DEPARTMENT OF HEALTH

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

Electronically delivered
November 8, 2022

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

RE: CCN: 245409
Cycle Start Date: September 28, 2022

Dear Administrator:

On October 24, 2022, we notified you a remedy was imposed. On November 7, 2022 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 November 1, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 8, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 24, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 11, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

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

Electronically delivered

November 8, 2022

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

Re: Reinspection Results
Event ID: HG4112 and U75Y12

Dear Administrator:

On November 7, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on September 28, 2022 and October 11, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Electronically delivered
October 6, 2022

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

RE: CCN: 245409
Cycle Start Date: September 28, 2022

Dear Administrator:

On September 28, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by December 28, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 28, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 09/28/2022 |

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

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| F 000 | INITIAL COMMENTS<br><br>On 9/27/22 and 9/28/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities.<br><br>The following complaints were found to be SUBSTANTIATED: H54094816C (MN87015 and MN87052), and H54094771C (MN87046) with a deficiency cited at F684 and F689.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by: | F 684 | | 10/25/22 |

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

Electronically Signed | 10/14/2022

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<br>Based on observation, interview, and document review the facility failed to have policy and procedure for ensuring residents were transported to scheduled outpatient appointments following hospitalization for 2 of 3 residents (R1, R3) which caused a delay in ongoing care and/or treatments.<br><br>Findings include:<br><br>R1's hospital discharge summary printed on 9/8/22, identified R1 had a primary diagnosis of nephrolithiasis (kidney stones). R1 also had diagnoses of bacteremia urinary tract infection, acute kidney injury, and stroke with dysphagia (difficulty swallowing). Imaging studies dated 8/4/22, identified a large 27-millimeter (mm) stone in the left renal pelvis and a 17 mm stone in the left lower pole calyx (these stones usually require active treatment as these are less likely to pass spontaneously).<br><br>R1's admission Minimum Data Set (MDS) dated 9/13/22, identified R1 had severely impaired cognition, unclear speech, sometimes made self-understood, and sometimes understood others. MDS identified R1 did not walk and used wheelchair for mobility. Further the MDS identified R1 was totally dependent on one staff with eating and for locomotion, totally dependent on two staff for transfers, extensive assist of two staff for bed mobility and toileting, and extensive assist of one staff with hygiene and dressing. R1 had impairment of range of motion (ROM) on one upper and lower side of body.<br><br>R1's physician visit dated 9/12/22, identified R1 had recent stroke on 7/6/22, with aphasia (loss of ability to understand or express speech) and right | F 684 | • R1: appointments rescheduled for 10/5/2022 and 11/3/2022.<br>• R3: appointment was rescheduled for 11/22/22.<br><br>• Facility prepared a procedure flow sheet that defines each duty or task regarding appointment scheduling, expected follow up timeline, assigned responsible party, alternative responsible party, daily audit of appointments in Epic supplemented with a daily cross reference audit of facility's records, daily log tracking appointments, etc.<br>• Education on this procedure was initiated immediately which included all parties involved in appointments: receptionist, nurse managers, social worker, and HUC for appointment scheduling and follow up; nurses, and CNAs for proper appointment etiquette, escort services, and timeliness.<br><br>• All residents with outside of facility appointments have a potential of being affected.<br>• Facility completed review of the past 30 days of appointment of current residents to validate no other missed appointments have occurred. If any missed appointments, provider and resident or responsible party notified, and appointment rescheduled for earliest convenience.<br>• New procedure implemented: orders will be reviewed by IDT in morning meeting during business days to ensure appointments ordered have been scheduled. | |

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| F 684 | Continued From page 2<br>sided hemiparesis (loss of strength to one side of the body). R1's neurological condition did not improve during her hospital stay. R1 was scheduled for a neurology outpatient appointment on 9/12/22. R1's left nephrostomy tube placed at last hospitalization for chronic staghorn calculi. R1 also scheduled to follow up with urology on 9/21/22, for staghorn calculi (type of kidney stone) removal with pre and post procedure antibiotic prophylaxis.<br><br>R1's Appointment Schedule and Instructions identified an outside appointment on 9/12/22, at 7:00 a.m. with neurology. Further identified an appointment on 9/21/22, for a lab visit at 12:00 p.m. followed by consultation with urologist MD-B at 1:15 p.m.<br><br>R1's September 2022 medication administration record, (MAR) identified the appointment on 9/12/22, with neurology at 7:00 a.m. The box had a chart code number "9" which instructed to see progress notes. Upon review of progress notes for 9/12/22, there was nothing documented regarding this appointment. The MAR also included an appointment on 9/21/22 at 12:00 p.m., come to appointment with full bladder. The corresponding box had a staff member's initials with a time stamp of 11:11 a.m. indicating R1 went to the appointment. No further documentation pertaining to the appointment was noted in R1's record.<br><br>R1's Order Summary dated 9/7/22, included oxycodone 2.5 milligrams (mg) three times daily via G-tube for pain.<br><br>Review of R1's record did not identify an increase of pain and/or infection symptoms between | F 684 | • Weekly audits will be completed x 1 month to validate that ordered appointments have been scheduled. Audits will be reviewed through the QAPI process to determine if the audits need to continue, change, or discontinue.<br><br>NHA or designee will be responsible for compliance. | |

