



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 27, 2025

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

RE: CCN: 245409
Cycle Start Date: March 12, 2025

Dear Administrator:

On April 25, 2025, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in blue ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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May 27, 2025

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

Re: Reinspection Results
Event ID: QSIC12

Dear Administrator:

On April 25, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 12, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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March 21, 2025

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

RE: CCN: 245409
Cycle Start Date: March 12, 2025

Dear Administrator:

On March 12, 2025, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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

Edenbrook of Rochester

March 21, 2025

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 June 12, 2025 (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 September 12, 2025 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

Edenbrook of Rochester

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is fluid and cursive, with the first letter of the last name being a large, stylized 'Z'.

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

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

PRINTED: 04/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/12/2025
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 3/10/25, 3/11/25 and 3/12/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H54097769C (MN110782 and MN1100962), with a deficiencies cited at F838, F867 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 838 SS=D	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this	F 838			4/23/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/31/2025

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

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F 838	Continued From page 1 assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and	F 838			

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F 838	Continued From page 2 those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a) (1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets	F 838			

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F 838	Continued From page 3 necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review the facility failed to ensure their Facility Assessment (FA) included resident diagnoses of organ transplant recipients who currently resided in the facility. In addition, the facility assessment failed to identify education on specific care or practices necessary to meet identified care needs regarding organ transplant recipients which had the potential to affect 1 of 1 resident (R1) and all future organ transplant residents reviewed for quality of care.	F 838	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility Assessment will be updated to include resident diagnosis of organ transplant recipients along with identifying education on specific care or practices necessary to meet identified care needs regarding organ transplant recipients. Update to facility assessment will meet		

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F 838	Continued From page 4 Findings include: The "Edenbrook Rochester Requirements of Participation Facility Assessment," revision dated 9/18/24, was reviewed and lacked evidence identifying organ transplant recipients and specific care or practices related to organ rejection monitoring. In addition, the (FA) further lacked training/competencies and provision of care related to organ transplant recipient monitoring, and care services. Record review identified: R1's admission Minimum Data Set (MDS) dated 6/28/24, identified R1 had a diagnosis of Liver transplant and end stage kidney disease. Attempted phone interview completed on 3/11/25 at 12:35 p.m., with the medical director office assistant (MDOA)-A who stated the medical director (MD)-A would be out of the office until 3/17/25. During an interview on 3/11/25 at 1:23 p.m., licensed practical nurse (LPN)-A identified he was the nurse responsible for R1's care. LPN-A stated he had never received any training related to organ transplant recipients and was unaware of the signs and symptoms for liver rejection monitoring. During an interview on 3/11/25 at 1:42 p.m., nurse manager (NM)-A identified she was the nurse manager for R1 and stated she did not remember receiving an education regarding organ transplant recipient care. NM-A stated they did not have any information on R1's liver transplant team and did not know how to get a hold of them.			F 838	this requirement for R1. New admissions diagnosis list will be reviewed for diagnosis of organ transplant or other diagnosis that are not consistent with current resident population. How the facility will identify other residents having the potential to be affected by the same deficient practice. No other residents within the facility are organ transplant recipients and/or other diagnosis that are not consistent with current resident population. . Future organ transplant residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. IDT will be educated on the Facility Assessment Policy and Procedure. The Facility Assessment will be updated to include resident diagnosis of organ transplant recipients along with identifying education on specific care or practices necessary to meet identified care needs regarding organ transplant recipients. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The facility will bring the updated Facility		

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F 838	Continued From page 5 During an interview on 3/11/25 at 3:23 p.m., director of nursing DON) indicated their facility assessment did not identify organ transplant recipient provision of services care or monitoring. DON stated they did not have access to R1's liver transplant team for coordination of care as R1 came from another facility and that information was not in R1's medical records. During an interview on 3/11/25 at 3:28 p.m., regional nurse manager (RNM)-A stated the facility assessment does not identify organ transplant recipients or education regarding provision of care or services. During an interview on 3/11/25 at 3:49 p.m., nurse practitioner (NP)-A stated the facility does not have contact information regarding R1's liver transplant care coordinator. During an interview on 3/11/25, at 4:55 p.m. the Administrator confirmed the facility assessment had not identified organ transplant recipients, and did not indicate specific care or practices related to organ transplant recipient care. During an interview on 3/12/25 at 9:20 a.m., via phone registered nurse liver transplant care coordinator (RNLTCC)-A stated she had wondered what happened to R1 as she had not heard from him in quite some time. RNLTCC-A stated with liver transplant recipients it is very important to be monitoring for liver rejection signs and symptoms, ensure anti-rejection medications are given daily, and will need routine monitoring of labs and ultrasounds of the liver. A policy for facility assessment was requested,			F 838	Assessment to QAPI for review and approval. IDT will audit new admissions diagnosis list, reviewed for diagnosis of organ transplant or other diagnosis that are not consistent with current resident population. Audits will be completed for 30 days and reviewed by QAPI to evaluate the need for continuation. Person responsible: Administrator or designee		

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F 838	Continued From page 6	F 838			
F 867	QAPI/QAA Improvement Activities	F 867			4/23/25
SS=F	CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to				

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F 867	Continued From page 7 adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse	F 867			

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F 867	Continued From page 8 resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility's Quality Assurance Performance	F 867			
			How corrective action will be accomplished for those residents found to		

