Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 20, 2025

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

RE: CCN: 245409
Cycle Start Date: January 13, 2025

Dear Administrator:

On January 23, 2025, we notified you a remedy was imposed. On February 7, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 4, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 7, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of January 23, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 7, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 4, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 20, 2025

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

Re: Reinspection Results
Event ID: JPZD12

Dear Administrator:

On February 7, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 13, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
January 23, 2025

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

RE: CCN: 245409
Cycle Start Date: January 13, 2025

Dear Administrator:

On January 13, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements, and the conditions in your facility constituted **Immediate Jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 10, 2025, the situation of immediate jeopardy to potential health and safety cited at F803 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 7, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 7, 2025, (42 CFR 488.417 (b)). They will also notify

the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 7, 2025, (42 CFR 488.417 (b)).

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.

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 $12,924; 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 February 7, 2025, 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 February 7, 2025. 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 plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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, Licensing and Certification Program 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 July 13, 2025 (six months after the identification of noncompliance), if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@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 01/13/2025

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 1/9/25 and 1/13/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F803 began on 1/3/25, when when R1 returned from the hospital with new diet texture orders and received a regular textured diet through 1/9/25 related to facility system failure when dietary orders are changed. The administrator, and director of nursing (DON) were notified of the IJ on 1/9/25 at 5:49 p.m. The IJ was removed on 1/10/25. The following complaints were reviewed: H54093503C (MN00109358) with a deficiency cited at F803 and F684 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		2/4/25

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

Electronically Signed | 01/28/2025

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

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F 684	Continued From page 1 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess and monitor non-pressure related skin injuries (bruises) for changes until resolved for 1 of 3 residents (R1), reviewed for injury of unknown origin. Findings include: R1's admission screener dated 12/13/24, directed staff to complete a full body skin audit and identified R1's skin color was normal, warm, and dry. Further identified R1 had a left forehead hematoma as a consequence of a fall, bilateral upper extremity bruising and on abdomen and trunk. Skin assessment did not include bruising color, characteristics, measurements, and pain. R1's admission Minimum Data Set (MDS) dated 12/19/24, identified R1's cognition was intact, diagnoses included diabetes with other open ulcer, obesity, and peripheral vascular disease. R1 was at risk for development of pressure ulcers. R1 had one venous/arterial ulcer and required a pressure relieving device for bed, nutrition, or hydration intervention to manage skin problems, pressure ulcer injury care, and application of nonsurgical dressings other than to feet.	F 684	R1: Skin assessment with measurements was completed on 1/13/25. R1: Care plan updated 1/13/25 to reflect monitoring for bruising, risk for bleeding. All residents have the potential to be affected by the deficient practice. Facility nurses and nursing assistants re-educated on the facilities expectations to monitor resident for changes in skin condition and abnormalities. · Facility nurses and nursing assistants were re-educated on inspecting skin thoroughly to determine any new skin alteration and to initiate monitoring of any concerns noted. · Skin Policy and Procedure reviewed on 1/13/25. No changes required. · Whole house care plan audit completed for other residents utilizing antiplatelet medications by 1/24/25. · All resident skin audit completed by 1/24/25. · Admission/Readmission audit tool in place for skin monitoring, care plan updates, treatment orders in place, anticoagulant monitoring for bruising. All admissions/readmissions will be audited to ensure skin monitoring, care	

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F 684	Continued From page 2 R1's record identified R1 was hospitalized from 12/23/24 to 1/3/25. R1's care plan revised 12/26/24, identified a focus, R1 was at risk for alteration in skin integrity related to pain, osteoarthritis, diabetes, increased body habitus (obese), heart disease, generalized weakness, decreased mobility, limited Range Of Motion (ROM) black box medications, antidepressants and venous ulcer on shin. Interventions dated 12/16/24 included but not limited to, provide R1 education to promote skin integrity, manage individual risk factors as applicable related to nutrition, friction, shearing, and continence; keep skin clean and dry; manage clinical conditions and contributing factors to decrease risk of skin breakdown-notify MD and/or Registered Dietician (RD) of any significant changes; provide diet, supplements, and vitamins; use a draw sheet and two people when pulled up in bed (to prevent shear), and use a pressure relieving cushion for wheelchair. An additional focus revised 12/23/24, identified R1 had an alteration in skin integrity related to venous sore due to increased edema. Interventions dated 12/19/24, included but not limited to assess/ monitor alteration in skin integrity and document status weekly. R1's progress note dated 1/3/25 at 10:16 p.m., identified R1 was readmitted from the hospital and had multiple bruises on the entire lower abdomen, left hand and wrist ... R1's readmission screener dated 1/3/25, identified R1 had bruising on left hand (palm) and bruising on lower abdomen and no interventions were in place for the skin alterations because	F 684	plan updates, treatment orders, and anticoagulant monitoring for bruising is in place. Facility will audit skin assessment tool 3x weekly for 1 month, then 2x weekly for 1 month, then 1x weekly for 1 month to ensure residents with skin abnormalities have appropriate documentation, and interventions in place. · Facility will audit 3x weekly for 1 month, then 2x weekly for 1 month, then 1x weekly for 1 month to ensure residents with any new skin integrity concerns have been addressed, treatments are in place, and updated on the care plan. · Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	

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F 684	Continued From page 3 they were not indicated. Skin assessment did not include bruising color, characteristics, measurements, and pain. R1's Weekly Skin check dated 1/3/25, identified bruising on left wrist and lower abdomen. Skin assessment lacked bruising color, characteristics, measurements, and pain. R1's order summary dated 1/4/25, included an order to administer aspirin 81 mg delayed release daily for coronary artery disease. R1's MD visit dated 1/8/25, identified during R1's hospitalization on 1/2/25, the visit note indicated R1 had experienced symptoms of a gastrointestinal bleed (GI) and directed to hold aspirin 81 mg in the setting of GI bleed. R1's January medication administration record (MAR), dated January 2025 identified R1 received aspirin 81 mg daily from 1/9/25 to 1/13/25, with no orders to hold. R1's Weekly Skin check dated 1/11/25, identified bruising on left face. Skin assessment lacked bruising color, characteristics, measurements, and pain. R1's record was reviewed between 12/13/24 through 1/13/25 and did not include a comprehensive skin assessment and monitoring of the bruises identified on 12/13/24, 1/3/25, and 1/11/25. Additionally R1's care plan did not include a focus that identified R1's risk and had actual bleeding/bruising with associated interventions to decrease the risk and protect R1's skin from further injury.	F 684		

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F 684	Continued From page 4 During an observation and interview on 1/13/25, at 10:32 a.m., R1 was seated in her wheelchair in her room wearing a short sleeve blue shirt. R1 was noted to have dark purple bruises on her left arm. R1 stated she just got done with a shower and thought the bruising was from her fall back in December but couldn't really remember. During an interview on 1/13/25 at 11:41 a.m., nursing assistant (NA)-C stated she had given R1 a shower today and further stated she had never bathed R1 before. NA-C told her nurse when it was time to do the skin assessment. NA-C remembered R1 had bruises up and down her left arm and a bruise on her right inner thigh that was dark purple. NA-C stated she has nowhere to document bruises that the nurse would do that. NA-C was not sure where the bruising was from. During an interview on 1/13/25 at 2:02 p.m., licensed practical nurse (LPN)-A indicated she was the nurse for R1 and did her skin assessment because it was her bath day today. LPN-A stated R1 did have healing bruises on her arms. LPN-A thought that the arm bruising had been there prior to R1's hospitalization. Today R1 did have some dark purple bruising on her inner thighs, "hopefully someone put that on her readmission assessment, I don't know what those are from." Upon resident admission/readmission a full body skin assessment should be documented with measurements and characteristics. LPN-A verified she did not measure any of R1's bruises or document characteristics. During an observation and interview on 1/13/25 at 2:33 p.m., R1 was lying in bed, LPN-B measured the following bruises:	F 684		