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| F 684 | Continued From page 3<br>9/21/22 and 9/28/22.<br><br>During an observation on 9/27/22, at 10:12 a.m. R1 was noted to be lying on her right side of her bed, R1 was unable to respond to questions and did not display non-verbal signs of pain.<br><br>During a phone interview on 9/26/22, at 3:51 p.m. operations manager of urology (OMU)-A stated on 9/21/22, R1 had an appointment with MD-B at 1:15 p.m. The appointment was for a surgical consult and consent to have her kidney stones removed. OMU-A stated the facility sent R1 to the clinic unaccompanied. In the waiting area, R1 was seen slumped down in her wheelchair moaning and seemed to be in a lot of pain. OMU-A indicated she did not feel R1 was safe to be unsupervised. OMU-A indicated R1 was not able to communicate with clinic staff even with the use of an interpreter. OMU-A stated since R1 was not able to communicate they were not able to obtain consent. OMU-A tried calling the family, but no one was able to assist at the last minute.<br><br>During a phone interview on 9/26/22, at 4:05 p.m. hospital social worker (HSW)-A verified that R1 was transported from the nursing home to the clinic on 9/21/22, unsupervised. The appointment was where the surgical team was going to get consent for her kidney stone removal. The family was unaware that this appointment was scheduled so they were not present. HSW-A confirmed the appointment had not yet been rescheduled. HSW-A indicated since the clinic was having issues with the facility sending patients who were unable to consent alone, they would be calling the family directly to reschedule appointments. | F 684 | | |

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| F 684 | Continued From page 4<br>During an interview on 9/27/22, at 10:18 a.m. licensed practical nurse (LPN)-A stated when residents had outside appointments, receptionist (R)-A scheduled the transportation and contacted the family member if the resident required someone to go with them. LPN-A was not sure who would make those arrangements when R-A was not working. LPN-A stated that R1 would not be safe to go to an outside appointment by herself because she could not communicate and was completely dependent on staff. LPN-A indicated when R1 sat up in her chair, she moaned quite a bit; LPN-A thought R1 moaned because she was in pain to which she received pain medication.<br><br>During an interview on 9/27/22, at 10:31 a.m. R-A indicated that she was the one who set up transportation, notified family members, and scheduled resident appointments. R-A indicated she would consult with nurse managers about the resident's cognition to ascertain if they could go to the appointment alone. R-A confirmed R1 went unsupervised to her appointment on 9/21/22, and was not aware of R1's cognitive issues until now. R-A was not sure if R1's appointment was ever rescheduled. R-A indicated rescheduling would be up to the nurse managers to complete.<br><br>During an interview on 9/27/22, at 10:50 a.m. clinical manager (CM)-A verified that R1 was sent out to her appointment on 9/21/22, unsupervised and stated she should have been supervised because of her cognition, English was not her first language, and R1 was non-verbal. CM-A explained upon admission the appointment guides were printed out and given to the health unit coordinator (HUC). The HUC would then enter the appointments into the order section in | F 684 | | |

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| F 684 | Continued From page 5 | F 684 | | |

the electronic health record. The orders populated to the MAR/TAR, so the floor nurse was aware. The appointment guide was also given to the receptionist. The receptionist would then set up transportation and get the appointment documents ready. CM-A indicated if the resident was cognitive then they could attend appointment alone. If the resident was not cognitive then the receptionist would arrange supervision and/or reach out to the family to assist with the appointment.

During a subsequent interview on 9/27/22, at 11:03 a.m. CM-A stated on 9/21/22, she had not received information back from the appointment and was not aware R1's appointment needed to be rescheduled.

During an interview on 9/27/22, at 11:06 a.m. director of nursing (DON) verified R1 was sent to her appointment unsupervised. DON stated R1 should not have been sent alone due to her impaired cognition and inability to communicate. DON stated she had no idea how R1 was sent to the appointment by herself or why no one called the family. DON indicated R-A typically set up the transportation for the appointments. DON stated MD-B was the urologist that R1 was supposed to have seen and that the normal process would have been for MD-B to have written a note to reschedule her appointment. DON verified the appointment had not been rescheduled.

During a phone interview on 9/27/22, at 12:58 p.m. FM-B verified she had not been notified of R1's appointment on 9/21/22. FM-B stated that the social worker at the clinic said R1 was sent to the appointment by herself and was not safe for R1. FM-B indicated R1's appointment was for us