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F 867	Continued From page 9 Improvement (QAPI) committee failed to identify, investigate, analyze, and respond to medication errors by developing and implementing action plans for process improvement. This had the potential to affect all 50 residents who resided in the facility. Findings include: Review of the facility Quality Assessment Performance Improvement Committee Agenda Minutes in conjunction with Medication Error reports from December 2024 to February 2025. The QA minutes were not all dated nor identify which members of the committee were present. The Medication Error reports were identified in QA however, the reports did not consistently include a causal analysis/investigation, nor measures developed and implemented to prevent reoccurrence. The Quality Assessment Performance Improvement Committee Agenda/Minutes were reviewed and did not identify the date or time of the meeting, nor did it identify who the members were of the committee who attended. Further the QA minutes consistently did not address specific action plans to decrease the medication error rates. January minutes: The facility's "Quality Assessment Performance Improvement Committee Agenda Minutes," form did not identify the date of the meeting nor quality members who were in attendance. The form identified Medication Errors as a topic to review and analyze. A goal for medication errors was not identified. In the section Current trends vs Historical Trends, Goals, included "1 medication error in December 2024, down from 6 medication errors in November 2024 due to tracking	F 867	have been affected by the deficient. IDT educated on the QAPI Policy and Procedure and requirements for documentation, data analysis, root cause analysis and the creation of process improvement plan. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Review of QAPI policy and Procedure with no changes In general, the QAA Committee will be fully educated on the QAPI Policy and Procedure and requirements for documentation, data analysis, root cause analysis and the creation of process improvement plan. All areas of QAPI were reviewed to ensure the completeness of data and analysis are documented. Review of tracking logs for each area were reviewed and updated as needed. Including but not limited to Fall, Wounds, Medication errors. A new tracking log for medication errors was developed to assist with analyzing all information.		

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F 867	Continued From page 10 medication not available from house stock or pharmacy. Process followed to notify provider and placing medication on hold when not available or getting medication delivered stat." The data collected for analysis included: The undated Agenda minutes identified for December 2024 the facility had one medication error: R17's medication was not available from the pharmacy due to it being a special-order medication, family provided the medication and did not include measures to prevent reoccurrence. February minutes: The facility's "Quality Assessment Performance Improvement Committee Agenda Minutes," form did not identify the date of the meeting nor quality members who were in attendance. The form identified Medication Errors as a topic to review and analyze. A goal for medication errors was not identified. In the section Current trends vs Historical Trends, Goals, included "5 medication errors in January 2025, up from one medication error in December 2024, due to tracking medication not available from house stock or pharmacy. Process followed to notify provider and placing medication on hold when not available or getting medication delivered stat. Two transcription errors, one entered as twice a day was ordered daily, one entered as self-administered instead of staff to administer, one medication not delivered from the pharmacy as new regulation state dialysis needs to supply, one over the counter eye drop not delivered due to a weather delay of ordered supplies, one resident was a readmit. one medication not delivered until night run and one medication were not sent at all." The section "Historical Actions	F 867	Specifically, QAA Committee will develop and implement an action plan for the collection of medication error data and investigating, analyzing and performing root cause analysis of all medication error as well as developing a performance improvement plan identified errors and responding to all reported medication errors for the past 30 days. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. An audit on discontinued medications was completed for the period of 01/7/2025 to 02/19/2025 for accuracy. Ongoing Audits will be performed weekly for 4 weeks and ongoing until substantial compliance is met as determined by QAPI. Additionally, all medication errors will be tracked and analyzed via QAPI committee. Identified errors and issues will be addressed through the process improvement plan. Meeting minutes will be audited for substantial compliance to the adherence of the QAPI Policy and Procedure. Results and analysis of these audits will be brought to the Corporate Compliance Officer for determination of substantial compliance and further review as needed. Person responsible: Administrator or designee		

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F 867	Continued From page 11 taken/New Action Plans/Steps," was left blank and did not identify who was responsible for the action step, did not specify what component of medication errors was being monitored daily at stand-up, nor specific activities associated with decreasing medication errors associated with types of medication errors that were identified in the report. The data collected for analysis included: Review of January 2025 Medication Error reports identified a total of five medication errors from 5 residents: 1. R4's Medication Error report dated 1/16/25 at 10:48 a.m., identified R4 received prophylactic Tamiflu 75 milligrams (mg) once daily for two weeks. Resident was receiving Tamiflu 75 MG BID (twice a day) for last eight days. Provider was updated and will discontinue Tamiflu as R4 has received adequate doses of prophylactic Tamiflu.R4 has not no adverse reactions from medication being given BID. Reviewed by IDT team. R4 had no adverse reaction. Medication was discontinued, provider stated he had sufficient medication for prophylaxis. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the error nor any education for retraining. The report is unclear as to how many extra doses R4 received. 2. R16's Medication Error report dated 1/20/25 at 11:47 a.m., identified R16 missed Sevelamer Carbonate (medication to reduce phosphorus levels in dialysis patients) on 1/17/25 at 8:00 a.m., 1/18/25 at 8:00 a.m., 12:00 p.m., and 5:00 p.m. doses. Omnicare contacted they stated that they do not supply this medication, stating that dialysis			F 867			

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F 867	Continued From page 12 is responsible. Dialysis notified of missed medication by assigned nurse on 1/18/25. This resident did not receive his 8:00 a.m., or 11:00 a.m., dose of Sevelamer Carbonate today before dialysis. The facility has no more on cards and this medication is not kept in the Omnicell. Writer called Omnicare to ask them about this and they said that this medication is not covered under insurance for R16 and they also said that it must be ordered through Dialysis. Writer then called Dialysis who stated that this does not create a problem that R16 did not get it today as it only means that the phosphorus will excrete via his bowel movements versus urination. Fax sent to Mayo Clinic Nursing Home office as well. Reviewed by IDT. Omnicare pharmacy stated they no longer supply this medication due to it being a non-covered med and that dialysis is responsible for it. Dialysis team notified. Dialysis ordered medication for resident to pick up from Mayo pharmacy. R16 was able to pick up medication and facility has it in stock to be administered. The report did not include measures to prevent reoccurrence for other dialysis patients. The report did not identify who made the errors nor any education for retraining. This would be six missed doses which reflects six medication errors. 3. R15's Medication Error report dated 1/20/25 at 11:47 a.m., identified R15's over the counter (OTC) medication Muro eye drops (an eye drop used to treat corneal edema) TID (three times a day) administration missed from 1/14/25 - 1/20/25. Reviewed by IDT. Medication has been ordered. Supply has been delayed due to weather in the states that supply warehouses are located. Attempted to locate medication at a local pharmacy, none of them carry this medication.	F 867			

