Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 22, 2023

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

RE: CCN: 245409
Cycle Start Date: January 18, 2023

Dear Administrator:

On February 1, 2023, we notified you a remedy was imposed. On February 16, 2023 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 10, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 16, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 1, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), 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 16, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 10, 2023, 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 Therefore, the NATCEP prohibition is rescinded.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 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 22, 2023

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

Re: Reinspection Results
Event ID: HJLH12

Dear Administrator:

On February 16, 2023 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 18, 2023. 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
February 1, 2023

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

RE: CCN: 245409
Cycle Start Date: January 18, 2023

Dear Administrator:

On January 18, 2023, 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 16, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 16, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 16, 2023.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; 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 16, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Edenbrook Of Rochester will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 16, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 18, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, 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

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 01/18/2023

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 1/17/23, and 1/18/23, a standard abbreviated survey was conducted at your facility. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was unsubstantiated: H54097428C (MN90035). The following complaint was substantiated: H54097484C (MN89541), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to use a gait belt during transfer and ensure facility shower chairs were	F 689	How corrective action will be accomplished for those residents found to have been affected by the deficient	2/10/23

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

Electronically Signed | 02/03/2023

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

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F 689	Continued From page 1 maintained for safety for 1 of 3 residents (R1) reviewed for falls. The facility's failures resulted in actual harm when R1 sustained a fall while being transferred incorrectly, and received a severe skin laceration after her fall when the shower chair seat fell onto her. R1 required transfer to the hospital and 16 stitches. Findings include: A facility Incident Report dated 12/21/22, at 7:53 a.m. indicated on 12/20/22, at 6:45 p.m. nursing assistant (NA)-A reported to licensed practical nurse (LPN)-C that R1 had fallen in shower room and needed assistance. R1 had completed her shower and was independently transferring from the shower chair to the wheelchair when R1's legs gave out, and NA-A assisted R1 to the floor. During the process of assisting R1 to the floor, the shower chair flipped over and landed on top of R1. When NA-B arrived to assist, he lifted the shower chair off of R1 and the seat cushion detached and fell onto R1's right lower extremity (RLE). A sharp metal piece created "a serious skin tear and laceration that appeared quite deep." Due to the large laceration and profuse bleeding, it was deemed necessary to transfer R1 to the emergency department (ED). R1's Face Sheet dated 12/13/22 indicated R1 was admitted to the facility on 12/13/22, for short term rehabilitation. R1's diagnoses included abnormalities of gait and mobility, severe morbid obesity, and metabolic encephalopathy (delirium: confused thinking and disrupted attention). R1's admission Minimum Data Set (MDS) dated 12/19/22, lacked identification of R1's cognitive status. The MDS indicated R1 required extensive	F 689	practice: R1 was sent immediately to the ED for further evaluation of wound acquired after fall on 12/20/22. Broken shower chair was discarded immediately following fall on 12/20/22. All shower equipment was inspected on 1-17-23 and any noted to be compromised, missing weight limitations, and/or did not have user manual available were immediately discarded and replacements were ordered. NA-A reeducated on proper gait belt usage prior to next scheduled shift on 12/21/22 to ensure deficient practice did not continue. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential of being affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Education to direct resident care staff: - Reeducate direct resident care staff on Gait-Transfer Belt Policy & Procedure - Reeducate direct resident care staff on use of the Kardex Reeducation Maintenance Director to ensure all shower equipment has weight limitations identified and visible to staff. Ensure the user manuals to all shower equipment is available for staff reference. Implement monthly preventative maintenance program for shower equipment including documentation.	

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F 689	Continued From page 2 assistance of one staff member with transferring and toileting. R1's care plan dated 12/13/22, indicated R1 had limited physical mobility related to metabolic encephalopathy, obesity, and functional decline. The care plan identified R1 required extensive assist of one staff member for transfers, required a gait belt, and was at moderate risk for falls. Further identified R1 was at risk for skin/wound infection related to large laceration of right lower extremity (RLE) requiring suture repair and antibiotics. R1's late entry FOCUS Note (interdisciplinary meeting note) dated 12/20/2022, at 6:45 p.m. identified the reason for the Interdisciplinary FOCUS Review was R1 had a fall and subsequent skin tear to the right lower shin on 12/20/22, at 6:45 p.m. R1's skin tear required 16 stitches. The note identified R1 required extensive assistance from one staff. New interventions: all staff educated to not complete transfers in shower room. During an interview on 01/18/23, at 10:45 a.m. NA-A stated she was with R1 when she had the fall. NA-A explained she had finished R1's shower, wheeled her over to the "dry area" just past the half-wall. She dried R1 off, applied gripper socks, and wiped the floor with a blanket. NA-A assured the wheelchair brakes were locked, held the back of the shower chair and directed R1 to self-transfer to the wheelchair. NA-A stated she had previously directed R1 to independently walk to her bathroom in her room and did not place a gait belt for support. NA-A stated she had not looked in the care plan or medical record to see how R1 transferred, and she was not aware R1	F 689	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Audits to be completed 5x weekly for 1 month, then 1x weekly for 2 months to ensure nursing staff are completing transfers correctly with required gait belt per the care plan. Audit of shower equipment preventative maintenance once weekly x 1 month, then once monthly x2 months. The date that each deficiency will be corrected: 2/10/23 Person responsible: NHA or designee	