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| F 684 | Continued From page 6<br>to give permission to do the surgery to get the kidney stone removed.<br><br>During an interview on 9/27/22, at 1:16 p.m. the administrator indicated the facility did not keep a log to track resident appointments.<br><br>During an interview on 9/27/22, at 2:59 p.m. R-A verified she had not set up transportation for R1's appointment with neurology on 9/12/22. R-A confirmed the appointment was on the hospital after-visit summary that they received on 9/7/22 when R1 was admitted. R-A indicated she was not aware of the appointment in a timely manner, so she did not make transportation arrangements. R-A stated she had not communicated the inability to set up transportation to family or the nurse manager nor did she reschedule the missed appointment.<br><br>During an interview on 9/27/22, at 3:21 p.m. DON verified she was not aware of R1's neurology appointment on 9/12/22, or that she missed the appointment. DON reviewed R1's appointment scheduled, and confirmed the appointment had not been rescheduled. Administrator stated, if a resident missed an appointment, the clinic would typically inform us that the appointment needed to be rescheduled. The administrator was not able to articulate the procedures the facility had in place to ensure residents with cognitive impairments made it to their scheduled appointments or procedures to reschedule missed appointments. Administrator stated she did not know R1 had an appointment on 9/12/22, why it was missed and not rescheduled. Administrator indicated they would have been aware of both appointments 9/12/22 and 9/21/22 as they were printed on the hospital AVS that was | F 684 | | |

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| F 684 | Continued From page 7<br>dated 9/7/22. At 4:12 p.m. the DON stated the facility would wait for the clinic to call back to reschedule. DON verified the clinic had not called back and both neurology and urology appointments remained unscheduled.<br><br>During a phone interview on 9/27/22, at 4:18 p.m. MD-A, verified she was R1's primary doctor. MD-A stated she had not been notified of R1's missed appointments. MD-A stated that R1 would not be safe to send to an outside appointment without supervision because she was dependent on staff and unable to communicate her needs. MD-A further stated, missing her neurology appointment on 9/12/22, would be a delay in care. MD-A stated but more concerning, was missing of her appointment on 9/21/22, for surgical consent for the procedure to have her kidney stone removed. That appointment would be very important if not urgent. MD-A indicated she should have been notified of the missed appointments.<br><br>An email correspondence dated 9/28/22, at 2:27 p.m. MD-B verified that he was R1's urologist and that that R1's appointment was scheduled for 9/21/22, to get surgical consult consent for a percutaneous nephrolithotomy (kidney stone removal surgery). MD-B verified this was not done due to R1 being unable to consent as she was sent alone to the appointment. The potential outcome from not getting the surgery timely is a risk of recurrent UTI/urosepsis, kidney function loss on the affected side, pain if the kidney becomes obstructed (currently un-obstructed with the nephrostomy tube in place, which needs to be exchanged every 3 months).<br><br>R3's hospital, After Visit Summary (AVS) dated | F 684 | | |

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|---|---|---|---|
| | 245409 | A. BUILDING _____ B. WING _____ | C 09/28/2022 |

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

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| F 684 | Continued From page 8<br>8/30/22, indicated R3 was hospitalized for non-specific encephalopathy (neurological disorder caused by exposure to toxic substances) and was started on levetiracetam (antiseizure medication) 750 milligrams (mg) twice a day. The summary also included R3 would need follow up with neurology scheduled for 9/19/22, at 1:00 p.m. with discussion of tapering the levetiracetam.<br><br>R3's admission record dated 8/30/22, identified diagnoses of unspecified toxic encephalopathy and Todd's paralysis, (a neurological condition with epilepsy, in which a seizure is followed by a brief period of temporary paralysis. The paralysis may be partial or complete but usually occurs on just one side of the body), and cognitive communication deficit.<br><br>R3's admission MDS dated 9/5/22, identified R3's cognition was intact. MDS identified R3 required limited assistance from one staff for hygiene, extensive assist of one staff with toileting, and supervision with all other activities of daily living. MDS indicated R3 uses walker and wheelchair for mobility.<br><br>R3's physician visit dated 9/7/22, identified that R3 was admitted for rehab services with a history significant for recurrent strokes. He was admitted to hospital after presenting with convulsions with language dysfunction and hemi-neglect (reduced awareness of stimuli on one side of space, even though there may be no sensory loss). R2 was started on levetiracetam 750 mg twice a day. R2 had future appointment on 9/19/22, with neurology.<br><br>R3's September 2022, medication administration | F 684 | | |

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| F 684 | Continued From page 9<br>record (MAR) identified neurology appointment on 9/19/22, at 1:00 p.m. The associated box on the record was marked with chart code "9" indicating to see progress note. Corresponding progress note did not include any documentation regarding the appointment.<br><br>R3's record did not indentify dose changes were made to the levetiracetam and did not indicate R3 had any adverse side effects as a result of continuing the same dose.<br><br>During an interview with CM-A, CM-B and DON on 9/28/22, at 10:19 a.m. CM-B verified he was not aware of R3's appointment on 9/19/22, with neurology and further verified the appointment was missed. DON and CM-A verified he missed his appointment and had an unawareness of why or how it got missed. DON then left the room. At 10:31 a.m. CM-B stated, we all sat down last night and tried to find why we were missing the resident appointments and why residents were sent unsupervised to appointments. CM-B indicated there were too many people involved with the appointments. CM-B stated plan was developed in which staff were assigned a task to ensure residents did not miss appointments. CM-B indicated they had not reviewed other residents for any missed appointments however, planned to do so.<br><br>During an interview with the administrator on 9/28/22, at 1:17 p.m. administrator verified she was not aware of R3's missed neurology appointment and stated they plan to go through all resident records to ensure all resident appointments have been completed and are up to date. Administrator stated the facility had a problem with ensuring the residents were getting | F 684 | | |