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F 867	Continued From page 13 Awaiting supply. 1/23/2025 Medication placed on hold and supply ordered via Amazon. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the error nor any education for retraining. This would be twenty-one missed doses which reflects twenty-one medication errors. 4. R14's Medication Error report dated 1/20/25 at 11:52 a.m., identified R14 missed Advair (inhaled medication to prevent flare-ups or worsening of chronic obstructive pulmonary disease) AM and PM on 1/17/25 to 1/19/25 indicating 6 missed doses. In addition, R14 missed Erythromycin Ophthalmic ointment (ointment used to treat eye infections) on 1/17/25. R14 was readmitted to the facility 1/17/2025. Erythromycin Ophthalmic ointment was a new medication and was delivered on the night run. Advair was not delivered. Reviewed by IDT. R14 readmitted to the facility on 1/17/2025. Erythromycin Ophthalmic ointment was a new medication and was delivered on the night run. Medication start date should have been the following day. Advair was not delivered. Pharmacy was contacted on 1/18/25 at 8:00 a.m., they stated Advair would be delivered on the run tonight. Pharmacy did not deliver Advair until 1/19/2025 at 9:33 pm. R14 had no adverse effects from missing doses. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the errors nor any education for retraining. This would be seven missed doses which reflects seven medication errors. 5. R3's Medication Error report dated 1/27/25 at 8:00 a.m., identified R3's Heparin (blood thinner)	F 867			

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F 867	Continued From page 14 order appears on MAR as completed as transcribed as self-med. No medication was administered by staff. Does not identify how many missed doses. Reviewed by IDT. R3 had no adverse reaction from missing doses. Order was corrected in the computer. Review of R3's MAR dated January 2025, identified R3 had nine omitted doses of heparin from 1/24/25 to 1/27/25 resulting in 9 medication errors. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the error nor any education for retraining. The report did not identify who made the errors nor any education for retraining. This would be nine missed doses which reflects nine medication errors. After reviewing the facility's data analysis from the medication error reports for January 2025, the medication error rate would be 44 medication errors and not 5 medication errors with a difference of 39 medication errors that were not brought forward to quality assurance. Review of Medication errors dated February 2025, the facility identified 12 medication errors however review of medication error reports identified 42 medication errors, a difference of 30 medication errors that were not accounted for. During an interview on 3/11/25 at 2:42 p.m., director of nursing stated the facility department heads meet monthly for QAPI meetings. DON indicated at each monthly meeting they will discuss medication errors from the previous month. DON verified the QAPI notes from February 2025 identified six medication errors and the error rate was up 5 medication errors from the previous month. DON verified there was	F 867			

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F 867	Continued From page 15 no new action plan in place to prevent future medication errors. DON further verified February 2025 medication errors increased to twelve, up seven from the previous month. DON stated they had not been tracking each omitted medication as one error rather identified if a resident who had several omitted doses as one error. DON indicated they had not completed an analysis of the February medication errors as they had not had their QAPI meeting for March yet, so no action plan was put in place to prevent future medication errors. During an interview on 3/11/25 at 3:49 p.m., nurse practitioner (NP)-A stated one omitted medication would be counted as one medication error and facility should be identifying this, should be analyzing for trends in medication errors to put prevention plans in place to prevent future medication errors. The facility policy, "QAPI Policy and Procedure," updated 5/5/24, identified It is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life and residents' choice and is based on the scope and complexity of services defined by the Facility Assessment. The objective of this requirement is the completion and implementation of the QAPI plan to identify the high risk, problem prone and high volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristic and needs of the residents ... PROCEDURE: 1. The facility will develop, implement, and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. 2. The plan describes the process	F 867			

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F 867	Continued From page 16 for identifying and correcting quality deficiencies and contains the necessary components such as: a. Tracking and measure performance; b. Establishing goals and thresholds for performance measurement; c. Identifying and prioritizing quality deficiencies; d. Systematically analyzing underlying causes of systemic quality deficiencies; e. Developing and implementing corrective action or performance improvement activities; and f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. 3. The facility maintains documentation and can demonstrate evidence that the program meets CMS requirements. 4. The facility presents evidence in the form of documentation to substantiate the ongoing implementation and QAPI program compliance with regulations to the State Survey Agency, Federal Surveyor or CMS if requested. 5. The Quality Assessment and Assurance Committee consists at a minimum of: a. The director of nursing services; b. The Medical Director or his/her designee; c. At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and d. The infection Preventionist - effective November 28, 2019 ... 4. Our QAPI plan includes the policies and procedures used to i. Identify and use data to monitor our performance ii. Establish goals and thresholds for our performance measurement iii. Utilize resident, staff and family input iv. Identify and prioritize problems and opportunities for improvement v. Systematically analyze underlying causes of systemic problems and adverse events vi. Develop corrective action or performance improvement activities ... Guidelines for Performance Improvement Projects (PIPs). Identified PIPs will be the center	F 867			

