holding an insulin pen of R1's Aspart insulin in her hand. LPN-A stated R1 had refused her insulin and her bowel medication. LPN-A stated she would report refused medications to the medical provider if it was written in the orders. LPN-A was observed to look through R1's MAR, and then stated she did not see an order to report these missed doses.

When interviewed on 11/10/21, at 10:01 a.m. registered nurse (RN)-A stated a nurse should re-approach a resident and offer the medication again if it was refused. RN-A said if the resident continues to refuse medications, "day after day," it should be reported to the physician. In the case of insulin, RN-A stated a nurse should also re-check the person's blood-sugar levels to make sure they are not developing hyperglycemia (high blood sugar).

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F 684	Continued From page 9	F 684		

When interviewed on 11/10/21, at 10: 03 a.m. LPN-B, a nurse manager, stated a nurse should attempt to talk the resident into taking their medications, and if they continued to refuse, make out an SBAR (an electronic form to notify the physician) or call the physician directly. LPN-B said missed doses of insulin should also be followed by an additional blood-sugar check.

When interviewed on 11/10/21, at 10:08 a.m. the director of nursing (DON) and assistant director of nursing (ADON) both stated an SBAR should be filled out when medications are refused. DON said generally they would wait until the second refusal. The DON also said it was expected that nurses would try to find why the resident does not want to take the medication and see if they were able to be more accommodating by changing time of administration, or determine if the person needed the medication at all, or see if it could be given only as needed/requested. DON stated an expectation of the nurse to provide education to the resident on the risks of refusing their treatment regime. Both DON and ADON said the refusal and interventions the nurse took should be documented in the resident's chart for continuity of care. DON stated she would know if an SBAR had been filled out in the EHR as it would flow over to a report they check routinely, but confirmed she had not seen any SBAR regarding R1's refusal of medications. DON stated R1 was at risk for hyperglycemia and at greater risk due to a history of diabetic ketoacidosis (DKA) from not taking insulin (DKA is a metabolic condition where there is an acid-base imbalance and generally requires hospitalization and is life threatening). DON also stated a concern about the possibility of bowel obstruction. DON said that had nursing

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	245409	A. BUILDING _____ B. WING _____	C 11/10/2021

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

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F 684	Continued From page 10	F 684		

leadership known about the continued refusal they could have had the medical provider talk with R1 about her risks related to refusing her medications. DON said the facility usually will have a resident sign a risk and benefit sheet if they choose to refuse their treatment as ordered, but confirmed this had not been done with R1.

When interviewed via telephone on 11/10/21, at 11:42 a.m. R1's physician (MD) stated it was facility practice to send an SBAR if a resident was refusing their medication regime, and stated an expectation to be notified, "right away" of refused medications. MD confirmed no SBAR had been received. MD stated she was concerned to hear R1 was refusing her insulin as R1 had a history of alcohol abuse, along with uncontrolled diabetes mellitus, which had already contributed to the neuropathy in her legs, and there was also the potential for DKA if not taking her insulin. MD also said R1 had very little insight into her condition

A facility policy titled, Policy & Procedure Care of the Diabetic Resident, dated 7/28/15 and revised 8/12/21. The stated purpose is as follows: "To assist the resident to establish a balance between diet, exercise, and insulin; prevent recurrence of hyperglycemia/hypoglycemia; recognize, assist and document the treatment of complications commonly associated with diabetes; and individualize teaching according to carefully assessed resident and family needs.
Diabetes Mellitus is a chronic, hereditary, or developmental disorder is which there is relative or absolute lack of insulin characterized by glucose intolerance." The policy included, "follow the resident's individual hyperglycemic protocol, if ordered by physician. If parameters are not in place update the physician as needed based on

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F 684	Continued From page 11 assessment and blood glucose reading." A facility policy titled, Policy & Procedure Change in Condition dated 8/1/15 and most recently revised 7/6/21. The stated purpose of the policy is: "The ensure prompt notification of the resident, the attending physician and Durable Power of Attorney/Responsible Part of changes in the resident's physical, psychosocial and/or mental condition and/or status. The document indicated the physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference unusual sign/symptom and/or the signs/symptoms are unrelieved by measures already prescribed. The document indicates that a refusal of treatment or medications (i.e. two (2) or more consecutive times) should be reported, and the nurse is to assess and document pertinent findings in the resident record and notify the physician or the Medical Director if the physician cannot be reached. A facility document titled Policy & Procedure Charting and Documentation dated 8/1/15 and most recently revised 7/6/21 indicates "documentation will include information on assessment, notifications, interventions and evaluation including but not limited to: ... (e.) refusal of medication/treatments or recommendations (f.) education provided to resident ..."	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 24, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: V27611

Dear Administrator:

The above facility was surveyed on November 9, 2021 through November 10, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 11/10/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/9/21 and 11/10/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H540900C (MN00078158), with deficiencies cited at licensing order 0265 and 0830. AND The following complaints were found to be UNSUBSTANTIATED:. H5409091C (MN00070079) H5409092C (MN00069610) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		12/10/21

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2 265	Continued From page 3 C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review, facility failed to notify a physician in a timely manner that 1 of 1 residents (R1) was refusing needed medications, including insulin. Findings include: R1's significant change Minimum Data Set (MDS) dated 11/4/21, identified cognitively intact, had a diagnosis of diabetes and did not refuse cares. R1's July-November 2021 Medication Administration Records (MAR) showed R1 refused an ordered Glargine insulin (long lasting insulin) once in July, 18 doses in August, 25 doses in September, 22 doses in October and 17 doses in November. A review of R1's MAR's showed the following pattern of refusing medications: -Vitamin B12 100 mg daily starting date 10/29/21 (helps prevent anemia and works with the nervous system), in October, one of two doses was refused, and in November 3/10 doses were refused. -Bisacodyl tablet 5 mg give 2 tabs daily for constipation, start date 11/01/21. Of 17 doses	2 265	Acknowledged	

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2 265	Continued From page 4	2 265		

offered, six were refused.
-Polyethylene glycol powder 17 Gm, give one scoop two times daily for constipation, start date 9/25/21 through 10/29/21, four of 10 doses were refused in September; in October 30/57 doses were refused and an additional 8 doses were not given for a variety of reasons. Medication was restarted after a one day hospital admission: start date 11/1/21. Of 17 doses, 14 were refused.
-Tylenol Extra Strength 500 mg give 2 tabs three times daily for pain, starting date 10/29/21. Of 7 doses in October, 5 were refused. Of 29 doses, 19 were refused in November.

R1's medical record and physician visit notes failed to identify the physician had been made aware R1 had been refusing the insulin or any of the other medications at all.

When interviewed on 11/10/21, at 10:01 a.m. registered nurse (RN)-A stated, if the resident continues to refuse medications, "day after day," it should be reported to the physician. In the case of insulin,

When interviewed on 11/10/21, at 10: 03 a.m. licensed practical nurse (LPN)-B, a nurse manager, stated a nurse should attempt to talk the resident into taking their medications, and if they continued to refuse, make out an SBAR (an electronic form to notify the physician) or call the physician directly. LPN-B said missed doses of insulin should also be followed by an additional blood-sugar check.

When interviewed on 11/10/21, at 10:08 a.m. the director of nursing (DON) and assistant director of nursing (ADON) both stated an SBAR should be filled out when medications are refused. DON said generally they would wait until the second

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2 265	Continued From page 5	2 265		

refusal. DON stated she would know if an SBAR had been filled out in the EHR as it would flow over to a report they check routinely, but confirmed she had not seen any SBAR regarding the refusal of medications.

When interviewed on 11/10/21, at 11:42 a.m. R1's physician (MD) stated it was facility practice to send an SBAR if a resident was refusing their medication regime, and stated an expectation to be notified "right away" of refused medications. MD confirmed no SBAR had been received. MD stated she was concerned to hear R1 was refusing her insulin.

The facility Policy & Procedure Care of the Diabetic Resident, dated 7/28/15 and revised 8/12/21, identified the purpose was as follows: "To assist the resident to establish a balance between diet, exercise, and insulin; prevent recurrence of hyperglycemia/hypoglycemia; recognize, assist and document the treatment of complications commonly associated with diabetes; and individualize teaching according to carefully assessed resident and family needs. Diabetes Mellitus is a chronic, hereditary, or developmental disorder is which there is relative or absolute lack of insulin characterized by glucose intolerance." The policy included, "follow the resident's individual hyperglycemic protocol, if ordered by physician. If parameters are not in place update the physician as needed based on assessment and blood glucose reading."

A facility policy titled Policy & Procedure Change in Condition dated 8/1/15 and most recently revised 7/6/21, included, a purpose of the policy is: "The ensure prompt notification of the resident, the attending physician and Durable Power of Attorney/Responsible Part of changes in the

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2 265	Continued From page 6 resident's physical, psychosocial and/or mental condition and/or status. The document indicates that the physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference unusual sign/symptom and/or the signs/symptoms are unrelieved by measures already prescribed. The document indicates that a refusal of treatment or medications (i.e. two (2) or more consecutive times) should be reported, and the nurse is to assess and document pertinent findings in the resident record and notify the physician or the Medical Director if the physician cannot be reached. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could provide education to nursing staff of the facility procedures on what to do if a resident is refusing their ordered medication/treatment regime. DON or designee could also provide training to nursing staff on the need to update medical providers when residents are refusing to take their medications or making unsafe decisions about their medications or ordered monitoring. The DON could audit nurses during medication administration to ensure all nurses, including temporary staff understand the importance of physician notification, and are taking appropriate action when indicated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		12/10/21