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| F 684 | Continued From page 10<br>to their appointments as scheduled, ensuring supervision with appointments as needed, and rescheduling of missed appointments. I have put a new system in place, and we will be doing daily audits in real time to ensure the new system is working.<br><br>Policy for resident outside appointments, rescheduling appointments, and scheduling transport was requested and not received. | F 684 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to provide safety and supervision for an outside medical appointment for a 1 of 3 residents (R1) who was non-verbal and dependent on staff for activities of daily living (ADL)'s.<br><br>Findings include:<br><br>R1's admission Minimum Data Set (MDS) dated 9/13/22, identified R1 had severely impaired cognition, unclear speech, sometimes made self-understood, and sometimes understood others. MDS identified R1 did not walk and used wheelchair for mobility. Further the MDS identified | F 689 | • R1: new appointments scheduled for 10/5/2022 and 11/3/2022<br><br>• All residents with outside of facility appointments have a potential of being affected.<br>• Facility completed review of the past 30 days of appointment of current residents to validate no other missed appointments have occurred. If any missed appointments, provider and resident or responsible party notified, and appointment rescheduled for earliest convenience. Any residents who did not have documented escort services | 10/25/22 |

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| F 689 | Continued From page 11<br>R1 was totally dependent on one staff with eating and for locomotion, totally dependent on two staff for transfers, extensive assist of two staff for bed mobility and toileting, and extensive assist of one staff with hygiene and dressing. R1 had impairment of range of motion (ROM) on one upper and lower side of body.<br><br>R1's physician visit note dated 9/12/22, identified R1 had a significant medical history to include a recent stroke on 7/6/22, with aphasia (loss of ability to understand or express speech, caused by brain damage), right sided hemiparesis (loss of strength to one side of the body). The note further identified R1 was scheduled to follow up with urology on 9/21/22, for staghorn calculi (type of kidney stone) removal.<br><br>During an observation on 9/27/22, at 10:12 a.m. R1 was noted to be lying on her right side in her bed. R1's eyes were open looking towards the window. R1 was not able to answer questions.<br><br>During a phone interview on 9/26/22, at 3:51 p.m. operations manager of urology (OMU)-A stated on 9/21/22, R1 had an appointment with MD-B at 1:15 p.m. The appointment was for a surgical consult and consent to have her kidney stones removed. OMU-A stated the facility sent R1 to the clinic unaccompanied. In the waiting area, R1 was seen slumped down in her wheelchair moaning and seemed to be in a lot of pain. OMU-A indicated she did not feel R1 was safe to be unsupervised. OMU-A indicated R1 was not able to communicate with clinic staff even with the use of an interpreter. OMU-A stated since R1 was not able to communicate they were not able to obtain consent. OMU-A tried calling the family, but no one was able to assist at the last minute. | F 689 | provided but were identified to have needed them at the time of the appointment will be noted to ensure they have an escort for future appointments.<br>• New procedure implemented: all appointments will be reviewed by IDT in morning meeting during business days to determine if a resident needs an escort or not. Residents who are not their own decision maker or need physical assistance outside the abilities of the facility the appointment is scheduled at will have an escort unless the decision maker is available and able to be on site for the appointment. The receptionist and nurse manager will ensure an escort is assigned prior to the appointment, and the nurse preparing the resident for the appointment will ensure they leave with one.<br>• Education on this procedure was initiated immediately which included all parties involved in appointments: receptionist, nurse managers, social worker, and HUC for appointment scheduling and follow up; nurses, and CNAs for proper appointment etiquette, escort services, and timeliness.<br><br>• Weekly audits will be completed x 1 month to validate that appointments have included an escort if needed. Audits will be reviewed through the QAPI process to determine if the audits need to continue, change, or discontinue.<br><br>NHA or designee will be responsible for compliance. | |

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| F 689 | Continued From page 12 | F 689 | | |

Family member (FM)-A told us the facility had not told her about the appointment.

During an interview on 9/27/22, at 10:18 a.m. licensed practical nurse (LPN)-A, stated when residents had outside appointments, receptionist (R)-A arranged the transport and contacted family members if the resident required someone to go with them. LPN-A was not aware of who was responsible if R-A was not working. LPN-A stated that R1 would not be safe to go to an outside appointment by herself because she could not communicate and was completely dependent on staff.

During an interview on 9/27/22, at 10:31 a.m. R-A indicated that she was the one who set up transportation, notified family members, and did the scheduling of resident appointments. R-A stated she would talk with clinical managers about the resident's cognition to ascertain if they could go to the appointments by themselves or required supervision. R-A confirmed R1 was sent to her appointment on 9/21/22 by herself. R-A stated she had not been aware of R1's cognitive issues until now and should have had someone with her. R-A indicated on 9/21/22, R1 had left the facility around 11:30 a.m. but was unaware of when R1 returned because she did not keep a log.

During an interview on 9/27/22, at 10:50 a.m. clinical manager (CM)-A verified that R1 was sent out to her appointment on 9/21/22, unsupervised. CM-A stated she should have been supervised because of her cognition, English was not R1's first language, and R1 was non-verbal.

During an interview on 9/27/22, at 10:56 a.m.