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F 684	Continued From page 5 -left upper triceps 10.8 centimeters (cm) x 9 cm, bruise is red in color with a light purple dusky color. -cluster of bruising on left forearm measured 17.3 cm x 3 cm, fading bruise almost the same color as the skin. -left lateral elbow measured 5.2 cm x 4 cm, dark purple bruise. -left hand thumb side measured 6 cm x 3.5 cm, wide dark purple bruise with some light fading in the margins. -right medial thigh bruising measured 9 cm x 12.5 cm, dark purple bruise with fading in the margins. -fading bruise on triceps/bicep area measured 17 cm x 11 cm. -Resolved skin tear on left triceps with slight skin discoloration measured 1.8 cm x 1.8 cm. During an interview on 1/13/25 at 1:52 p.m., LPN-C stated skin assessments were completed once a week on the residents bath day and documented in the weekly skin assessment. When staff find a bruise it would also be documented in risk management, a skin progress note, reported to the oncoming nurse and to the DON. Once the bruise is healed, we would discontinue it off the treatment administration record (TAR). During an interview on 1//13/25 at 1:58 p.m., LPN-C stated when a bruise was found on a resident, it was documented and investigated on how it got there. LPN-C further stated If if could not be determined how the bruise ws sustained then prevention measures were taken and documented. LPN-C indicated measurements of the bruise were not taken unless the bruise increases in size and that would be documented in a skin assessment. LPN-C stated there was no	F 684		

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F 684	Continued From page 6 daily monitoring of bruises that he knows of. .During an interview on 1/13/25 at 2:14 p.m., LPN- B indicated he was a unit manager. LPN-B stated on admission/readmission nursing would complete a skin assessment. LPN-B further stated with bruises, nurses should document color, location, size, pain. "I would expect measurements for it to be monitored daily until healed." LPN-B stated when a nurse first found a bruise a nursing order should be put in to the electronic health record to monitor for healing which would populate on the TAR alerting the nurse to check the bruise and document on healing. LPN-B stated he was more focused on getting skin assessments for pressure ulcers done and the assessing and monitoring for bruises "kind of fell off the radar." LPN-B verified R1's bruises did not include measurements, characteristics, size, and pain. During an interview on 1/13/25 at 2:47 p.m., director of nursing (DON) stated with new admissions and readmissions nursing would do a skin assessment in the admission and readmission screener. DON further stated with bruises the facility did not measure but would monitor them until they healed and document in a weekly skin assessment. DON was unable to articulate the size a bruise would need to be before you would measure it. During an interview on 1/13/25 at 2:48 p.m., regional nurse manager (RNM)-A stated the facility did not have a non-pressure skin care policy. Staff would utilize our pressure ulcer prevention policy. For an injury of unknown origin (bruises) staff would follow our abuse policy.	F 684		

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F 684	Continued From page 7 Facility policy. "Pressure Injury Prevention and Wound Care Management," revised 3/4/24, identified ... purpose: to promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown ...Policy: It is the policy of this facility that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care ...5. Resident's skin will be monitored daily during cares by nursing assistant and skin check will be completed weekly by licensed nurse ...7. Skin impairments, including pressure injuries, non-pressure injury wounds, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the Wound Nurse, or designee, using the PCC Weekly Wound Assessment. a. Weekly documentation will include pertinent characteristics of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues, and a description of any drainage, eschar, necrosis, odor, tunneling, or undermining. b. Wounds/skin alterations may be grouped or clustered together into one measurement following these guidelines: Pressure injuries cannot be clustered. Wounds need to be close in proximity and in same anatomical location on the body. Wounds must have the same etiology. 8. Documentation of the wound characteristics will be completed in PCC using the PCC Skin and Wound Assessment. This assessment is started in the mobile application. If a device is not available or in need of service, the documentation will be completed in the resident's electronic medical record. Consent for photography will be obtained in the admission packet. 9. Daily, the clinicians responsible for	F 684		

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F 684	Continued From page 8 caring for the resident will assess the status of the dressing if present, (intact, soiled, leaking), and evaluate for complications such as infection and/or uncontrolled pain ...12. Wound and skin care interventions will be monitored and evaluated for effectiveness. Care plans will include specific and measurable goals and interventions. The care plan will be reviewed and revised at least quarterly, or with significant change in condition ... Facility policy, "Policy and Procedure Vulnerable Adult Abuse and Neglect prevention revised on 10/29/24, identified ... 15. Injuries of Unknown Source: An injury should be classified as an "injury of unknown source" when all of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. (a) Examples of when an Injury of Unknown Source should be reported: i. Bruising, scratches, redness, or any other bodily injury that is suspicious in location and size. Some examples include A. bruising that looks like an object, e.g. fingers, equipment, etc. B. the location of the bruise is in an area not susceptible to bruising, e.g. breast, inner thigh, groin area, etc ...	F 684		
F 803 SS=J	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F 803		2/4/25

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F 803	Continued From page 9 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a system to provide the correct physician ordered textured diet for 1 of 1 resident (R1) who was at risk for choking and history of aspiration pneumonia. This resulted in a immediate jeopardy for R1 and has the likelihood to effect current and future residents who required changes to textured diets to prevent choking/aspiration. The immediate Jeopardy (IJ) began on 1/3/25, when R1 returned from the hospital with new diet texture orders and received a regular textured	F 803	¿ R1□s diet card was changed to reflect appropriate diet order on 1/9/25. ¿ Review/revise R1□s care plan including aspiration precautions, ordered meal texture, and other relevant information accordingly. Ensure R1□s meal ticket reflects ordered diet. ¿ R1□s care plan was updated to reflect appropriate diet order and aspiration precautions on 1/9/25. ¿ 54 residents in house audited to verify PCC orders, care plans, and tray cards match: identified 11 residents with altered	

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F 803	Continued From page 10 diet through 1/9/25 related to facility system failure when dietary orders are changed. The administrator and director of nursing (DON) were notified of the IJ on 1/9/25 at 5:49 p.m. The IJ was removed on 1/10/25, but noncompliance remained at the lower scope and severity, level D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: International Dysphagia Diet Standard Initiative (IDDSI) Level 5 Minced and Moist Diet tool dated January 2019, identified foods that are soft and moist but with no liquid leaking/dripping from the food, biting is not required, minimal chewing is required, lumps of 4 millimeters (mm) in size, lumps can be mashed with tongue, foods can easily be mashed with just a little pressure from the fork, and should be able to scoop food onto the fork with no liquid dripping and no crumbles falling off the fork ...may be used if you are not able to bite off pieces of food safely but have some basic chewing ability. Some people may be able to bite off a large piece of food but are not able to chew it down into little pieces that are safe to swallow. Minced & Moist foods only need a small amount of chewing and for the tongue to 'collect' the food into a ball and bring it to the back of the mouth for swallowing. It's important that Minced & Moist foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat. These foods are eaten using a spoon or a fork ...examples of foods to avoid ...tough or fibrous foods-steak and pineapple ...crumbly bits-dry cake crumble ... International Dysphagia Diet Standard Initiative	F 803	texture diet. ¿ Diet and Diet order policy dated 12/11/23 was reviewed. No changes were required. ¿ Diet order procedure was reviewed and dietary manager, dietary assistant manager, and AM cook were provided education on the diet orders to be changed in Martin Brothers dietary ticket program, email notifications reviewed daily from Martin Brothers program, diet orders in Martin Brothers tray card program will be reviewed for unmatched and unreviewed tray card notifications upon receipt of diet order change. ¿ Dietary staff educated on all staff members who have access to Martin Brothers program. ¿ All residents reviewed to ensure all therapeutic diets are appropriate, care planned, and implemented. ¿ 11 residents with altered texture diets were identified and reviewed to ensure diet card reflects appropriate diet order. ¿ 11 residents with altered texture diets were reviewed to ensure care plan reflects appropriate diet order. ¿ Nursing administration, dietary staff educated on diet order communication form before next worked shift. Education provided electronically on 1-9-25, small group and 1 to 1 educations provided on 1-10-25. ¿ All residents have the potential to be affected by the deficient practice. ¿ Dietary manager or designee will review and update tray tickets at receipt of diet order change. ¿ Dietary manager, assistant manager, or	