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F 867	Continued From page 17 of the QAPI program. Identified areas of improvement will stay as focal issues until desired outcomes have been achieved. If the measures of interventions implemented are not delivering results, the details will need to be adjusted either at the quarterly, preferably monthly, meeting or sooner as appropriate. Once achieved they will be maintained and discussed routinely, however new focal points or PIPs will be introduced. Performance improvement activities must track medical errors and adverse resident events, analyze causes, and implement preventative actions and mechanisms that include feedback and learning throughout the facility. Responsibility and Accountability The administrator has responsibility and is accountable to the governing body and our corporation for ensuring that QAPI is implemented throughout our organization. QAPI activities and discussion will be a standing item on our regular governing body meeting agendas. The administrator will, report on and solicit input on all QAPI activities on a regular basis. The administrator is responsible for assuring that all QAPI activities and required documentation is provided to our corporation ... Conducting Performance Improvement Projects (PIPs) Our organization will conduct Performance Improvement Projects that are designed to take a systematic approach to revise and improve care or services in areas that we identify as needing attention. We will conduct PIPS that will lead to changes and guide corrective actions in our systems, which cross multiple departments, and have impact on the quality of life and quality of care for residents living in our community. We will conduct PIPs that will improve care and service delivery, increase efficiencies, lead to improved staff and resident outcomes, and lead to greater staff, resident, and family satisfaction. An			F 867			

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F 867	Continued From page 18 important aspect of our PIPs is a plan to determine the effectiveness of our performance improvement activities and whether the improvement is sustained. Method to Identify Potential Topics for PIPs The QAA committee will review data and input on a quarterly, preferably monthly, basis to look for potential topics for PIPs. We will monitor and analyze data, and review feedback and input from residents, staff, families, volunteers, providers, and stakeholders. We will look at issues, concerns, and areas that need improvement as well as areas that will improve the quality of life and quality of care and services for the residents living and staying in our community. Factors we will consider: high-risk, high-volume, or problem-prone areas that affect health outcomes, quality of care and services, and areas that affect staff. In addition, we will consider: o Existing standards or guidelines that are available to provide direction for the PIP o Measures that can be used to monitor progress o Quality Measures publically reported on Nursing Home Compare o Evidence based practices o Projects that require systemic changes o Projects that require environmental changes o Projects affecting staff Criteria for Prioritizing and Selecting PIPs Our QAA committee will prioritize topics for PIPS based on the current needs of the residents and our organization. Priority will be given to areas we define as high-risk to residents and staff, high-prevalence, or high-volume areas, and areas that are problem-prone. The QAA committee will use the CMS Prioritizing Worksheet for Performance Improvement Projects to prioritize PIPs. Consideration will be given to include staff most affected by the PIP. Anticipated training needs will be discussed as well as other resources to complete the PIP. The QAA committee will provide guidance on how to	F 867			

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F 867	Continued From page 19 address issues that arise and need immediate corrective action. How and When PIP Charters Will be Developed A project charter will be developed for each Performance Improvement Project at the beginning of the project that clearly establishes the goals, scope, timing, milestones, team roles, and responsibilities. The PIP charter will be developed by the QAA committee and then will be given to the team that will carry out the PIP. Designating a PIP Team When designating a PIP team, the QAA committee will consider and give opportunity to all staff in the organization. The QAA committee will ensure that the team is interdisciplinary, there is representation from each job role that is affected by the project, and resident and/or family member representation is included, if appropriate. When chosen to participate on a PIP team, staff with direct care responsibilities will be replaced so that the needs of residents continue to be met. A team leader will be selected that has the ability to coordinate, organize, and direct the work. How the Team will Conduct the PIP: The PIP teams will consider each PIP a learning process. The team will follow steps and processes that are needed for any quality improvement project. The responsibilities for the PIP teams will be to determine what information is needed for the PIP and how to obtain the information. They will determine a timeline based on the PIP Charter. Requests for needed supplies, staff availability, and equipment will be made to the QAA committee. The QAA committee will respond in a timely manner to assure momentum is maintained. The team will develop an action plan using the organization's usual format. Interventions that will make change will be implemented by the team. The team will use root cause analysis to ensure that the root cause and contributing factors are identified.	F 867			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/12/2025
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 867	Continued From page 20 When determining and implementing interventions, PDSA cycles will be used. The team will select and/or create measurement tools to ensure that the changes they are implementing are having the desired effect team will be accountable to the QAA committee. Process for Documenting and Communicating Performance Improvement and Trends in Performance Measures: For ongoing monitoring of the PIP, we will use the CMS PIP Inventory to include milestones, PDSAs, outcomes, and other lessons learned from the PIP. Information about PIPs will be shared with staff, resident, and families. Systemic Approach to Quality Improvement: Our facility uses a systematic approach to determine when in-depth analysis is needed to fully understand identified problems, causes of the problems, and implications of a change. To get at the underlying cause(s) of issue, we bring teams together to identify the root cause and contributing factors using the Five Whys, Flowcharting, and the Fishbone Diagram. Preventing Future Events and Promoting Sustained Improvement To prevent future events and promote sustained improvement our organization develops actions to address the identified root cause and/or contributing factors of an issue/event that will affect change at the systems level. We use Plan-Do-Study-Act cycles to test actions and recognize and address "unintended" consequences of planned changes. Ensuring Planned Changes/Interventions are Implemented and Effective To ensure the planned changes/interventions are implemented and effective in making and sustaining improvements, our organization chooses indicators/measures that tie directly to the new action and conducts ongoing periodic measurement and review to ensure that the new action has been adopted and	F 867			

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F 867	Continued From page 21	F 867			
F 880	Infection Prevention & Control	F 880			4/23/25
SS=D	CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions				

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F 880	Continued From page 22 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP)-(an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented for management of an indwelling catheter to reduce	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient. Staff will be educated on enhanced barrier policy and procedures to regain full compliance with regulations.		