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2 830	Continued From page 7 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observations, interview and document review, facility failed to respond to 1 of 1 resident's (R1) continued refusal of medications which had the potential to result in adverse outcomes such as, but not limited to hyperglycemia (high blood sugar), nutritional deficits and bowel impaction. Findings include: R1's significant change Minimum Data Set (MDS) dated 11/4/21, included cognitively intact with diagnoses including diabetes, and received insulin daily. R1 did not reject cares. R1's admission MDS dated 7/23/21, included moderate cognitive impairment with diagnosis of diabetes, received insulin daily and did not reject cares. R1's care plan included diabetes, however, did not identify R1 had any refusal of insulin. R1's Medication Administration Records (MAR) R1 identified Glargine insulin (long lasting) 300/ml	2 830	Acknowledged	

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2 830	Continued From page 8 (a concentrated formulary for persons who require high doses of insulin) give 90 units every night at bedtime starting on 7/16/21 through 7/20/21 when the dose was increased to 95 units when R1's blood sugar exceeded 200 each night. On 7/23/21 a dose was not documented as having been given. In August, nurses administered 19 of 31 doses. Eleven doses were listed as "held" and 7 doses were listed as "refused." Twelve nightly bed-time blood sugar levels were not recorded. In September, nurses administered only 5 of 30 doses of R1's Glargine with the remainder marked as refused. Twenty nightly bed-time blood sugar levels were not recorded. In October, nurses administered only 6 of 28 doses, and recorded only 6 nightly bed-time blood sugar levels by 11/09/21. R1's November 2021 MAR, indicated an order was initiated 11/02/21-11/03/21 for Aspart Insulin (fast acting) 100/unit/ml, give 90 units one time daily in the morning, but was not documented as having been given on 11/2/21, and documented as refused by R1 on 11/3/21. On 11/03/21 the order was revised to be given per a sliding scale (dose titrated to R1's blood-sugar level) with each meal. From 11/03/21 until the date of survey, only 4 of 21 doses of the Aspart insulin were given. No additional blood-sugar monitoring was noted on the dates that R1's Aspart was refused. A review of R1's MAR's showed the following pattern of refusing medications: -Vitamin B12 100 mg daily starting date 10/29/21 (helps prevent anemia and works with the nervous system), in October, one of two doses was refused, and in November 3/10 doses were refused. -Bisacodyl tablet 5 mg give 2 tabs daily for constipation, start date 11/01/21. Of 17 doses	2 830		

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	00916	A. BUILDING: _____ B. WING _____	C 11/10/2021

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2 830	Continued From page 9	2 830		

offered, six were refused.
-Polyethylene glycol powder 17 Gm, give one scoop two times daily for constipation, start date 9/25/21 through 10/29/21, 4 of 10 doses were refused in September; in October 30/57 doses were refused and an additional 8 doses were not given for a variety of reasons. Medication was restarted after a one day hospital admission: start date 11/1/21. Of 17 doses, 14 were refused.
-Tylenol Extra Strength 500 mg give 2 tabs three times daily for pain, starting date 10/29/21. Of 7 doses in October, 5 were refused. Of 29 doses, 19 were refused in November.

R1's progress notes failed to show nurses reported any of R1's refusals of insulin or of the other medications listed, even when R1's progress note showed she had complained on 9/21/21 that she had not had a bowel movement (BM) in 10 days. Nurse notified provider of no BM, but did not indicate the refusal of bowel medications. Progress notes failed to indicate nurses had done any follow-up assessments related to her refusal of medications or attempted to educate R1 about the risks of not following her ordered medication regime.

When interviewed on 11/9/21, at 2:00 p.m. R1 stated, the facility did not, "give me my medications like I took them at home." R1 said she did not like to take Tylenol, and she did not believe she needed insulin, or at least not the way it had been ordered at the facility. R1 stated a belief that she did not require insulin if her blood sugars remained below 200, and was unable to state the consequences of refusing insulin. R1 was able to describe her lower legs as feeling almost as if they were paralyzed, and understood this was due to her diabetes, but had no stated insight to correlate the importance of glucose

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2 830	Continued From page 10	2 830		

management with the nerve dysfunction that has already occurred. R1 said the nurses told her it was her right to refuse her medications, but had not explained any risks of doing so.

On 11/10/21, 9:59 a.m. a licensed practical nurse (LPN)-A was observed to be leaving R1's room after administering medications. She was holding an insulin pen of R1's Aspart insulin in her hand. LPN-A stated R1 had refused her insulin and her bowel medication. LPN-A stated she would report refused medications to the medical provider if it was written in the orders. LPN-A was observed to look through R1's MAR, and then stated she did not see an order to report these missed doses.