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F 803	Continued From page 11 (IDDSI) Level 7 Regular: meant for individuals who do not have issues chewing or swallowing. R1's care plan dated 12/16/24, identified a focus, R1 had the potential for altered nutritional status related to pain, osteoarthritis, diabetes, increased body habitus, heart disease, generalized weakness, decreased mobility, antidepressants and on Ozempic (injectable diabetic) medication. Interventions dated 12/16/24, identified R1 was to receive a level 7 regular liberalized renal diet. On 12/18/24, identified R1 required set up assist with eating. R1's admission minimum data set (MDS) dated 12/19/24, identified R1's cognition was intact, diagnoses were diabetes, chronic obstructive pulmonary disease (COPD), and dyspnea (shortness of breath). R1 was independent with eating and required a therapeutic diet. R1's progress note dated 12/23/24 at 9:39 a.m., identified R1 was sent to the emergency department (ED) for altered mental status, abdominal breathing 30+ breaths per minute, possible aspiration as there was vomit beside her. R1 unable to speak clearly only mumbling. R1's emergency department (ED) note dated 12/23/24 at 10:21 p.m., identified R1 presented to the ED with shortness of breath from the nursing home, R1 had vomited and was noted to be aspirating on the vomit, was hypoxic and oxygen saturations were 80% (normal 90-100%) on 8 liters of oxygen. Antibiotics started because chest Xray shows right lower lobe pneumonia ...will be admitted to the intensive care unit given her new BiPAP (a machine that helps remove carbon dioxide) status.	F 803	am cook will change the diet manually on the tray card when a diet order is changed. ¿ Dietary manager, nurse administration educated on updating care plans as it pertains to their scope of practice and care plan is updated upon order changes. ¿ Medical Director will be updated with deficient practice and correction plan. ¿ Audits will be completed 3x□s a week for one month, 2x□s a week for 1 month, 1 time per week for 1 month to ensure dietary orders, interventions, and supervision are being provided per care plan for all residents. ¿ Audits will be completed 3x□s a week for one month, 2x□s a week for 1 month, 1 time per week for 1 month to ensure dietary orders are reflected on dietary cards. ¿ Review and analysis of these audits will be reviewed at QAPI to determine ongoing frequency and duration of audits. ¿ Medical Director will be updated with deficient practice and correction plan. ¿ Audits will be completed 3x□s a week for one month, 2x□s a week for 1 month, 1 time per week for 1 month to ensure dietary orders, interventions, and supervision are being provided per care plan for all residents. ¿ Audits will be completed 3x□s a week for one month, 2x□s a week for 1 month, 1 time per week for 1 month to ensure dietary orders are reflected on dietary cards. ¿ Review and analysis of these audits will be reviewed at QAPI to determine	

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F 803	Continued From page 12 R1's after visit summary (AVS) dated 12/23/24 to 1/3/25, identified R1 was hospitalized for acute hypoxemic(low level of oxygen in the blood)/hypercapnic (carbon dioxide buildup) respiratory failure presumed secondary too aspiration pneumonia (developed following presumed episode of emesis) and COPD exacerbation requiring BiPAP. She was also encephalopathic (a change in how your brain functions requiring medical intervention) on admission. R1 participated in a bedside dysphagia (difficulty in swallowing) evaluation on 12/26/24, to assess safety with oral intake/risks for aspiration. Factors contributing to aspiration risk include generalized weakness, respiratory status cognitive involvement and decreased activity intolerance. History of odynophagia (painful swallowing) secondary to Warthin's tumors (benign tumor occurring in the salivary glands) noted in the electronic medical record. Discharge orders included: Dysphagia clinical evaluation results: R1 participated in oral trials of thin liquids, puree and solid consistencies resulting in no observable signs of aspiration/penetration. However prolonged mastication with very small bite of cracker. No oral retention/pocketing. Current diet: solids IDDSI level 5 minced and moist, recommended form of medications crushed with puree. Recommendations: Dysphagia treatment. Aspiration precautions: Recommended Aspiration Precautions: Watch closely for signs of aspiration, Sit upright with all oral intake and when completing oral cares, Eat small bites, take small sips, eat slowly, Empty mouth before adding more food or liquid, Good oral care 3-5 times a day. Compensation Techniques/Adaptive Equipment: Requires supervision/assistance.	F 803	ongoing frequency and duration of audits.	

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F 803	Continued From page 13 Positioning: Positioning Recommendations: Upright as possible for all oral intakes take small sips, eat slowly, empty mouth before adding more food or liquid, minimize talking during meals, avoid lying down for 15 minutes after meals, good oral care 3-5 times a day every shift. Follow-up Information: Recommend dysphagia therapist evaluate and treat. Frequency and duration to be determined by the evaluating therapist. R1's physician order summary dated 1/3/25, included an order for liberalized renal diet Level 5 minced and moist texture with level 0 thin (regular) consistency. Aspiration precautions: Watch closely for signs of aspiration, Sit upright with all oral intake and when completing oral cares, Eat small bites, take small sips, eat slowly, empty mouth before adding more food or liquid, Good oral care 3-5 times a day. Review of R1's medical record identified R1's care plan and Kardex (abbreviated care plan for direct care staff) was not updated to include Level 5 minced and moist diet nor any interventions identified on the hospital discharge summary including but not limited to: R1 required supervision/assistance, minimize talking during meals, and avoid laying down for 15 minutes after meal. R1's progress note dated 1/5/25 at 10:36 p.m., identified R1 needed constant reminders to use call light. R1 stayed in her room the entire shift and had supper in bed and was able to feed self with appropriate set up. Oxygen saturations were 89% on room air with head of bed elevated, denied shortness of breath and pain. R1's physician visit dated 1/8/25 identified R1	F 803		

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F 803	Continued From page 14 followed a renal diet. Since admission to the facility average intake at meals ranging from 76-100%. Identified assessment plan for dysphagia to remain minced and moist renal diet and thin liquids. R1's Kardex dated 1/9/24 identified R1 required a level 7 regular renal diet. During an interview on 1/9/25 at 4:28 p.m., nursing assistant (NA)-A stated to ensure a resident received the right diet, staff would verify the food on the plate against the meal ticket and could also check the care plan as well. During an interview on 1/9/25 at 4:29 p.m. NA-B stated when staff have to serve food to a resident when they are eating in their room, we would verify the food ticket against what was served on the plate, if staff had questions they would ask the nurse. During an interview on 1/9/25 at 4:31 p.m. licensed practical nurse (LPN)-C stated when we deliver food to residents in their rooms, we would check the food ticket against what is plated. If there were any discrepancies we would ask the kitchen. During an interview on 1/9/25 at 4:33 p.m. registered nurse (RN)-A if there was a discrepancy with the food and the meal ticket, we could check the care plan and would notify my nurse manager. During an interview on 1/9/25 at 4:25 p.m., director of nursing (DON) verified R1's care plan was not updated with level 5 minced and moist diet and the care plan identified R1 was to receive	F 803		