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| F 689 | Continued From page 13<br>CM-B, stated he was here the day of the appointment, but was not aware of her appointment. CM-B verified R1 did go to the appointment by herself unsupervised and was not safe to do so.<br><br>During an interview on 9/27/22, at 11:08 a.m. director of nursing (DON) verified R1 was sent to her appointment unsupervised and should not have been, due to her impaired cognition and inability to communicate. DON stated she had no idea how or why R1 was sent herself to the appointment by herself.<br><br>During a phone interview on 9/27/22, at 12:58 p.m. FM-B verified she had not been notified of R1's appointment on 9/21/22. FM-B stated R1 was not safe because she could not do anything for herself and could not talk.<br><br>During a phone interview on 9/27/22, at 4:18 p.m. MD-A, verified she was R1's primary doctor, was not aware that R1 was sent to her urology appointment on 9/21/22, unsupervised. MD-A stated that R1 would not be safe to send to an outside appointment without supervision because she was dependent on staff and unable to communicate her needs. Someone should have been with to provide consent for her surgery.<br><br>Facility policy for resident appointments and transportation services was requested and not received. | F 689 | | |

Electronically delivered
October 6, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: HG4111

Dear Administrator:

The above facility was surveyed on September 27, 2022 through September 28, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 09/28/2022 |

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

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 9/27/22 and 9/28/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>The following complaint was found to be SUBSTANTIATED: H54094816C (MN87015 and MN87052) and H54094771C (MN87046), with a licensing order issued at 0830 and 1665.<br><br>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 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.<br><br>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 | 2 000 | | |

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| 2 000 | Continued From page 2<br>not required at the bottom of the first page of state form.<br><br>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<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to have policy and procedure for ensuring residents were transported to scheduled outpatient appointments following hospitalization for 2 of 3 residents (R1, R3) which caused a delay in ongoing care and/or treatments.<br><br>Findings include: | 2 830 | Corrected | 10/25/22 |

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| 2 830 | Continued From page 3<br><br>R1's hospital discharge summary printed on 9/8/22, identified R1 had a primary diagnosis of nephrolithiasis (kidney stones). R1 also had diagnoses of bacteremia urinary tract infection, acute kidney injury, and stroke with dysphagia (difficulty swallowing). Imaging studies dated 8/4/22, identified a large 27-millimeter (mm) stone in the left renal pelvis and a 17 mm stone in the left lower pole calyx (these stones usually require active treatment as these are less likely to pass spontaneously).<br><br>R1's admission Minimum Data Set (MDS) dated 9/13/22, identified R1 had severely impaired cognition, unclear speech, sometimes made self-understood, and sometimes understood others. MDS identified R1 did not walk and used wheelchair for mobility. Further the MDS identified R1 was totally dependent on one staff with eating and for locomotion, totally dependent on two staff for transfers, extensive assist of two staff for bed mobility and toileting, and extensive assist of one staff with hygiene and dressing. R1 had impairment of range of motion (ROM) on one upper and lower side of body.<br><br>R1's physician visit dated 9/12/22, identified R1 had recent stroke on 7/6/22, with aphasia (loss of ability to understand or express speech) and right sided hemiparesis (loss of strength to one side of the body). R1's neurological condition did not improve during her hospital stay. R1 was scheduled for a neurology outpatient appointment on 9/12/22. R1's left nephrostomy tube placed at last hospitalization for chronic staghorn calculi. R1 also scheduled to follow up with urology on 9/21/22, for staghorn calculi (type of kidney stone) removal with pre and post procedure antibiotic prophylaxis. | 2 830 | | |

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| 2 830 | Continued From page 4<br><br>R1's Appointment Schedule and Instructions identified an outside appointment on 9/12/22, at 7:00 a.m. with neurology. Further identified an appointment on 9/21/22, for a lab visit at 12:00 p.m. followed by consultation with urologist MD-B at 1:15 p.m.<br><br>R1's September 2022 medication administration record, (MAR) identified the appointment on 9/12/22, with neurology at 7:00 a.m. The box had a chart code number "9" which instructed to see progress notes. Upon review of progress notes for 9/12/22, there was nothing documented regarding this appointment. The MAR also included an appointment on 9/21/22 at 12:00 p.m., come to appointment with full bladder. The corresponding box had a staff member's initials with a time stamp of 11:11 a.m. indicating R1 went to the appointment. No further documentation pertaining to the appointment was noted in R1's record.<br><br>R1's Order Summary dated 9/7/22, included oxycodone 2.5 milligrams (mg) three times daily via G-tube for pain.<br><br>Review of R1's record did not identify an increase of pain and/or infection symptoms between 9/21/22 and 9/28/22.<br><br>During an observation on 9/27/22, at 10:12 a.m. R1 was noted to be lying on her right side of her bed, R1 was unable to respond to questions and did not display non-verbal signs of pain.<br><br>During a phone interview on 9/26/22, at 3:51 p.m. operations manager of urology (OMU)-A stated on 9/21/22, R1 had an appointment with MD-B at 1:15 p.m. The appointment was for a surgical consult and consent to have her kidney stones | 2 830 | | |