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F 689	Continued From page 3 required a gait belt. NA-A stated she was an agency nursing assistant and did not know the residents well. NA-A stated as R1 was standing, the chair started sliding backwards. This caused R1 to sit back down hard toward the front of chair. Because she was not all the way back, she started sliding off the front of the chair. NA-A reported R1 was a large lady, she could not keep R1 from falling off the shower chair, but she assisted R1 to the floor. The shower chair then tipped over and landed on top of R1. When the shower chair was picked up and moved by NA-B, the seat fell off, and a sharp metal piece cut R1's RLE. NA-A stated again she had not put a gait belt on R1 to assist with transfers because she did not know R1 needed a gait belt. NA-A had access to the care plan but did not review it before transferring R1. Attempts to contact NA-B on 01/18/23, at 1:06 p.m. and 01/24/23, at 9:22 a.m. were not successful and no return telephone call was received. On 01/22/23, at 7:56 a.m. the facility provided a picture of the broken shower chair and the bottom of the seat cushion. There was approximately eight jagged holes on the bottom of the seat cushion where the mounting brackets had been. The metal brackets that connected the seat to the PVC pipe frame were not pictured. During an observation on 1/18/23, at 12:00 p.m. bath chairs #47 and #101 observed on the floor in service (but not in use at the time), did not have weight stickers, and labels were not legible. During an interview on 1/18/23, at 12:38 p.m. the director of maintenance director (DM)-A stated	F 689		

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F 689	Continued From page 4 the facility utilizes the TELS Building Management software system to schedule and track preventive maintenance tasks. DM-A stated the facility performed monthly visual inspections of the shower chairs. DM-A then logged into the TELS system, and stated monthly shower chair inspections were not included as a task. DM-A stated he would have to enter shower chair inspections as a monthly task, but does not have any documentation of these visual inspections. During an interview on 1/17/23, at 3:05 p.m. family member (FM)-A confirmed R1 was hospitalized and receiving antibiotics. FM-A stated R1 was very confused and did not remember she was in a nursing home when she fell. R1 stated she was at home when she fell. FM-A further stated with R1's confusion, cognitive communication deficit, and being a poor historian, an interview with R1 would not be credible. During an interview on 1/18/23, at 8:50 a.m. DM-A was re-interviewed and stated he had looked at the shower chair after the incident. DM-A stated it looked like there had been rust on the metal mounting brackets of the chair seat. DM-A further stated when R1 fell onto the shower chair, due to her excessive weight, she broke the mounting brackets. DM-A stated the facility did not have manufacturer's user manual due to the shower chair estimated to be greater than ten years old. DM-A stated due to the age of the shower chair and the inability to purchase replacement mounting brackets, the shower chair was thrown away. A new replacement shower chair was just purchased. DM-A identified after the accident, he looked at the other three facility shower chairs but two of the chairs in service did not identify weight restrictions. Due to the age of	F 689		

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F 689	Continued From page 5 the two shower chairs, DM-A stated he was not able to identify the name brand or model number to identify what the maintenance schedule was per the manufacturer for these chairs. DM-A identified the facility uses the TELS Preventative Maintenance System for all equipment in the facility; no alerts for repair nor prevented maintenance had been recorded in the system for the shower chair involved in the incident. During an interview on 1/18/23, at 9:54 a.m. the administrator stated an awareness of the R1's fall. The administrator stated NA-A should have used a gait belt for R1's transfers. During an interview on 1/18/23, at 2:30 p.m. LPN-F stated there were no issues with the shower chair prior to R1's fall. LPN-F stated if there was a problem with the shower chair or any equipment concern, the equipment would be removed from service and taken to DM-A's office. LPN-F stated there were other shower chairs in the facility and the nursing assistants would move them around as they needed to so residents received their shower. During an interview on 1/18/23, at 11:10 a.m. the director of nursing (DON) stated it was reported to her that R1 stood up and fell back to the shower chair and began to fall to the floor. NA-A assisted R1 to the floor but R1 did not sustain an injury from the fall. When NA-B picked up the shower chair the cushion fell off and struck R1's RLE and "tore her leg open." The DON stated NA-A did not have a gait belt placed and should have. The DON stated R1 was assessed to require extensive assistants to transfer which required a gait belt to be used. DON stated NA-A knew she should have used a gait but did not;	F 689		