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F 803	Continued From page 15 a regular textured diet. DON explained NA's were trained to verify the food on resident's plates by the meal ticket and not the care plan. The facility had seven (7) days to update the care plan with diet changes. During an observation and interview on 1/9/25 at 12:53 p.m. R1 was seated in her wheelchair and had her tray table in front of her. R1 stated she would normally eat in the dining room but had gotten up late today so would be eating in her room. At 1:20 p.m., an unknown male nursing assistant delivered R1's meal tray and set it up on R1's tray table. Male aide then left the room. R1 attempted to use the side of her fork to cut off a bite of the roast beef and stated, "this meat is tough." R1 took one bite at a time taking several minutes to chew and swallow each bite. After R1 swallowed a bite of her pineapple upside down cobbler, R1 coughed two times. R1 stated she was "supposed to have moist and minced roast beef" but they were not moist or minced nor were the carrots. R1's meal ticket dated 1/9/25 located on her tray included, "Noon," regular level 7 diet. Entrée roast beef, beef gravy, mashed potatoes, carrots, and pineapple upside down cobbler. R1 stated "my meal ticket doesn't say moist and minced." At 2:03 p.m., licensed practical nurse (LPN)-A entered R1's room looked at R1's meal ticket that identified the regular diet, and reported R1 had received the wrong diet then removed the tray. LPN-A stated that R1 usually ate in the dining room and would be observed for aspiration as there is staff in the dining room during meal time. . During an interview on 1/9/25 at 2:08 p.m., LPN-A stated she was unsure how R1's meal ticket did not match the current MD order and	F 803		

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F 803	Continued From page 16 deferred the question to the dietary staff as they handle the meal tickets. LPN-A reported until she was prompted to refer to the record she was not aware R1 required her medications crushed in apple sauce and not whole; LPN-A gave R1 her medications whole this morning based on R1's response when she was asked how she took her pills. During an interview on 1/9/25 at 2:44 p.m., health unit coordinator (HUC)-A stated with a new admit she would be responsible to put new orders into the EHR physician orders which would include including diet orders and a nurse managers would doublecheck the entry to ensure accuracy. The clinical managers would be responsible to notify the kitchen staff with new diet orders. During an interview on 1/9/25 at 2:50 p.m. LPN-B stated he was one of the nurse managers. LPN-B stated the HUC would normally put the orders into the EHR and one of the nurse managers would be responsible to doublecheck the orders. LPN-B stated he was unsure who would be responsible for notifying the kitchen staff of new diet orders. The facility used to use a diet communication paper form but have not used one for quite some time. During an interview on 1/9/25 at 2:18 p.m., cook (C)-A stated residents who have new diet orders that would go through my manager (culinary director-CD). Level 5 diet is moist and minced, residents on this diet may not have teeth or have difficulty swallowing. For the noon meal today to meet the level 5 minced diet, the roast beef would have to be put through the food processor, similar to mashed-chunky texture, mashed potatoes would be fine, the carrots would have to go	F 803		

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	245409	A. BUILDING _____ B. WING _____	C 01/13/2025

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EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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F 803	Continued From page 17 through the food processor too. During an interview on 1/9/25 at 2:23 p.m., culinary director (CD)-A stated when a new diet was ordered, nursing would enter it into the electronic health record (EHR), would typically email her that there was a diet change order, and/or verbally communicate the order. CD-A would then put the information on a dietary communication form, keep the form in a folder on her desk, then would enter the diet information into the Martin Brothers system that allows the meal ticket to print out which was used to inform dietary and nursing staff at meal times what was supposed to be plated. CD-A explained she was the only person who had access to to change diets in the system. CD-A did not get an email from nursing about R1's diet change when she returned from the hospital and had herself just returned from vacation. CD-A verified the ticketing system currently identified R1 was to receive a regular textured diet. CD-A verified R1's dismissal summary identified R1 was to receive a level 5 diet minced and moist starting on 1/3/25, and this was not done. R1 would have received the wrong textured diet from 1/3/25 to 1/9/25 due the meal ticket being wrong. During an interview on 1/9/25 at 2:52 p.m., DON stated the kitchen should have access to the resident discharge summary to see what the residents diet order was. DON indicated whoever was doing the admission should have notified the kitchen of a new diet order. The risk of R1 receiving the wrong textured diet would be aspiration and choking risk. Further R1 should have received her pills crushed in applesauce and not whole.	F 803		

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F 803	Continued From page 18 During a phone interview on 1/9/25 at 3:13 p.m., speech therapist (ST)-A stated he had not been asked to evaluate R1 for swallowing. A person who received a regular diet who should have had a level 5 minced and moist diet would be at risk for aspiration and choking. For a level 5 minced and moist diet the food should be cut up small enough to fit through a fork tine, be well moistened with no excess fluid. Someone on a level 5 diet typically can not chew food particles or swallow well. During a interview on 1/9/25 at 4:34 p.m., nurse practitioner (NP)-A stated R1 had clear orders to receive a level 5 moist and minced textured diet. NP-A further stated if R1 had been receiving a regular diet since 1/3/25, the risk would be aspiration and pneumonia. NP-A indicated with this type of diet her pills should be crushed and not given whole. During a phone interview on 1/9/25 at 4:58 p.m., medical director (MD)-A stated R1's level 5 diet would require supervision with eating and the risk would be aspiration. MD-A stated signs and symptoms to watch for aspiration while eating would be a new cough, problems with breathing, choking, spitting up, fever and fatigue. Facility policy, Diet and Diet Orders," revised 12/11/23, identified Policy: All diets will be prescribed by the Attending Physician. The Dietitian will review diets for accuracy and therapeutic goals and recommend changes to the Physician as deemed appropriate. Purpose: The purpose of this policy is to provide consistency and accuracy in all diets provided to our residents and patients. Procedure: 1. All diets must be prescribed by the Attending physician and	F 803		

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F 803	Continued From page 19 reviewed by the Dietitian. 2. Upon admission, the diet order is entered into the EMR, using the terminology on the attached "Diet Conversion Chart". The diet ordered should match the terminology used by Dietary Services. 3. Diets are ordered or changed in writing and communicated to the Dietary department. 4. All diet orders should include diet type (e.g. regular or therapeutic), diet texture, and liquid consistency. 5. Specific requests such as "high protein", "low potassium", "high fiber", etc. will be assessed by the Dietitian and adjusted on the resident tray card and listed in the care plan. 9. The facility will utilize a tray identification system to ensure diet accuracy in the service of the meals. 10. The Dietitian, Speech-Language Pathologist and Nursing department will document significant information relating to the resident's response to the diet offered in the resident's medical record, including the care plan. When diet orders are changed, the care plan and tray card will be updated to reflect the change in order. 11. Residents on therapeutic or mechanically altered diets will not receive foods or fluids outside the diet order unless approved by the Attending physician in conjunction with the Dietitian, nursing and/or therapy ... Responsibilities: o Dietitian - Monitor compliance with policy by ensuring accuracy of diets and communicating changes or recommendations. Ensures that care plan is updated with diet changes. o Food Service Director/Dietary Manager - Ensures that food provided is consistent with diet order and that tray card accurately reflects resident/patient diet order and food preferences.- Nursing Department - Enters diet orders in EMR per Physicians order and in compliance with approved diet type and texture. In cooperation with the other departments,	F 803		

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F 803	Continued From page 20 ensures appropriate diet and liquids are provided and reports any discrepancies The IJ was removed on 1/10/25, when it was verified through observation, interview and document review the facility completed the following: - Reviewed and revised policies and procedures related to serving resident meals and ensuring residents receive correct textured meals. - Educated to procedures as appropriate. -Educated all nursing staff to utilize diet communication form and give to kitchen staff and on updating the care plan for diet orders. - Educated dietary and all staff who serve resident food to recognize each specific diet type/textured meal. - Educated dietary staff related to the importance of ensuring the meal ticket is updated. - Educated all staff who serve resident food items on the importance of checking the diet slip, ensure the resident is getting the correct textured food, and then delivering the correct diet order to the resident. - Developed and implemented a plan to complete all training before each staff worked their next shift.	F 803		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 23, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: JPZD11