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F 880	Continued From page 23 the risk of infection to others for 1 of 1 resident (R1) reviewed for quality of care. Findings include: R1's face sheet identified diagnoses of obstructive and reflux uropathy and need of assistance with personal cares. R1's order summary dated 6/19/24, identified R1 had an order to provide catheter care every shift, ensure catheter is anchored via Velcro or tape. R1's care plan revised 8/2/24, identified a focus of actual/potential for alteration in elimination related to obstructive and reflux uropathy ...goal identified will have no signs and symptoms of infection after completion of treatment through next review. Intervention dated 6/20/24 identified to change Foley catheter as ordered and monitor/document/report signs and symptoms of UTI: abdominal pain, weakness, functional decline, nausea, vomiting, dark cloudy urine, blood in urine and pus in urine. Did not identify EBP precautions. An additional focus revised 2/18/25 identified a focus related to renal failure due to end stage renal disease and had fistula created, waiting for fistula to mature, no start date for dialysis, does not want dialysis initiated. Intervention dated 7/2/24 identified to use enhanced barrier precautions. Care plan does not identify what cares identify the need for EBP nor does the foley catheter identify the need for EBP. During an observation and interview on 3/11/25 at 1:16 p.m., upon entrance to R1's room a paper sign was hung on the wall to the right side of R2's door. Two, "STOP" signs noted at the top on			F 880	How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Review of Enhanced Barrier Precautions Policy and Procedure with no changes. Staff will be educated on the facility policy Enhanced Barrier Precautions. With the emphasize Identification of when to use gown, gloves and proper hand washing. Residents reviewed to ensure that Enhanced Barrier Precautions are in place as required. Residents with Enhanced Barrier Precautions reviewed and assessed for continued requirement of precautions and care plan accuracy. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The facility will complete audits 3 times a week for 4 weeks, weekly times 4 weeks specific to staff adherence to Enhanced Barrier Precautions infection prevention practices. Results of the audits will be brought to QAPI for review and determination of ongoing audits.		

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F 880	Continued From page 24 either side. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person." The sign also had color pictures of hand cleanser, gloves, and gown. During an interview on 3/11/25 at 1:23 p.m., licensed practical nurse (LPN)-A verified R1's catheter was lying on the floor and should not be related to infection control concerns. During an observation on 3/12/25 at 10:10 a.m., R1 was lying in bed and his catheter bag was hooked to the bed control cord and the bottom of the catheter bag was lying on the floor. At 2:17 p.m., NA-A verified the catheter bag was lying on the floor and should not be. NA-A stated he would have to find a catheter bag covering to put it in. At 10:19 a.m., LPN-A verified the catheter bag was lying on the floor, walked into R1's room with washing his hands and picked up the catheter bag without applying EBP per the room signage and hooked the catheter to the bed. LPN-A then picked up R1's breakfast tray and walked out of the room without washing his hands, walked down the hall, set the breakfast tray on the cart in between the east and west hallways, then proceeded to walk down the hall. LPN-A stated R1 should be on EBP precautions due to his	F 880	Person responsible: Director of Nursing or designee		

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F 880	Continued From page 25 Foley catheter and fistula and stated he should have used them in addition to washing his hands before and after entering/leaving the room. During an interview on 3/12/25 at 10:26 a.m., director of nursing DON stated staff should be using EBP's when touching R1's catheter bag. All residents with EBP have a sign clearly posted outside their room and staff should be looking for that and following our policy for EBP to help prevent the spread of infection. DON further stated staff should be washing hands prior to entrance of a room, after leaving a resident's room and between glove changes. DON stated not following EBP would be an infection control issue. Facility policy, "enhance Barrier Precautions," dated 3/6/24, identified it is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with chronic wounds requiring a dressing, indwelling medical devices or residents with "infection or colonization with an MDRO" 1. "Enhanced Barrier Precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Enhanced Barrier Precautions will not only focus on residents with infection or colonization with MDRO's but will also address residents at risk for developing or becoming colonized. Enhanced Barrier Precautions are precautions that are between Standard Precautions and Contact Precautions.			F 880			

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F 880	Continued From page 26 Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities. Novel or Targeted MDROs include: "Pan-resistant organisms Carbapenem's-producing carbapenem-resistant Enterobacter ales, carbapenems-producing carbapenem-resistant Pseudomonas spp., carbapenems-producing carbapenem-resistant Acinetobacter baumannii, and Candida auris"1Additional MDROs that are epidemiologically important include: "Methicillin-resistant Staphylococcus aureus (MRSA), ESBL-producing Enterobacterales, Vancomycin-resistant Enterococci (VRE),Multidrug-resistant Pseudomonas aeruginosa, Drug-resistant Streptococcus pneumoniae. "The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-Contact Resident Care Activities include1: Policy & Procedure: Enhanced Barrier Precautions: Dressing, Bathing/showering, Transferring, providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care: any skin opening requiring a dressing"1. Standard Precautions should be applied to all residents at all times. 2. Transmission-based precautions should be applied to all residents when standard precautions alone do not prevent pathogen transmission. 3. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide	F 880			

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F 880	Continued From page 27 opportunities for transfer of MDROs to staff hands and clothing. A. EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. b. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. c. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. d. EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. 4. Post clear signage on the door/wall outside resident room a. Type of precautions i. Contact Link: Contact Precaution sign ii. Droplet Link: Droplet Precaution sign iii. Airborne Link: Airborne Precaution sign iv. Enhanced Barrier Precautions Link: EBP Sign 5. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: 1. Dressing 2. Bathing/showering 3. Transferring 4. Providing hygiene 5. Changing linens 6. Changing briefs or assisting with toileting 7. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator 8. Wound care: any skin opening requiring a dressing" 1 ii. In general, gowns and gloves would not be recommended when performing transfers in common areas such			F 880			

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F 880	Continued From page 28 as dining or activity rooms, where contact is anticipated to be shorter in duration. Outside the resident's room, EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. iii. Residents are not restricted to their rooms or limited from participation in group activities. Because EBP do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 6. Facility will ensure PPE and alcohol-based hand rub are readily accessible to staff. 7. Communication and education will be provided to all staff caring for or entering resident room for directions. 8. The Infection Preventionist may consult Public Health when needed for additional decisions regarding practices to prevent the spread of MDROs. Requested a handwashing policy and was not received.	F 880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 21, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: QSIC11

Dear Administrator:

The above facility was surveyed on March 10, 2025, through March 12, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Edenbrook Of Rochester

March 21, 2025

Page 2

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

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

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

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

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

Please feel free to call me with any questions.