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F 689	Continued From page 6 NA-A also had access to care plan which directed the proper equipment for transfers. After the accident, the DON did not provide re-education to all staff on following care plans and gait belt usage, however, informed all staff the new policy of not transferring residents in the shower rooms due to small size and slip hazard. The facility policy Gait-Transfer Belt Policy & Procedure dated 8/1/15, directed staff to use a transfer/gait belt with transfers.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 1, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: HJLH11

Dear Administrator:

The above facility was surveyed on January 17, 2023 through January 18, 2023 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.

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

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 01/18/2023

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
2 000	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 1/17/23, and 1/18/23, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health. Your facility was found in compliance with the Minnesota State Licensure. The following complaint was unsubstantiated:	2 000		

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2 000	Continued From page 1 H54097428C (MN90035). The following complaint was substantiated: H54097484C (MN89541), with a licensing order issued at 4658.0520 Subp 1. MDH is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	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 use a gait belt during transfer and ensure facility shower chairs were maintained for safety for 1 of 3 residents (R1)	2 830	Corrected.	2/10/23

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2 830	Continued From page 2 reviewed for falls. The facility's failures resulted in actual harm when R1 sustained a fall while being transferred incorrectly, and received a severe skin laceration after her fall when the shower chair seat fell onto her. R1 required transfer to the hospital and 16 stitches. Findings include: A facility Incident Report dated 12/21/22, at 7:53 a.m. indicated on 12/20/22, at 6:45 p.m. nursing assistant (NA)-A reported to licensed practical nurse (LPN)-C that R1 had fallen in shower room and needed assistance. R1 had completed her shower and was independently transferring from the shower chair to the wheelchair when R1's legs gave out, and NA-A assisted R1 to the floor. During the process of assisting R1 to the floor, the shower chair flipped over and landed on top of R1. When NA-B arrived to assist, he lifted the shower chair off of R1 and the seat cushion detached and fell onto R1's right lower extremity (RLE). A sharp metal piece created "a serious skin tear and laceration that appeared quite deep." Due to the large laceration and profuse bleeding, it was deemed necessary to transfer R1 to the emergency department (ED). R1's Face Sheet dated 12/13/22 indicated R1 was admitted to the facility on 12/13/22, for short term rehabilitation. R1's diagnoses included abnormalities of gait and mobility, severe morbid obesity, and metabolic encephalopathy (delirium: confused thinking and disrupted attention). R1's admission Minimum Data Set (MDS) dated 12/19/22, lacked identification of R1's cognitive status. The MDS indicated R1 required extensive assistance of one staff member with transferring and toileting.	2 830		

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2 830	Continued From page 3 R1's care plan dated 12/13/22, indicated R1 had limited physical mobility related to metabolic encephalopathy, obesity, and functional decline. The care plan identified R1 required extensive assist of one staff member for transfers, required a gait belt, and was at moderate risk for falls. Further identified R1 was at risk for skin/wound infection related to large laceration of right lower extremity (RLE) requiring suture repair and antibiotics. R1's late entry FOCUS Note (interdisciplinary meeting note) dated 12/20/2022, at 6:45 p.m. identified the reason for the Interdisciplinary FOCUS Review was R1 had a fall and subsequent skin tear to the right lower shin on 12/20/22, at 6:45 p.m. R1's skin tear required 16 stitches. The note identified R1 required extensive assistance from one staff. New interventions: all staff educated to not complete transfers in shower room. During an interview on 01/18/23, at 10:45 a.m. NA-A stated she was with R1 when she had the fall. NA-A explained she had finished R1's shower, wheeled her over to the "dry area" just past the half-wall. She dried R1 off, applied gripper socks, and wiped the floor with a blanket. NA-A assured the wheelchair brakes were locked, held the back of the shower chair and directed R1 to self-transfer to the wheelchair. NA-A stated she had previously directed R1 to independently walk to her bathroom in her room and did not place a gait belt for support. NA-A stated she had not looked in the care plan or medical record to see how R1 transferred, and she was not aware R1 required a gait belt. NA-A stated she was an agency nursing assistant and did not know the residents well. NA-A stated as R1 was standing,	2 830		