When interviewed on 11/10/21, at 10:01 a.m. registered nurse (RN)-A stated a nurse should re-approach a resident and offer the medication again if it was refused. RN-A said if the resident continues to refuse medications, "day after day," it should be reported to the physician. In the case of insulin, RN-A stated a nurse should also re-check the person's blood-sugar levels to make sure they are not developing hyperglycemia (high blood sugar).

When interviewed on 11/10/21, at 10: 03 a.m. LPN-B, a nurse manager, stated a nurse should attempt to talk the resident into taking their medications, and if they continued to refuse, make out an SBAR (an electronic form to notify the physician) or call the physician directly. LPN-B said missed doses of insulin should also be followed by an additional blood-sugar check.

When interviewed on 11/10/21, at 10:08 a.m. the director of nursing (DON) and assistant director of nursing (ADON) both stated an SBAR should be filled out when medications are refused. DON

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2 830	Continued From page 11 said generally they would wait until the second refusal. The DON also said it was expected that nurses would try to find why the resident does not want to take the medication and see if they were able to be more accommodating by changing time of administration, or determine if the person needed the medication at all, or see if it could be given only as needed/requested. DON stated an expectation of the nurse to provide education to the resident on the risks of refusing their treatment regime. Both DON and ADON said the refusal and interventions the nurse took should be documented in the resident's chart for continuity of care. DON stated she would know if an SBAR had been filled out in the EHR as it would flow over to a report they check routinely, but confirmed she had not seen any SBAR regarding R1's refusal of medications. DON stated R1 was at risk for hyperglycemia and at greater risk due to a history of diabetic ketoacidosis (DKA) from not taking insulin (DKA is a metabolic condition where there is an acid-base imbalance and generally requires hospitalization and is life threatening). DON also stated a concern about the possibility of bowel obstruction. DON said that had nursing leadership known about the continued refusal they could have had the medical provider talk with R1 about her risks related to refusing her medications. DON said the facility usually will have a resident sign a risk and benefit sheet if they choose to refuse their treatment as ordered, but confirmed this had not been done with R1. When interviewed via telephone on 11/10/21, at 11:42 a.m. R1's physician (MD) stated it was facility practice to send an SBAR if a resident was refusing their medication regime, and stated an expectation to be notified, "right away" of refused medications. MD confirmed no SBAR had been	2 830		

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2 830	Continued From page 12	2 830		

received. MD stated she was concerned to hear R1 was refusing her insulin as R1 had a history of alcohol abuse, along with uncontrolled diabetes mellitus, which had already contributed to the neuropathy in her legs, and there was also the potential for DKA if not taking her insulin. MD also said R1 had very little insight into her condition

A facility policy titled, Policy & Procedure Care of the Diabetic Resident, dated 7/28/15 and revised 8/12/21. The stated purpose is as follows: "To assist the resident to establish a balance between diet, exercise, and insulin; prevent recurrence of hyperglycemia/hypoglycemia; recognize, assist and document the treatment of complications commonly associated with diabetes; and individualize teaching according to carefully assessed resident and family needs.
Diabetes Mellitus is a chronic, hereditary, or developmental disorder is which there is relative or absolute lack of insulin characterized by glucose intolerance." The policy included, "follow the resident's individual hyperglycemic protocol, if ordered by physician. If parameters are not in place update the physician as needed based on assessment and blood glucose reading."

A facility policy titled, Policy & Procedure Change in Condition dated 8/1/15 and most recently revised 7/6/21. The stated purpose of the policy is: "The ensure prompt notification of the resident, the attending physician and Durable Power of Attorney/Responsible Part of changes in the resident's physical, psychosocial and/or mental condition and/or status. The document indicated the physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference unusual sign/symptom and/or the signs/symptoms are

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2 830	Continued From page 13 unrelieved by measures already prescribed. The document indicates that a refusal of treatment or medications (i.e. two (2) or more consecutive times) should be reported, and the nurse is to assess and document pertinent findings in the resident record and notify the physician or the Medical Director if the physician cannot be reached. A facility document titled Policy & Procedure Charting and Documentation dated 8/1/15 and most recently revised 7/6/21 indicates "documentation will include information on assessment, notifications, interventions and evaluation including but not limited to: ... (e.) refusal of medication/treatments or recommendations (f.) education provided to resident ..." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could provide education to all nursing staff to ensure nurses understand the consequence to a resident if they continually refuse their medications, specifically, high risk medications such as insulin. Expectations for nursing response to a resident making unsafe choices about or refusing their medical treatment regime could be taught and a system for clear documentation of nursing response, and physician notification be implemented or reviewed. In addition, DON or designee could design a simple sheet of directions for high-risk situations for temporary staff to refer to when on duty. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		