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

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/10/25, 3/11/25 and 3/12/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

03/31/25

Minnesota Department of Health

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54097769C (MN110782 and MN1100962) with licensing orders issued at 0255, 1390 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000			

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility's Quality Assurance Performance Improvement (QAPI) committee failed to identify, investigate, analyze, and respond to medication errors by developing and implementing action plans for process improvement. This had the potential to affect all 50 residents who resided in the facility.	2 255	Corrected		4/23/25

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2 255	Continued From page 3 Findings include: Review of the facility Quality Assessment Performance Improvement Committee Agenda Minutes in conjunction with Medication Error reports from December 2024 to February 2025. The QA minutes were not all dated nor identify which members of the committee were present. The Medication Error reports were identified in QA however, the reports did not consistently include a causal analysis/investigation, nor measures developed and implemented to prevent reoccurrence. The Quality Assessment Performance Improvement Committee Agenda/Minutes were reviewed and did not identify the date or time of the meeting, nor did it identify who the members were of the committee who attended. Further the QA minutes consistently did not address specific action plans to decrease the medication error rates. January minutes: The facility's "Quality Assessment Performance Improvement Committee Agenda Minutes," form did not identify the date of the meeting nor quality members who were in attendance. The form identified Medication Errors as a topic to review and analyze. A goal for medication errors was not identified. In the section Current trends vs Historical Trends, Goals, included "1 medication error in December 2024, down from 6 medication errors in November 2024 due to tracking medication not available from house stock or pharmacy. Process followed to notify provider and placing medication on hold when not available or getting medication delivered stat." The data collected for analysis included: The undated Agenda minutes identified for December 2024 the facility had one medication	2 255			

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2 255	Continued From page 4 error: R17's medication was not available from the pharmacy due to it being a special-order medication, family provided the medication and did not include measures to prevent reoccurrence. February minutes: The facility's "Quality Assessment Performance Improvement Committee Agenda Minutes," form did not identify the date of the meeting nor quality members who were in attendance. The form identified Medication Errors as a topic to review and analyze. A goal for medication errors was not identified. In the section Current trends vs Historical Trends, Goals, included "5 medication errors in January 2025, up from one medication error in December 2024, due to tracking medication not available from house stock or pharmacy. Process followed to notify provider and placing medication on hold when not available or getting medication delivered stat. Two transcription errors, one entered as twice a day was ordered daily, one entered as self-administered instead of staff to administer, one medication not delivered from the pharmacy as new regulation state dialysis needs to supply, one over the counter eye drop not delivered due to a weather delay of ordered supplies, one resident was a readmit. one medication not delivered until night run and one medication were not sent at all." The section "Historical Actions taken/New Action Plans/Steps," was left blank and did not identify who was responsible for the action step, did not specify what component of medication errors was being monitored daily at stand-up, nor specific activities associated with decreasing medication errors associated with types of medication errors that were identified in the report.	2 255			

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2 255	Continued From page 5 The data collected for analysis included: Review of January 2025 Medication Error reports identified a total of five medication errors from 5 residents: 1. R4's Medication Error report dated 1/16/25 at 10:48 a.m., identified R4 received prophylactic Tamiflu 75 milligrams (mg) once daily for two weeks. Resident was receiving Tamiflu 75 MG BID (twice a day) for last eight days. Provider was updated and will discontinue Tamiflu as R4 has received adequate doses of prophylactic Tamiflu.R4 has not no adverse reactions from medication being given BID. Reviewed by IDT team. R4 had no adverse reaction. Medication was discontinued, provider stated he had sufficient medication for prophylaxis. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the error nor any education for retraining. The report is unclear as to how many extra doses R4 received. 2. R16's Medication Error report dated 1/20/25 at 11:47 a.m., identified R16 missed Sevelamer Carbonate (medication to reduce phosphorus levels in dialysis patients) on 1/17/25 at 8:00 a.m., 1/18/25 at 8:00 a.m., 12:00 p.m., and 5:00 p.m. doses. Omnicare contacted they stated that they do not supply this medication, stating that dialysis is responsible. Dialysis notified of missed medication by assigned nurse on 1/18/25. This resident did not receive his 8:00 a.m., or 11:00 a.m., dose of Sevelamer Carbonate today before dialysis. The facility has no more on cards and this medication is not kept in the Omnicell. Writer called Omnicare to ask them about this and they said that this medication is not covered under insurance for R16 and they also said that it must be ordered through Dialysis. Writer then called	2 255			

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2 255	Continued From page 6 Dialysis who stated that this does not create a problem that R16 did not get it today as it only means that the phosphorus will excrete via his bowel movements versus urination. Fax sent to Mayo Clinic Nursing Home office as well. Reviewed by IDT. Omnicare pharmacy stated they no longer supply this medication due to it being a non-covered med and that dialysis is responsible for it. Dialysis team notified. Dialysis ordered medication for resident to pick up from Mayo pharmacy. R16 was able to pick up medication and facility has it in stock to be administered. The report did not include measures to prevent reoccurrence for other dialysis patients. The report did not identify who made the errors nor any education for retraining. This would be six missed doses which reflects six medication errors. 3. R15's Medication Error report dated 1/20/25 at 11:47 a.m., identified R15's over the counter (OTC) medication Muro eye drops (an eye drop used to treat corneal edema) TID (three times a day) administration missed from 1/14/25 - 1/20/25. Reviewed by IDT. Medication has been ordered. Supply has been delayed due to weather in the states that supply warehouses are located. Attempted to locate medication at a local pharmacy, none of them carry this medication. Awaiting supply. 1/23/2025 Medication placed on hold and supply ordered via Amazon. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the error nor any education for retraining. This would be twenty-one missed doses which reflects twenty-one medication errors. 4. R14's Medication Error report dated 1/20/25 at 11:52 a.m., identified R14 missed Advair (inhaled	2 255			