Dear Administrator:

The above facility was surveyed on January 9, 2025, through January 13, 2025, 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. o

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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@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 01/13/2025

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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 1/9/25 and 1/13/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H54093503C (MN00109358) with a licensing order issued at 0830 and 1050. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess and monitor non-pressure related skin injuries (bruises) for changes until resolved for 1 of 3 residents (R1), reviewed for injury of unknown origin. Findings include: R1's admission screener dated 12/13/24, directed staff to complete a full body skin audit and identified R1's skin color was normal, warm, and	2 830	R1: Skin assessment with measurements was completed on 1/13/25. R1: Care plan updated 1/13/25 to reflect monitoring for bruising, risk for bleeding. All residents have the potential to be affected by the deficient practice. Facility nurses and nursing assistants re-educated on the facilities expectations to monitor resident for changes in skin condition and abnormalities. ¿ Facility nurses and nursing assistants	2/4/25

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2 830	Continued From page 3 dry. Further identified R1 had a left forehead hematoma as a consequence of a fall, bilateral upper extremity bruising and on abdomen and trunk. Skin assessment did not include bruising color, characteristics, measurements, and pain. R1's admission Minimum Data Set (MDS) dated 12/19/24, identified R1's cognition was intact, diagnoses included diabetes with other open ulcer, obesity, and peripheral vascular disease. R1 was at risk for development of pressure ulcers. R1 had one venous/arterial ulcer and required a pressure relieving device for bed, nutrition, or hydration intervention to manage skin problems, pressure ulcer injury care, and application of nonsurgical dressings other than to feet. R1's record identified R1 was hospitalized from 12/23/24 to 1/3/25. R1's care plan revised 12/26/24, identified a focus, R1 was at risk for alteration in skin integrity related to pain, osteoarthritis, diabetes, increased body habitus (obese), heart disease, generalized weakness, decreased mobility, limited Range Of Motion (ROM) black box medications, antidepressants and venous ulcer on shin. Interventions dated 12/16/24 included but not limited to, provide R1 education to promote skin integrity, manage individual risk factors as applicable related to nutrition, friction, shearing, and continence; keep skin clean and dry; manage clinical conditions and contributing factors to decrease risk of skin breakdown-notify MD and/or Registered Dietician (RD) of any significant changes; provide diet, supplements, and vitamins; use a draw sheet and two people when pulled up in bed (to prevent shear), and use a pressure relieving cushion for wheelchair. An	2 830	were re-educated on inspecting skin thoroughly to determine any new skin alteration and to initiate monitoring of any concerns noted. ¿ Skin Policy and Procedure reviewed on 1/13/25. No changes required. ¿ Whole house care plan audit completed for other residents utilizing antiplatelet medications by 1/24/25. ¿ All resident skin audit completed by 1/24/25. ¿ Admission/Readmission audit tool in place for skin monitoring, care plan updates, treatment orders in place, anticoagulant monitoring for bruising. All admissions/readmissions will be audited to ensure skin monitoring, care plan updates, treatment orders, and anticoagulant monitoring for bruising is in place. Facility will audit skin assessment tool 3x weekly for 1 month, then 2x weekly for 1 month, then 1x weekly for 1 month to ensure residents with skin abnormalities have appropriate documentation, and interventions in place. ¿ Facility will audit 3x weekly for 1 month, then 2x weekly for 1 month, then 1x weekly for 1 month to ensure residents with any new skin integrity concerns have been addressed, treatments are in place, and updated on the care plan. ¿ Analysis of these audits will be brought to the QAPI committee to determine ongoing frequency and duration of audits	

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2 830	Continued From page 4 additional focus revised 12/23/24, identified R1 had an alteration in skin integrity related to venous sore due to increased edema. Interventions dated 12/19/24, included but not limited to assess/ monitor alteration in skin integrity and document status weekly. R1's progress note dated 1/3/25 at 10:16 p.m., identified R1 was readmitted from the hospital and had multiple bruises on the entire lower abdomen, left hand and wrist ... R1's readmission screener dated 1/3/25, identified R1 had bruising on left hand (palm) and bruising on lower abdomen and no interventions were in place for the skin alterations because they were not indicated. Skin assessment did not include bruising color, characteristics, measurements, and pain. R1's Weekly Skin check dated 1/3/25, identified bruising on left wrist and lower abdomen. Skin assessment lacked bruising color, characteristics, measurements, and pain. R1's order summary dated 1/4/25, included an order to administer aspirin 81 mg delayed release daily for coronary artery disease. R1's MD visit dated 1/8/25, identified during R1's hospitalization on 1/2/25, the visit note indicated R1 had experienced symptoms of a gastrointestinal bleed (GI) and directed to hold aspirin 81 mg in the setting of GI bleed. R1's January medication administration record (MAR), dated January 2025 identified R1 received aspirin 81 mg daily from 1/9/25 to 1/13/25, with no orders to hold.	2 830		

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2 830	Continued From page 5 R1's Weekly Skin check dated 1/11/25, identified bruising on left face. Skin assessment lacked bruising color, characteristics, measurements, and pain. R1's record was reviewed between 12/13/24 through 1/13/25 and did not include a comprehensive skin assessment and monitoring of the bruises identified on 12/13/24, 1/3/25, and 1/11/25. Additionally R1's care plan did not include a focus that identified R1's risk and had actual bleeding/bruising with associated interventions to decrease the risk and protect R1's skin from further injury. During an observation and interview on 1/13/25, at 10:32 a.m., R1 was seated in her wheelchair in her room wearing a short sleeve blue shirt. R1 was noted to have dark purple bruises on her left arm. R1 stated she just got done with a shower and thought the bruising was from her fall back in December but couldn't really remember. During an interview on 1/13/25 at 11:41 a.m., nursing assistant (NA)-C stated she had given R1 a shower today and further stated she had never bathed R1 before. NA-C told her nurse when it was time to do the skin assessment. NA-C remembered R1 had bruises up and down her left arm and a bruise on her right inner thigh that was dark purple. NA-C stated she has nowhere to document bruises that the nurse would do that. NA-C was not sure where the bruising was from. During an interview on 1/13/25 at 2:02 p.m., licensed practical nurse (LPN)-A indicated she was the nurse for R1 and did her skin assessment because it was her bath day today. LPN-A stated R1 did have healing bruises on her arms. LPN-A thought that the arm bruising had	2 830		

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2 830	Continued From page 6 been there prior to R1's hospitalization. Today R1 did have some dark purple bruising on her inner thighs, "hopefully someone put that on her readmission assessment, I don't know what those are from." Upon resident admission/readmission a full body skin assessment should be documented with measurements and characteristics. LPN-A verified she did not measure any of R1's bruises or document characteristics. During an observation and interview on 1/13/25 at 2:33 p.m., R1 was lying in bed, LPN-B measured the following bruises: -left upper triceps 10.8 centimeters (cm) x 9 cm, bruise is red in color with a light purple dusky color. -cluster of bruising on left forearm measured 17.3 cm x 3 cm, fading bruise almost the same color as the skin. -left lateral elbow measured 5.2 cm x 4 cm, dark purple bruise. -left hand thumb side measured 6 cm x 3.5 cm, wide dark purple bruise with some light fading in the margins. -right medial thigh bruising measured 9 cm x 12.5 cm, dark purple bruise with fading in the margins. -fading bruise on triceps/bicep area measured 17 cm x 11 cm. -Resolved skin tear on left triceps with slight skin discoloration measured 1.8 cm x 1.8 cm. During an interview on 1/13/25 at 1:52 p.m., LPN-C stated skin assessments were completed once a week on the residents bath day and documented in the weekly skin assessment. When staff find a bruise it would also be documented in risk management, a skin progress note, reported to the oncoming nurse and to the DON. Once the bruise is healed, we would	2 830		