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| 2 830 | Continued From page 5<br><br>removed. OMU-A stated the facility sent R1 to the clinic unaccompanied. In the waiting area, R1 was seen slumped down in her wheelchair moaning and seemed to be in a lot of pain. OMU-A indicated she did not feel R1 was safe to be unsupervised. OMU-A indicated R1 was not able to communicate with clinic staff even with the use of an interpreter. OMU-A stated since R1 was not able to communicate they were not able to obtain consent. OMU-A tried calling the family, but no one was able to assist at the last minute.<br><br>During a phone interview on 9/26/22, at 4:05 p.m. hospital social worker (HSW)-A verified that R1 was transported from the nursing home to the clinic on 9/21/22, unsupervised. The appointment was where the surgical team was going to get consent for her kidney stone removal. The family was unaware that this appointment was scheduled so they were not present. HSW-A confirmed the appointment had not yet been rescheduled. HSW-A indicated since the clinic was having issues with the facility sending patients who were unable to consent alone, they would be calling the family directly to reschedule appointments.<br><br>During an interview on 9/27/22, at 10:18 a.m. licensed practical nurse (LPN)-A stated when residents had outside appointments, receptionist (R)-A scheduled the transportation and contacted the family member if the resident required someone to go with them. LPN-A was not sure who would make those arrangements when R-A was not working. LPN-A stated that R1 would not be safe to go to an outside appointment by herself because she could not communicate and was completely dependent on staff. LPN-A indicated when R1 sat up in her chair, she moaned quite a bit; LPN-A thought R1 moaned | 2 830 | | |

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| 2 830 | Continued From page 6<br><br>because she was in pain to which she received pain medication.<br><br>During an interview on 9/27/22, at 10:31 a.m. R-A indicated that she was the one who set up transportation, notified family members, and scheduled resident appointments. R-A indicated she would consult with nurse managers about the resident's cognition to ascertain if they could go to the appointment alone. R-A confirmed R1 went unsupervised to her appointment on 9/21/22, and was not aware of R1's cognitive issues until now. R-A was not sure if R1's appointment was ever rescheduled. R-A indicated rescheduling would be up to the nurse managers to complete.<br><br>During an interview on 9/27/22, at 10:50 a.m. clinical manager (CM)-A verified that R1 was sent out to her appointment on 9/21/22, unsupervised and stated she should have been supervised because of her cognition, English was not her first language, and R1 was non-verbal. CM-A explained upon admission the appointment guides were printed out and given to the health unit coordinator (HUC). The HUC would then enter the appointments into the order section in the electronic health record. The orders populated to the MAR/TAR, so the floor nurse was aware. The appointment guide was also given to the receptionist. The receptionist would then set up transportation and get the appointment documents ready. CM-A indicated if the resident was cognitive then they could attend appointment alone. If the resident was not cognitive then the receptionist would arrange supervision and/or reach out to the family to assist with the appointment.<br><br>During a subsequent interview on 9/27/22, at 11:03 a.m. CM-A stated on 9/21/22, she had not | 2 830 | | |

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| 2 830 | Continued From page 7<br><br>received information back from the appointment and was not aware R1's appointment needed to be rescheduled.<br><br>During an interview on 9/27/22, at 11:06 a.m. director of nursing (DON) verified R1 was sent to her appointment unsupervised. DON stated R1 should not have been sent alone due to her impaired cognition and inability to communicate. DON stated she had no idea how R1 was sent to the appointment by herself or why no one called the family. DON indicated R-A typically set up the transportation for the appointments. DON stated MD-B was the urologist that R1 was supposed to have seen and that the normal process would have been for MD-B to have written a note to reschedule her appointment. DON verified the appointment had not been rescheduled.<br><br>During a phone interview on 9/27/22, at 12:58 p.m. FM-B verified she had not been notified of R1's appointment on 9/21/22. FM-B stated that the social worker at the clinic said R1 was sent to the appointment by herself and was not safe for R1. FM-B indicated R1's appointment was for us to give permission to do the surgery to get the kidney stone removed.<br><br>During an interview on 9/27/22, at 1:16 p.m. the administrator indicated the facility did not keep a log to track resident appointments.<br><br>During an interview on 9/27/22, at 2:59 p.m. R-A verified she had not set up transportation for R1's appointment with neurology on 9/12/22. R-A confirmed the appointment was on the hospital after-visit summary that they received on 9/7/22 when R1 was admitted. R-A indicated she was not aware of the appointment in a timely manner, so she did not make transportation | 2 830 | | |

