



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

August 4, 2023

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

RE: CCN: 245409  
Cycle Start Date: April 6, 2023

Dear Administrator:

On April 24, 2023, we informed you that we may impose enforcement remedies.

On May 16, 2023, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On July 3, 2023 and July 19, 2023, the Minnesota Departments of Health and Public Safety, completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 16, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 6, 2023, be discontinued as of July 16, 2023. (42 CFR 488.417 (b))

In the CMS letter of May 16, 2023, you were informed that, if you have not achieved substantial compliance by July 6, 2023, 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), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 6, 2023. This does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing



Edenbrook Of Rochester

August 4, 2023

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Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)





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Electronically delivered

June 27, 2023

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

RE: CCN: 245409  
Cycle Start Date: April 6, 2023

Dear Administrator:

On April 24, 2023, we informed you that we may impose enforcement remedies.

On June 15, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted 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.

## REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 6, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 6, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 6, 2023.

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



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

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

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 6, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Edenbrook Of Rochester will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 6, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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



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

#### DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Rochester District Office  
18 Woodlake Drive, Rochester MN, 55904  
Email: Lisa.Krebs@state.mn.us  
Office (507) 206-2728

#### 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 October 6, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or



termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

## APPEAL RIGHTS

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

[Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@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  
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to [Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov).

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

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

Nursing Home Informal Dispute Process  
Minnesota Department of Health



Edenbrook Of Rochester

June 27, 2023

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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/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_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](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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)





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June 27, 2023

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

Re: Event ID: G22P11

Dear Administrator:

The above facility survey was completed on June 15, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/03/2023  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245409</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/15/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EDENBROOK OF ROCHESTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1875 19TH STREET NORTHWEST</b><br><b>ROCHESTER, MN 55901</b>                 |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 000                                                             | INITIAL COMMENTS<br><br>On 6/14/23 and 6/15/23, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed, H54092762C (MN94238) with a deficiency issued at F655.<br><br>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.<br><br>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 655<br>SS=D                                                     | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.                                                                                                                                                                                                                                                                                                                                                                                                                        | F 655                                                                      |                                                                                                                          |  | 6/30/23                                                                |

|                                                                       |       |            |
|-----------------------------------------------------------------------|-------|------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE  |
| Electronically Signed                                                 |       | 06/28/2023 |

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.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245409</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                  |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/15/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EDENBROOK OF ROCHESTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1875 19TH STREET NORTHWEST</b><br><b>ROCHESTER, MN 55901</b>                                              |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                              |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 655                                                             | <p>Continued From page 1</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders.</p> <p>(B) Physician orders.</p> <p>(C) Dietary orders.</p> <p>(D) Therapy services.</p> <p>(E) Social services.</p> <p>(F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to offer and/or provide a written copy of the baseline care plan to resident or resident representative, for 1 of 3 (R1) residents reviewed for care planning.</p> | F 655                                                                      |                                                                                                                                                       |  |                                                                        |
|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | How corrective action will be accomplished for those residents found to have been affected by the deficient.<br>Affected resident discharged 5/29/23. |  |                                                                        |
|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | How the facility will identify other residents                                                                                                        |  |                                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>EDENBROOK OF ROCHESTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1875 19TH STREET NORTHWEST</b><br><b>ROCHESTER, MN 55901</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |
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| F 655                                                             | <p>Continued From page 2</p> <p>Findings include:</p> <p>R1's admission, Minimum Data Set (MDS), dated 5/28/23, indicated R1 had diagnoses of umbilical hernia repair, long term use of anticoagulants and chronic kidney disease. R1 had moderate cognitive impairment and required limited to extensive assist of 1 staff with most activities of daily living (ADL's).</p> <p>R1's baseline care plan summary, dated 5/24/23, identified R1's vision was partially impaired and hearing impaired. Initial admission goals to participate in physical rehabilitation and return home. Specifically, will return to own home. Discharge caregiver will be family member (FM)-A. Will assess for home therapy services.</p> <p>During an interview on 6/15/23, at 11:23 a.m. R1's resident representative (RR)-1 indicated she had attended R1's care conference on 5/26/23, and requested a copy of R1's care plan. RR-1 stated she was told by social worker (SW) one would be emailed to her; however, she never did. RR-1 indicated she emailed the facility again requesting a copy and someone did not get back to her until 5/31/23.</p> <p>During an interview on 6/15/23 at 6:10 p.m., director of nursing (DON) stated, if the resident or resident representative would ask for a copy of the baseline care plan, we would give them a copy, if not we typically don't. We would usually go over the baseline care plan in a residents care conference. DON indicated there was no documentation to support that a baseline care plan was offered to R1 or his representative.</p> <p>During an interview on 6/15/23, at 6:11 p.m., the</p> | F 655                                                                      | <p>having the potential to be affected by the same deficient practice.<br/>All new residents have the potential to be affected by this deficient practice.<br/>Facility will complete an audit of the last 30 days of new admissions still residing in the facility and any current resident who was not offered their baseline care plan will be provided one.</p> <p>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.<br/>Baseline Care Plan policy reviewed and updated to reflect requirement to provide the resident and their representative a copy of the baseline care plan at the initial care conference.<br/>Education to IDT on Baseline Care Plan Policy and regulations.<br/>Facility will provide all residents with a copy of the baseline care plan upon completion.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.<br/>NHA or designee will ensure compliance through audits of baseline care plans to ensure it was offered to the resident and/or their representative twice weekly for 4 weeks, then once weekly for 4 weeks.<br/>Analysis of these audits will be brought to the QAPI committed to determine ongoing frequency and duration of audits.</p> <p>The date that each deficiency will be</p> |  |                                                                        |



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245409</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/15/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EDENBROOK OF ROCHESTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1875 19TH STREET NORTHWEST</b><br><b>ROCHESTER, MN 55901</b>                 |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 655                                                             | <p>Continued From page 3</p> <p>administrator stated, we have not provided people with a written copy of care plan unless they ask for it. I don't think we typically document that in the record.</p> <p>Facility policy, Baseline Care Plan, sated 2/14/22, does not identify providing a written copy of baseline care plan to resident or resident representative or documenting in the medical record.</p> | F 655                                                                      | <p>corrected.<br/>6/30/23</p> <p>Person responsible:<br/>NHA or Designee</p>                                             |  |                                                                        |



Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>00916 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                      |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/15/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EDENBROOK OF ROCHESTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1875 19TH STREET NORTHWEST<br>ROCHESTER, MN 55901 |                                                                                                                          |                                                   |
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| 2 000                                                      | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:<br/>On 6/14/23 and 6/15/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure.</p> <p>The following complaint was reviewed during the</p> |                                                                 | 2 000                                                                                      |                                                                                                                          |                                                   |

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

06/28/23



Minnesota Department of Health

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                           |                                                                                                                          |  |                                                                    |
|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
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| 2 000                                                             | <p>Continued From page 1<br/>survey, H54092762C (MN94238).</p> <p>Minnesota Department of Health is documenting<br/>the State Licensing Correction Orders using<br/>Federal software.<br/>The facility is enrolled in ePOC and therefore a<br/>signature is not required at the bottom of the first<br/>page of state form. Although no plan of correction<br/>is required, it is required that the facility<br/>acknowledge receipt of the electronic documents.</p> | 2 000                                                                     |                                                                                                                          |  |                                                                    |