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2 830	Continued From page 7 discontinue it off the treatment administration record (TAR). During an interview on 1//13/25 at 1:58 p.m., LPN-C stated when a bruise was found on a resident, it was documented and investigated on how it got there. LPN-C further stated If if could not be determined how the bruise ws sustained then prevention measures were taken and documented. LPN-C indicated measurements of the bruise were not taken unless the bruise increases in size and that would be documented in a skin assessment. LPN-C stated there was no daily monitoring of bruises that he knows of. .During an interview on 1/13/25 at 2:14 p.m., LPN- B indicated he was a unit manager. LPN-B stated on admission/readmission nursing would complete a skin assessment. LPN-B further stated with bruises, nurses should document color, location, size, pain. "I would expect measurements for it to be monitored daily until healed." LPN-B stated when a nurse first found a bruise a nursing order should be put in to the electronic health record to monitor for healing which would populate on the TAR alerting the nurse to check the bruise and document on healing. LPN-B stated he was more focused on getting skin assessments for pressure ulcers done and the assessing and monitoring for bruises "kind of fell off the radar." LPN-B verified R1's bruises did not include measurements, characteristics, size, and pain. During an interview on 1/13/25 at 2:47 p.m., director of nursing (DON) stated with new admissions and readmissions nursing would do a skin assessment in the admission and readmission screener. DON further stated with bruises the facility did not measure but would	2 830		

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2 830	Continued From page 8 monitor them until they healed and document in a weekly skin assessment. DON was unable to articulate the size a bruise would need to be before you would measure it. During an interview on 1/13/25 at 2:48 p.m., regional nurse manager (RNM)-A stated the facility did not have a non-pressure skin care policy. Staff would utilize our pressure ulcer prevention policy. For an injury of unknown origin (bruises) staff would follow our abuse policy. Facility policy. "Pressure Injury Prevention and Wound Care Management," revised 3/4/24, identified ... purpose: to promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown ...Policy: It is the policy of this facility that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care ...5. Resident's skin will be monitored daily during cares by nursing assistant and skin check will be completed weekly by licensed nurse ...7. Skin impairments, including pressure injuries, non-pressure injury wounds, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the Wound Nurse, or designee, using the PCC Weekly Wound Assessment. a. Weekly documentation will include pertinent characteristics of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues, and a description of any drainage, eschar, necrosis, odor, tunneling, or undermining. b. Wounds/skin alterations may be grouped or clustered together into one measurement following these guidelines: Pressure injuries cannot be clustered. Wounds	2 830		

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2 830	Continued From page 9 need to be close in proximity and in same anatomical location on the body. Wounds must have the same etiology. 8. Documentation of the wound characteristics will be completed in PCC using the PCC Skin and Wound Assessment. This assessment is started in the mobile application. If a device is not available or in need of service, the documentation will be completed in the resident's electronic medical record. Consent for photography will be obtained in the admission packet. 9. Daily, the clinicians responsible for caring for the resident will assess the status of the dressing if present, (intact, soiled, leaking), and evaluate for complications such as infection and/or uncontrolled pain ...12. Wound and skin care interventions will be monitored and evaluated for effectiveness. Care plans will include specific and measurable goals and interventions. The care plan will be reviewed and revised at least quarterly, or with significant change in condition ... Facility policy, "Policy and Procedure Vulnerable Adult Abuse and Neglect prevention revised on 10/29/24, identified ... 15. Injuries of Unknown Source: An injury should be classified as an "injury of unknown source" when all of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. (a) Examples of when an Injury of Unknown Source should be reported: i. Bruising, scratches, redness, or any other bodily injury that is suspicious in location and size. Some examples include A. bruising that	2 830		

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2 830	Continued From page 10 looks like an object, e.g. fingers, equipment, etc. B. the location of the bruise is in an area not susceptible to bruising, e.g. breast, inner thigh, groin area, etc ... SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents with skin alterations to include bruising to assure they are receiving the necessary treatment/services to prevent bruising and to promote healing of bruising. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for skin alteration development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21050	MN Rule 4658.0625 Subp. 1 Menus; Meal Planning Subpart 1. Menu planning. All menus must be planned in advance, dated, and followed. Any changes in the meals actually served must be of equal nutritional value. The general menu for a seven-day period must be posted prior to the start of that seven-day period at a location readily accessible to residents, and any changes to the general menu must be noted on that posted menu. All menus and any changes for the current and following seven-day periods must be	21050		2/4/25

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21050	Continued From page 11 posted in the dietary area. Records of menus and of foods purchased must be filed for six months. A variety of foods must be provided. A file of tested recipes adjusted to a yield appropriate for the size of the home must be maintained. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a system to provide the correct physician ordered textured diet for 1 of 1 resident (R1) who was at risk for choking and history of aspiration pneumonia. Findings include: International Dysphagia Diet Standard Initiative (IDDSI) Level 5 Minced and Moist Diet tool dated January 2019, identified foods that are soft and moist but with no liquid leaking/dripping from the food, biting is not required, minimal chewing is required, lumps of 4 millimeters (mm) in size, lumps can be mashed with tongue, foods can easily be mashed with just a little pressure from the fork, and should be able to scoop food onto the fork with no liquid dripping and no crumbles falling off the fork ...may be used if you are not able to bite off pieces of food safely but have some basic chewing ability. Some people may be able to bite off a large piece of food but are not able to chew it down into little pieces that are safe to swallow. Minced & Moist foods only need a small amount of chewing and for the tongue to 'collect' the food into a ball and bring it to the back of the mouth for swallowing. It's important that Minced & Moist foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat. These foods are eaten using a spoon or a fork	21050	· R1's diet card was changed to reflect appropriate diet order on 1/9/25. · Review/revise R1's care plan including aspiration precautions, ordered meal texture, and other relevant information accordingly. Ensure R1's meal ticket reflects ordered diet. · R1's care plan was updated to reflect appropriate diet order and aspiration precautions on 1/9/25. · 54 residents in house audited to verify PCC orders, care plans, and tray cards match: identified 11 residents with altered texture diet. · Diet and Diet order policy dated 12/11/23 was reviewed. No changes were required. · Diet order procedure was reviewed and dietary manager, dietary assistant manager, and AM cook were provided education on the diet orders to be changed in Martin Brothers dietary ticket program, email notifications reviewed daily from Martin Brothers program, diet orders in Martin Brothers tray card program will be reviewed for unmatched and unreviewed tray card notifications upon receipt of diet order change. · Dietary staff educated on all staff members who have access to Martin Brothers program. · All residents reviewed to ensure all	