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| 2 830 | Continued From page 8<br><br>arrangements. R-A stated she had not communicated the inability to set up transportation to family or the nurse manager nor did she reschedule the missed appointment.<br><br>During an interview on 9/27/22, at 3:21 p.m. DON verified she was not aware of R1's neurology appointment on 9/12/22, or that she missed the appointment. DON reviewed R1's appointment scheduled, and confirmed the appointment had not been rescheduled. Administrator stated, if a resident missed an appointment, the clinic would typically inform us that the appointment needed to be rescheduled. The administrator was not able to articulate the procedures the facility had in place to ensure residents with cognitive impairments made it to their scheduled appointments or procedures to reschedule missed appointments. Administrator stated she did not know R1 had an appointment on 9/12/22, why it was missed and not rescheduled. Administrator indicated they would have been aware of both appointments 9/12/22 and 9/21/22 as they were printed on the hospital AVS that was dated 9/7/22. At 4:12 p.m. the DON stated the facility would wait for the clinic to call back to reschedule. DON verified the clinic had not called back and both neurology and urology appointments remained unscheduled.<br><br>During a phone interview on 9/27/22, at 4:18 p.m. MD-A, verified she was R1's primary doctor. MD-A stated she had not been notified of R1's missed appointments. MD-A stated that R1 would not be safe to send to an outside appointment without supervision because she was dependent on staff and unable to communicate her needs. MD-A further stated, missing her neurology appointment on 9/12/22, would be a delay in care. MD-A stated but more concerning, was missing of | 2 830 | | |

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| 2 830 | Continued From page 9<br><br>her appointment on 9/21/22, for surgical consent for the procedure to have her kidney stone removed. That appointment would be very important if not urgent. MD-A indicated she should have been notified of the missed appointments.<br><br>An email correspondence dated 9/28/22, at 2:27 p.m. MD-B verified that he was R1's urologist and that that R1's appointment was scheduled for 9/21/22, to get surgical consult consent for a percutaneous nephrolithotomy (kidney stone removal surgery). MD-B verified this was not done due to R1 being unable to consent as she was sent alone to the appointment. The potential outcome from not getting the surgery timely is a risk of recurrent UTI/urosepsis, kidney function loss on the affected side, pain if the kidney becomes obstructed (currently un-obstructed with the nephrostomy tube in place, which needs to be exchanged every 3 months).<br><br>R3's hospital, After Visit Summary (AVS) dated 8/30/22, indicated R3 was hospitalized for non-specific encephalopathy (neurological disorder caused by exposure to toxic substances) and was started on levetiracetam (antiseizure medication) 750 milligrams (mg) twice a day. The summary also included R3 would need follow up with neurology scheduled for 9/19/22, at 1:00 p.m. with discussion of tapering the levetiracetam.<br><br>R3's admission record dated 8/30/22, identified diagnoses of unspecified toxic encephalopathy and Todd's paralysis, (a neurological condition with epilepsy, in which a seizure is followed by a brief period of temporary paralysis. The paralysis may be partial or complete but usually occurs on just one side of the body), and cognitive | 2 830 | | |

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| 2 830 | Continued From page 10<br>communication deficit.<br><br>R3's admission MDS dated 9/5/22, identified R3's cognition was intact. MDS identified R3 required limited assistance from one staff for hygiene, extensive assist of one staff with toileting, and supervision with all other activities of daily living. MDS indicated R3 uses walker and wheelchair for mobility.<br><br>R3's physician visit dated 9/7/22, identified that R3 was admitted for rehab services with a history significant for recurrent strokes. He was admitted to hospital after presenting with convulsions with language dysfunction and hemi-neglect (reduced awareness of stimuli on one side of space, even though there may be no sensory loss). R2 was started on levetiracetam 750 mg twice a day. R2 had future appointment on 9/19/22, with neurology.<br><br>R3's September 2022, medication administration record (MAR) identified neurology appointment on 9/19/22, at 1:00 p.m. The associated box on the record was marked with chart code "9" indicating to see progress note. Corresponding progress note did not include any documentation regarding the appointment.<br><br>R3's record did not indentify dose changes were made to the levetiracetam and did not indicate R3 had any adverse side effects as a result of continuing the same dose.<br><br>During an interview with CM-A, CM-B and DON on 9/28/22, at 10:19 a.m. CM-B verified he was not aware of R3's appointment on 9/19/22, with neurology and further verified the appointment was missed. DON and CM-A verified he missed his appointment and had an unawareness of why | 2 830 | | |

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| 2 830 | Continued From page 11<br><br>or how it got missed. DON then left the room. At 10:31 a.m. CM-B stated, we all sat down last night and tried to find why we were missing the resident appointments and why residents were sent unsupervised to appointments. CM-B indicated there were too many people involved with the appointments. CM-B stated plan was developed in which staff were assigned a task to ensure residents did not miss appointments. CM-B indicated they had not reviewed other residents for any missed appointments however, planned to do so.<br><br>During an interview with the administrator on 9/28/22, at 1:17 p.m. administrator verified she was not aware of R3's missed neurology appointment and stated they plan to go through all resident records to ensure all resident appointments have been completed and are up to date. Administrator stated the facility had a problem with ensuring the residents were getting to their appointments as scheduled, ensuring supervision with appointments as needed, and rescheduling of missed appointments. I have put a new system in place, and we will be doing daily audits in real time to ensure the new system is working.<br><br>Policy for resident outside appointments, rescheduling appointments, and scheduling transport was requested and not received.<br><br>Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are getting to their required MD appointments and rescheduling them if an appointment is missed to prevent a delay in care of needed medical services. The director of | 2 830 | | |