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2 830	Continued From page 4 the chair started sliding backwards. This caused R1 to sit back down hard toward the front of chair. Because she was not all the way back, she started sliding off the front of the chair. NA-A reported R1 was a large lady, she could not keep R1 from falling off the shower chair, but she assisted R1 to the floor. The shower chair then tipped over and landed on top of R1. When the shower chair was picked up and moved by NA-B, the seat fell off, and a sharp metal piece cut R1's RLE. NA-A stated again she had not put a gait belt on R1 to assist with transfers because she did not know R1 needed a gait belt. NA-A had access to the care plan but did not review it before transferring R1. Attempts to contact NA-B on 01/18/23, at 1:06 p.m. and 01/24/23, at 9:22 a.m. were not successful and no return telephone call was received. On 01/22/23, at 7:56 a.m. the facility provided a picture of the broken shower chair and the bottom of the seat cushion. There was approximately eight jagged holes on the bottom of the seat cushion where the mounting brackets had been. The metal brackets that connected the seat to the PVC pipe frame were not pictured. During an observation on 1/18/23, at 12:00 p.m. bath chairs #47 and #101 observed on the floor in service (but not in use at the time), did not have weight stickers, and labels were not legible. During an interview on 1/18/23, at 12:38 p.m. the director of maintenance director (DM)-A stated the facility utilizes the TELS Building Management software system to schedule and track preventive maintenance tasks. DM-A stated the facility performed monthly visual inspections	2 830		

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2 830	Continued From page 5 of the shower chairs. DM-A then logged into the TELS system, and stated monthly shower chair inspections were not included as a task. DM-A stated he would have to enter shower chair inspections as a monthly task, but does not have any documentation of these visual inspections. During an interview on 1/17/23, at 3:05 p.m. family member (FM)-A confirmed R1 was hospitalized and receiving antibiotics. FM-A stated R1 was very confused and did not remember she was in a nursing home when she fell. R1 stated she was at home when she fell. FM-A further stated with R1's confusion, cognitive communication deficit, and being a poor historian, an interview with R1 would not be credible. During an interview on 1/18/23, at 8:50 a.m. DM-A was re-interviewed and stated he had looked at the shower chair after the incident. DM-A stated it looked like there had been rust on the metal mounting brackets of the chair seat. DM-A further stated when R1 fell onto the shower chair, due to her excessive weight, she broke the mounting brackets. DM-A stated the facility did not have manufacturer's user manual due to the shower chair estimated to be greater than ten years old. DM-A stated due to the age of the shower chair and the inability to purchase replacement mounting brackets, the shower chair was thrown away. A new replacement shower chair was just purchased. DM-A identified after the accident, he looked at the other three facility shower chairs but two of the chairs in service did not identify weight restrictions. Due to the age of the two shower chairs, DM-A stated he was not able to identify the name brand or model number to identify what the maintenance schedule was per the manufacturer for these chairs. DM-A identified the facility uses the TELS Preventative	2 830		

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2 830	Continued From page 6 Maintenance System for all equipment in the facility; no alerts for repair nor prevented maintenance had been recorded in the system for the shower chair involved in the incident. During an interview on 1/18/23, at 9:54 a.m. the administrator stated an awareness of the R1's fall. The administrator stated NA-A should have used a gait belt for R1's transfers. During an interview on 1/18/23, at 2:30 p.m. LPN-F stated there were no issues with the shower chair prior to R1's fall. LPN-F stated if there was a problem with the shower chair or any equipment concern, the equipment would be removed from service and taken to DM-A's office. LPN-F stated there were other shower chairs in the facility and the nursing assistants would move them around as they needed to so residents received their shower. During an interview on 1/18/23, at 11:10 a.m. the director of nursing (DON) stated it was reported to her that R1 stood up and fell back to the shower chair and began to fall to the floor. NA-A assisted R1 to the floor but R1 did not sustain an injury from the fall. When NA-B picked up the shower chair the cushion fell off and struck R1's RLE and "tore her leg open." The DON stated NA-A did not have a gait belt placed and should have. The DON stated R1 was assessed to require extensive assistants to transfer which required a gait belt to be used. DON stated NA-A knew she should have used a gait but did not; NA-A also had access to care plan which directed the proper equipment for transfers. After the accident, the DON did not provide re-education to all staff on following care plans and gait belt usage, however, informed all staff the new policy of not transferring residents in the shower rooms	2 830		

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2 830	Continued From page 7 due to small size and slip hazard. The facility policy Gait-Transfer Belt Policy & Procedure dated 8/1/15, directed staff to use a transfer/gait belt with transfers. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. Additionally follow manufacturer's recommendations for routine safety inspections and preventative maintenance. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		