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21050	Continued From page 12 ...examples of foods to avoid ...tough or fibrous foods-steak and pineapple ...crumbly bits-dry cake crumble ... International Dysphagia Diet Standard Initiative (IDDSI) Level 7 Regular: meant for individuals who do not have issues chewing or swallowing. R1's care plan dated 12/16/24, identified a focus, R1 had the potential for altered nutritional status related to pain, osteoarthritis, diabetes, increased body habitus, heart disease, generalized weakness, decreased mobility, antidepressants and on Ozempic (injectable diabetic) medication. Interventions dated 12/16/24, identified R1 was to receive a level 7 regular liberalized renal diet. On 12/18/24, identified R1 required set up assist with eating. R1's admission minimum data set (MDS) dated 12/19/24, identified R1's cognition was intact, diagnoses were diabetes, chronic obstructive pulmonary disease (COPD), and dyspnea (shortness of breath). R1 was independent with eating and required a therapeutic diet. R1's progress note dated 12/23/24 at 9:39 a.m., identified R1 was sent to the emergency department (ED) for altered mental status, abdominal breathing 30+ breaths per minute, possible aspiration as there was vomit beside her. R1 unable to speak clearly only mumbling. R1's emergency department (ED) note dated 12/23/24 at 10:21 p.m., identified R1 presented to the ED with shortness of breath from the nursing home, R1 had vomited and was noted to be aspirating on the vomit, was hypoxic and oxygen saturations were 80% (normal 90-100%) on 8 liters of oxygen. Antibiotics started because chest	21050	therapeutic diets are appropriate, care planned, and implemented. · 11 residents with altered texture diets were identified and reviewed to ensure diet card reflects appropriate diet order. · 11 residents with altered texture diets were reviewed to ensure care plan reflects appropriate diet order. · Nursing administration, dietary staff educated on diet order communication form before next worked shift. Education provided electronically on 1-9-25, small group and 1 to 1 educations provided on 1-10-25. · All residents have the potential to be affected by the deficient practice. · Dietary manager or designee will review and update tray tickets at receipt of diet order change. · Dietary manager, assistant manager, or am cook will change the diet manually on the tray card when a diet order is changed. · Dietary manager, nurse administration educated on updating care plans as it pertains to their scope of practice and care plan is updated upon order changes. · Medical Director will be updated with deficient practice and correction plan. · Audits will be completed 3x's a week for one month, 2x's a week for 1 month, 1 time per week for 1 month to ensure dietary orders, interventions, and supervision are being provided per care plan for all residents. · Audits will be completed 3x's a week for one month, 2x's a week for 1 month, 1 time per week for 1 month to ensure dietary orders are reflected on dietary cards.	

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21050	Continued From page 13 Xray shows right lower lobe pneumonia ...will be admitted to the intensive care unit given her new BiPAP (a machine that helps remove carbon dioxide) status. R1's after visit summary (AVS) dated 12/23/24 to 1/3/25, identified R1 was hospitalized for acute hypoxemic(low level of oxygen in the blood)/hypercapnic (carbon dioxide buildup) respiratory failure presumed secondary too aspiration pneumonia (developed following presumed episode of emesis) and COPD exacerbation requiring BiPAP. She was also encephalopathic (a change in how your brain functions requiring medical intervention) on admission. R1 participated in a bedside dysphagia (difficulty in swallowing) evaluation on 12/26/24, to assess safety with oral intake/risks for aspiration. Factors contributing to aspiration risk include generalized weakness, respiratory status cognitive involvement and decreased activity intolerance. History of odynophagia (painful swallowing) secondary to Warthin's tumors (benign tumor occurring in the salivary glands) noted in the electronic medical record. Discharge orders included: Dysphagia clinical evaluation results: R1 participated in oral trials of thin liquids, puree and solid consistencies resulting in no observable signs of aspiration/penetration. However prolonged mastication with very small bite of cracker. No oral retention/pocketing. Current diet: solids IDDSI level 5 minced and moist, recommended form of medications crushed with puree. Recommendations: Dysphagia treatment. Aspiration precautions: Recommended Aspiration Precautions: Watch closely for signs of aspiration, Sit upright with all oral intake and when completing oral cares, Eat small bites, take small sips, eat slowly, Empty mouth before adding	21050	· Review and analysis of these audits will be reviewed at QAPI to determine ongoing frequency and duration of audits. · Medical Director will be updated with deficient practice and correction plan. · Audits will be completed 3x's a week for one month, 2x's a week for 1 month, 1 time per week for 1 month to ensure dietary orders, interventions, and supervision are being provided per care plan for all residents. · Audits will be completed 3x's a week for one month, 2x's a week for 1 month, 1 time per week for 1 month to ensure dietary orders are reflected on dietary cards. · Review and analysis of these audits will be reviewed at QAPI to determine ongoing frequency and duration of audits.	

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21050	Continued From page 14 more food or liquid, Good oral care 3-5 times a day. Compensation Techniques/Adaptive Equipment: Requires supervision/assistance. Positioning: Positioning Recommendations: Upright as possible for all oral intakes take small sips, eat slowly, empty mouth before adding more food or liquid, minimize talking during meals, avoid lying down for 15 minutes after meals, good oral care 3-5 times a day every shift. Follow-up Information: Recommend dysphagia therapist evaluate and treat. Frequency and duration to be determined by the evaluating therapist. R1's physician order summary dated 1/3/25, included an order for liberalized renal diet Level 5 minced and moist texture with level 0 thin (regular) consistency. Aspiration precautions: Watch closely for signs of aspiration, Sit upright with all oral intake and when completing oral cares, Eat small bites, take small sips, eat slowly, empty mouth before adding more food or liquid, Good oral care 3-5 times a day. Review of R1's medical record identified R1's care plan and Kardex (abbreviated care plan for direct care staff) was not updated to include Level 5 minced and moist diet nor all interventions identified on the hospital discharge summary including but not limited to: R1 required supervision/assistance, minimize talking during meals, and avoid laying down for 15 minutes after meal. R1's progress note dated 1/5/25 at 10:36 p.m., identified R1 needed constant reminders to use call light. R1 stayed in her room the entire shift and had supper in bed and was able to feed self with appropriate set up. Oxygen saturations were 89% on room air with head of bed elevated, denied shortness of breath and pain.	21050		

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21050	Continued From page 15 R1's physician visit dated 1/8/25 identified R1 followed a renal diet. Since admission to the facility average intake at meals ranging from 76-100%. Identified assessment plan for dysphagia to remain minced and moist renal diet and thin liquids. R1's Kardex dated 1/9/24 identified R1 required a level 7 regular renal diet. During an interview on 1/9/25 at 4:28 p.m., nursing assistant (NA)-A stated to ensure a resident received the right diet, staff would verify the food on the plate against the meal ticket and could also check the care plan as well. During an interview on 1/9/25 at 4:29 p.m. NA-B stated when staff have to serve food to a resident when they are eating in their room, we would verify the food ticket against what was served on the plate, if staff had questions they would ask the nurse. During an interview on 1/9/25 at 4:31 p.m. licensed practical nurse (LPN)-C stated when we deliver food to residents in their rooms, we would check the food ticket against what is plated. If there were any discrepancies we would ask the kitchen. During an interview on 1/9/25 at 4:33 p.m. registered nurse (RN)-A if there was a discrepancy with the food and the meal ticket, we could check the care plan and would notify my nurse manager. During an interview on 1/9/25 at 4:25 p.m., director of nursing (DON) verified R1's care plan was not updated with level 5 minced and moist	21050		

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21050	Continued From page 16 diet and the care plan identified R1 was to receive a regular textured diet. DON explained NA's were trained to verify the food on resident's plates by the meal ticket and not the care plan. The facility had seven (7) days to update the care plan with diet changes. During an observation and interview on 1/9/25 at 12:53 p.m. R1 was seated in her wheelchair and had her tray table in front of her. R1 stated she would normally eat in the dining room but had gotten up late today so would be eating in her room. At 1:20 p.m., an unknown male nursing assistant delivered R1's meal tray and set it up on R1's tray table. Male aide then left the room. R1 attempted to use the side of her fork to cut off a bite of the roast beef and stated, "this meat is tough." R1 took one bite at a time taking several minutes to chew and swallow each bite. After R1 swallowed a bite of her pineapple upside down cobbler, R1 coughed two times. R1 stated she was "supposed to have moist and minced roast beef" but they were not moist or minced nor were the carrots. R1's meal ticket dated 1/9/25 located on her tray included, "Noon," regular level 7 diet. Entrée roast beef, beef gravy, mashed potatoes, carrots, and pineapple upside down cobbler. R1 stated "my meal ticket doesn't say moist and minced." At 2:03 p.m., licensed practical nurse (LPN)-A entered R1's room looked at R1's meal ticket that identifed the regular diet, and reported R1 had recieved the wrong diet then removed the tray. LPN-A stated that R1 usually ate in the dining room and would be observed for aspiration as there is staff in the dining room during meal time. . During an interview on 1/9/25 at 2:08 p.m., LPN-A stated she was unsure how R1's meal ticket did not match the current MD order and	21050		