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| 2 830 | Continued From page 12<br><br>nursing or designee, could track resident outside provider appointments and conduct random audits; to ensure appropriate care and services are implemented; to better ensure implementation of treatment.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.<br><br>Based on observation, interview, and document review the facility failed to provide safety and supervision for an outside medical appointment for a 1 of 3 residents (R1) who was non-verbal and completely dependent on staff for activities of daily living (ADL)'s.<br><br>Findings include:<br><br>R1's admission Minimum Data Set (MDS) dated 9/13/22, identified R1 had severely impaired cognition, unclear speech, sometimes made self-understood, and sometimes understood others. MDS identified R1 did not walk and used wheelchair for mobility. Further the MDS identified R1 was totally dependent on one staff with eating and for locomotion, totally dependent on two staff for transfers, extensive assist of two staff for bed mobility and toileting, and extensive assist of one staff with hygiene and dressing. R1 had impairment of range of motion (ROM) on one upper and lower side of body.<br><br>R1's physician visit note dated 9/12/22, identified R1 had a significant medical history to include a recent stroke on 7/6/22, with aphasia (loss of ability to understand or express speech, caused by brain damage), right sided hemiparesis (loss of strength to one side of the body). The note | 2 830 | | |

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| 2 830 | Continued From page 13<br><br>further identified R1 was scheduled to follow up with urology on 9/21/22, for staghorn calculi (type of kidney stone) removal.<br><br>During an observation on 9/27/22, at 10:12 a.m. R1 was noted to be lying on her right side in her bed. R1's eyes were open looking towards the window. R1 was not able to answer questions.<br><br>During a phone interview on 9/26/22, at 3:51 p.m. operations manager of urology (OMU)-A stated on 9/21/22, R1 had an appointment with MD-B at 1:15 p.m. The appointment was for a surgical consult and consent to have her kidney stones removed. OMU-A stated the facility sent R1 to the clinic unaccompanied. In the waiting area, R1 was seen slumped down in her wheelchair moaning and seemed to be in a lot of pain. OMU-A indicated she did not feel R1 was safe to be unsupervised. OMU-A indicated R1 was not able to communicate with clinic staff even with the use of an interpreter. OMU-A stated since R1 was not able to communicate they were not able to obtain consent. OMU-A tried calling the family, but no one was able to assist at the last minute. Family member (FM)-A told us the facility had not told her about the appointment.<br><br>During an interview on 9/27/22, at 10:18 a.m. licensed practical nurse (LPN)-A, stated when residents had outside appointments, receptionist (R)-A arranged the transport and contacted family members if the resident required someone to go with them. LPN-A was not aware of who was responsible if R-A was not working. LPN-A stated that R1 would not be safe to go to an outside appointment by herself because she could not communicate and was completely dependent on staff. | 2 830 | | |

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| 2 830 | Continued From page 14<br><br>During an interview on 9/27/22, at 10:31 a.m. R-A indicated that she was the one who set up transportation, notified family members, and did the scheduling of resident appointments. R-A stated she would talk with clinical managers about the resident's cognition to ascertain if they could go to the appointments by themselves or required supervision. R-A confirmed R1 was sent to her appointment on 9/21/22 by herself. R-A stated she had not been aware of R1's cognitive issues until now and should have had someone with her. R-A indicated on 9/21/22, R1 had left the facility around 11:30 a.m. but was unaware of when R1 returned because she did not keep a log.<br><br>During an interview on 9/27/22, at 10:50 a.m. clinical manager (CM)-A verified that R1 was sent out to her appointment on 9/21/22, unsupervised. CM-A stated she should have been supervised because of her cognition, English was not R1's first language, and R1 was non-verbal.<br><br>During an interview on 9/27/22, at 10:56 a.m. CM-B, stated he was here the day of the appointment, but was not aware of her appointment. CM-B verified R1 did go to the appointment by herself unsupervised and was not safe to do so.<br><br>During an interview on 9/27/22, at 11:08 a.m. director of nursing (DON) verified R1 was sent to her appointment unsupervised and should not have been, due to her impaired cognition and inability to communicate. DON stated she had no idea how or why R1 was sent herself to the appointment by herself.<br><br>During a phone interview on 9/27/22, at 12:58 p.m. FM-B verified she had not been notified of | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00916 | A. BUILDING: _____ B. WING _____ | C 09/28/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 15<br><br>R1's appointment on 9/21/22. FM-B stated R1 was not safe because she could not do anything for herself and could not talk.<br><br>During a phone interview on 9/27/22, at 4:18 p.m. MD-A, verified she was R1's primary doctor, was not aware that R1 was sent to her urology appointment on 9/21/22, unsupervised. MD-A stated that R1 would not be safe to send to an outside appointment without supervision because she was dependent on staff and unable to communicate her needs. Someone should have been with to provide consent for her surgery.<br><br>Facility policy for resident appointments and transportation services was requested and not received.<br><br>SUGGESTED METHOD OF CORRECTION: The DON or designee could ensure staff are educated on policies and procedures to keep residents safe when needing supervision with outside appointments. The DON or designee could identify and audit all residents at risk for harm as a vulnerable adult and update/implement measures to keep each resident safe. Results of those findings should go to the Quality Assurance Performance Improvement (QAPI) for determination of effectiveness, compliance and the need for further monitoring.<br><br>TIME ALLOWED FOR CORRECTION: 21 DAYS | 2 830 | | |