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2 255	Continued From page 7 medication to prevent flare-ups or worsening of chronic obstructive pulmonary disease) AM and PM on 1/17/25 to 1/19/25 indicating 6 missed doses. In addition, R14 missed Erythromycin Ophthalmic ointment (ointment used to treat eye infections) on 1/17/25. R14 was readmitted to the facility 1/17/2025. Erythromycin Ophthalmic ointment was a new medication and was delivered on the night run. Advair was not delivered. Reviewed by IDT. R14 readmitted to the facility on 1/17/2025. Erythromycin Ophthalmic ointment was a new medication and was delivered on the night run. Medication start date should have been the following day. Advair was not delivered. Pharmacy was contacted on 1/18/25 at 8:00 a.m., they stated Advair would be delivered on the run tonight. Pharmacy did not deliver Advair until 1/19/2025 at 9:33 pm. R14 had no adverse effects from missing doses. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the errors nor any education for retraining. This would be seven missed doses which reflects seven medication errors. 5. R3's Medication Error report dated 1/27/25 at 8:00 a.m., identified R3's Heparin (blood thinner) order appears on MAR as completed as transcribed as self-med. No medication was administered by staff. Does not identify how many missed doses. Reviewed by IDT. R3 had no adverse reaction from missing doses. Order was corrected in the computer. Review of R3's MAR dated January 2025, identified R3 had nine omitted doses of heparin from 1/24/25 to 1/27/25 resulting in 9 medication errors. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the error nor	2 255			

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2 255	Continued From page 8 any education for retraining. The report did not identify who made the errors nor any education for retraining. This would be nine missed doses which reflects nine medication errors. After reviewing the facility's data analysis from the medication error reports for January 2025, the medication error rate would be 44 medication errors and not 5 medication errors with a difference of 39 medication errors that were not brought forward to quality assurance. Review of Medication errors dated February 2025, the facility identified 12 medication errors however review of medication error reports identified 42 medication errors, a difference of 30 medication errors that were not accounted for. During an interview on 3/11/25 at 2:42 p.m., director of nursing stated the facility department heads meet monthly for QAPI meetings. DON indicated at each monthly meeting they will discuss medication errors from the previous month. DON verified the QAPI notes from February 2025 identified six medication errors and the error rate was up 5 medication errors from the previous month. DON verified there was no new action plan in place to prevent future medication errors. DON further verified February 2025 medication errors increased to twelve, up seven from the previous month. DON stated they had not been tracking each omitted medication as one error rather identified if a resident who had several omitted doses as one error. DON indicated they had not completed an analysis of the February medication errors as they had not had their QAPI meeting for March yet, so no action plan was put in place to prevent future medication errors.	2 255			

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2 255	Continued From page 9 During an interview on 3/11/25 at 3:49 p.m., nurse practitioner (NP)-A stated one omitted medication would be counted as one medication error and facility should be identifying this, should be analyzing for trends in medication errors to put prevention plans in place to prevent future medication errors. The facility policy, "QAPI Policy and Procedure," updated 5/5/24, identified It is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life and residents' choice and is based on the scope and complexity of services defined by the Facility Assessment. The objective of this requirement is the completion and implementation of the QAPI plan to identify the high risk, problem prone and high volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristic and needs of the residents ... PROCEDURE: 1. The facility will develop, implement, and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. 2. The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as: a. Tracking and measure performance; b. Establishing goals and thresholds for performance measurement; c. Identifying and prioritizing quality deficiencies; d. Systematically analyzing underlying causes of systemic quality deficiencies; e. Developing and implementing corrective action or performance improvement activities; and f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. 3. The facility maintains documentation and can demonstrate evidence that the program meets	2 255			

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2 255	Continued From page 10 CMS requirements. 4. The facility presents evidence in the form of documentation to substantiate the ongoing implementation and QAPI program compliance with regulations to the State Survey Agency, Federal Surveyor or CMS if requested. 5. The Quality Assessment and Assurance Committee consists at a minimum of: a. The director of nursing services; b. The Medical Director or his/her designee; c. At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and d. The infection Preventionist - effective November 28, 2019 ... 4. Our QAPI plan includes the policies and procedures used to i. Identify and use data to monitor our performance ii. Establish goals and thresholds for our performance measurement iii. Utilize resident, staff and family input iv. Identify and prioritize problems and opportunities for improvement v. Systematically analyze underlying causes of systemic problems and adverse events vi. Develop corrective action or performance improvement activities ... Guidelines for Performance Improvement Projects (PIPs). Identified PIPs will be the center of the QAPI program. Identified areas of improvement will stay as focal issues until desired outcomes have been achieved. If the measures of interventions implemented are not delivering results, the details will need to be adjusted either at the quarterly, preferably monthly, meeting or sooner as appropriate. Once achieved they will be maintained and discussed routinely, however new focal points or PIPs will be introduced. Performance improvement activities must track medical errors and adverse resident events, analyze causes, and implement preventative actions and mechanisms that include feedback and learning throughout the facility. Responsibility and Accountability The administrator has	2 255			