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21050	Continued From page 17 deferred the question to the dietary staff as they handle the meal tickets. LPN-A reported until she was prompted to refer to the record she was not aware R1 required her medications crushed in apple sauce and not whole; LPN-A gave R1 her medications whole this morning based on R1's response when she was asked how she took her pills. During an interview on 1/9/25 at 2:44 p.m., health unit coordinator (HUC)-A stated with a new admit she would be responsible to put new orders into the EHR physician orders which would include including diet orders and a nurse managers would doublecheck the entry to ensure accuracy. The clinical managers would be responsible to notify the kitchen staff with new diet orders. During an interview on 1/9/25 at 2:50 p.m. LPN-B stated he was one of the nurse managers. LPN-B stated the HUC would normally put the orders into the EHR and one of the nurse managers would be responsible to doublecheck the orders. LPN-B stated he was unsure who would be responsible for notifying the kitchen staff of new diet orders. The facility used to use a diet communication paper form but have not used one for quite some time. During an interview on 1/9/25 at 2:18 p.m., cook (C)-A stated residents who have new diet orders that would go through my manager (culinary director-CD). Level 5 diet is moist and minced, residents on this diet may not have teeth or have difficulty swallowing. For the noon meal today to meet the level 5 minced diet, the roast beef would have to be put through the food processor, similar to mashed-chunky texture, mashed potatoes would be fine, the carrots would have to go through the food processor too.	21050		

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	00916	A. BUILDING: _____ B. WING _____	C 01/13/2025

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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21050	Continued From page 18 During an interview on 1/9/25 at 2:23 p.m., culinary director (CD)-A stated when a new diet was ordered, nursing would enter it into the electronic health record (EHR), would typically email her that there was a diet change order, and/or verbally communicate the order. CD-A would then put the information on a dietary communication form, keep the form in a folder on her desk, then would enter the diet information into the Martin Brothers system that allows the meal ticket to print out which was used to inform dietary and nursing staff at meal times what was supposed to be plated. CD-A explained she was the only person who had access to to change diets in the system. CD-A did not get an email from nursing about R1's diet change when she returned from the hospital and had herself just returned from vacation. CD-A verified the ticketing system currently identified R1 was to receive a regular textured diet. CD-A verified R1's dismissal summary identified R1 was to receive a level 5 diet minced and moist starting on 1/3/25, and this was not done. R1 would have received the wrong textured diet from 1/3/25 to 1/9/25 due the meal ticket being wrong. During an interview on 1/9/25 at 2:52 p.m., DON stated the kitchen should have access to the resident discharge summary to see what the residents diet order was. DON indicated whoever was doing the admission should have notified the kitchen of a new diet order. The risk of R1 receiving the wrong textured diet would be aspiration and choking risk. Further R1 should have received her pills crushed in applesauce and not whole. During a phone interview on 1/9/25 at 3:13 p.m., speech therapist (ST)-A stated he had not been	21050		

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21050	Continued From page 19 asked to evaluate R1 for swallowing. A person who received a regular diet who should have had a level 5 minced and moist diet would be at risk for aspiration and choking. For a level 5 minced and moist diet the food should be cut up small enough to fit through a fork tine, be well moistened with no excess fluid. Someone on a level 5 diet typically can not chew food particles or swallow well. During a interview on 1/9/25 at 4:34 p.m., nurse practitioner (NP)-A stated R1 had clear orders to receive a level 5 moist and minced textured diet. NP-A further stated if R1 had been receiving a regular diet since 1/3/25, the risk would be aspiration and pneumonia. NP-A indicated with this type of diet her pills should be crushed and not given whole. During a phone interview on 1/9/25 at 4:58 p.m., medical director (MD)-A stated R1's level 5 diet would require supervision with eating and the risk would be aspiration. MD-A stated signs and symptoms to watch for aspiration while eating would be a new cough, problems with breathing, choking, spitting up, fever and fatigue. Facility policy, Diet and Diet Orders," revised 12/11/23, identified Policy: All diets will be prescribed by the Attending Physician. The Dietitian will review diets for accuracy and therapeutic goals and recommend changes to the Physician as deemed appropriate. Purpose: The purpose of this policy is to provide consistency and accuracy in all diets provided to our residents and patients. Procedure: 1. All diets must be prescribed by the Attending physician and reviewed by the Dietitian. 2. Upon admission, the diet order is entered into the EMR, using the terminology on the attached "Diet Conversion	21050		

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21050	Continued From page 20 Chart". The diet ordered should match the terminology used by Dietary Services. 3. Diets are ordered or changed in writing and communicated to the Dietary department. 4. All diet orders should include diet type (e.g. regular or therapeutic), diet texture, and liquid consistency. 5. Specific requests such as "high protein", "low potassium", "high fiber", etc. will be assessed by the Dietitian and adjusted on the resident tray card and listed in the care plan. 9. The facility will utilize a tray identification system to ensure diet accuracy in the service of the meals. 10. The Dietitian, Speech-Language Pathologist and Nursing department will document significant information relating to the resident's response to the diet offered in the resident's medical record, including the care plan. When diet orders are changed, the care plan and tray card will be updated to reflect the change in order. 11. Residents on therapeutic or mechanically altered diets will not receive foods or fluids outside the diet order unless approved by the Attending physician in conjunction with the Dietitian, nursing and/or therapy ... Responsibilities: o Dietitian - Monitor compliance with policy by ensuring accuracy of diets and communicating changes or recommendations. Ensures that care plan is updated with diet changes. o Food Service Director/Dietary Manager - Ensures that food provided is consistent with diet order and that tray card accurately reflects resident/patient diet order and food preferences.- Nursing Department - Enters diet orders in EMR per Physicians order and in compliance with approved diet type and texture. In cooperation with the other departments, ensures appropriate diet and liquids are provided and reports any discrepancies The IJ was removed on 1/10/25, when it was	21050		

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21050	Continued From page 21 verified through observation, interview and document review the facility completed the following: - Reviewed and revised policies and procedures related to serving resident meals and ensuring residents receive correct textured meals. - Educated to procedures as appropriate. -Educated all nursing staff to utilize diet communication form and give to kitchen staff and on updating the care plan for diet orders. - Educated dietary and all staff who serve resident food to recognize each specific diet type/textured meal. - Educated dietary staff related to the importance of ensuring the meal ticket is updated. - Educated all staff who serve resident food items on the importance of checking the diet slip, ensure the resident is getting the correct textured food, and then delivering the correct diet order to the resident. - Developed and implemented a plan to complete all training before each staff worked their next shift. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure standard and alternate menus are approved by the registered or licensed dietician periodically or as often as changed/needed, to ensure meal tickets accuratle reflect actual diet orders and accurately reflect the nutritional needs of the residents of the facility. The facility could update/create policies and procedures, and educate staff on these changes. The administrator or designee could perform audits periodically, determined by QAPI, to ensure all menus have been approved by the facility's registered or licensed dietician. The facility could	21050		

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21050	Continued From page 22 report audit findings to QAPI for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21050		