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2 255	Continued From page 11 responsibility and is accountable to the governing body and our corporation for ensuring that QAPI is implemented throughout our organization. QAPI activities and discussion will be a standing item on our regular governing body meeting agendas. The administrator will, report on and solicit input on all QAPI activities on a regular basis. The administrator is responsible for assuring that all QAPI activities and required documentation is provided to our corporation ... Conducting Performance Improvement Projects (PIPs) Our organization will conduct Performance Improvement Projects that are designed to take a systematic approach to revise and improve care or services in areas that we identify as needing attention. We will conduct PIPS that will lead to changes and guide corrective actions in our systems, which cross multiple departments, and have impact on the quality of life and quality of care for residents living in our community. We will conduct PIPs that will improve care and service delivery, increase efficiencies, lead to improved staff and resident outcomes, and lead to greater staff, resident, and family satisfaction. An important aspect of our PIPs is a plan to determine the effectiveness of our performance improvement activities and whether the improvement is sustained. Method to Identify Potential Topics for PIPs The QAA committee will review data and input on a quarterly, preferably monthly, basis to look for potential topics for PIPs. We will monitor and analyze data, and review feedback and input from residents, staff, families, volunteers, providers, and stakeholders. We will look at issues, concerns, and areas that need improvement as well as areas that will improve the quality of life and quality of care and services for the residents living and staying in our community. Factors we will consider: high-risk, high-volume, or problem-prone areas that affect	2 255			

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2 255	Continued From page 12 health outcomes, quality of care and services, and areas that affect staff. In addition, we will consider: o Existing standards or guidelines that are available to provide direction for the PIP o Measures that can be used to monitor progress o Quality Measures publically reported on Nursing Home Compare o Evidence based practices o Projects that require systemic changes o Projects that require environmental changes o Projects affecting staff Criteria for Prioritizing and Selecting PIPs Our QAA committee will prioritize topics for PIPS based on the current needs of the residents and our organization. Priority will be given to areas we define as high-risk to residents and staff, high-prevalence, or high-volume areas, and areas that are problem-prone. The QAA committee will use the CMS Prioritizing Worksheet for Performance Improvement Projects to prioritize PIPs. Consideration will be given to include staff most affected by the PIP. Anticipated training needs will be discussed as well as other resources to complete the PIP. The QAA committee will provide guidance on how to address issues that arise and need immediate corrective action. How and When PIP Charters Will be Developed A project charter will be developed for each Performance Improvement Project at the beginning of the project that clearly establishes the goals, scope, timing, milestones, team roles, and responsibilities. The PIP charter will be developed by the QAA committee and then will be given to the team that will carry out the PIP. Designating a PIP Team When designating a PIP team, the QAA committee will consider and give opportunity to all staff in the organization. The QAA committee will ensure that the team is interdisciplinary, there is representation from each job role that is affected by the project, and resident and/or family member representation is included, if appropriate. When chosen to	2 255			

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2 255	Continued From page 13 participate on a PIP team, staff with direct care responsibilities will be replaced so that the needs of residents continue to be met. A team leader will be selected that has the ability to coordinate, organize, and direct the work. How the Team will Conduct the PIP: The PIP teams will consider each PIP a learning process. The team will follow steps and processes that are needed for any quality improvement project. The responsibilities for the PIP teams will be to determine what information is needed for the PIP and how to obtain the information. They will determine a timeline based on the PIP Charter. Requests for needed supplies, staff availability, and equipment will be made to the QAA committee. The QAA committee will respond in a timely manner to assure momentum is maintained. The team will develop an action plan using the organization's usual format. Interventions that will make change will be implemented by the team. The team will use root cause analysis to ensure that the root cause and contributing factors are identified. When determining and implementing interventions, PDSA cycles will be used. The team will select and/or create measurement tools to ensure that the changes they are implementing are having the desired effect team will be accountable to the QAA committee. Process for Documenting and Communicating Performance Improvement and Trends in Performance Measures: For ongoing monitoring of the PIP, we will use the CMS PIP Inventory to include milestones, PDSAs, outcomes, and other lessons learned from the PIP. Information about PIPs will be shared with staff, resident, and families. Systemic Approach to Quality Improvement: Our facility uses a systematic approach to determine when in-depth analysis is needed to fully understand identified problems, causes of the problems, and implications of a change. To get at	2 255			

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2 255	Continued From page 14 the underlying cause(s) of issue, we bring teams together to identify the root cause and contributing factors using the Five Whys, Flowcharting, and the Fishbone Diagram. Preventing Future Events and Promoting Sustained Improvement To prevent future events and promote sustained improvement our organization develops actions to address the identified root cause and/or contributing factors of an issue/event that will affect change at the systems level. We use Plan-Do-Study-Act cycles to test actions and recognize and address "unintended" consequences of planned changes. Ensuring Planned Changes/Interventions are Implemented and Effective To ensure the planned changes/interventions are implemented and effective in making and sustaining improvements, our organization chooses indicators/measures that tie directly to the new action and conducts ongoing periodic measurement and review to ensure that the new action has been adopted and is performed consistently ... SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administrator will be responsible for implementation.	2 255			

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2 255	Continued From page 15	2 255			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.				
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced	21390		4/23/25	
			Corrected		

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21390	Continued From page 16 barrier precautions (EBP)-(an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented for management of an indwelling catheter to reduce the risk of infection to others for 1 of 1 resident (R1) reviewed for quality of care. Findings include: R1's face sheet identified diagnoses of obstructive and reflux uropathy and need of assistance with personal cares. R1's order summary dated 6/19/24, identified R1 had an order to provide catheter care every shift, ensure catheter is anchored via Velcro or tape. R1's care plan revised 8/2/24, identified a focus of actual/potential for alteration in elimination related to obstructive and reflux uropathy ...goal identified will have no signs and symptoms of infection after completion of treatment through next review. Intervention dated 6/20/24 identified to change Foley catheter as ordered and monitor/document/report signs and symptoms of UTI: abdominal pain, weakness, functional decline, nausea, vomiting, dark cloudy urine, blood in urine and pus in urine. Did not identify EBP precautions. An additional focus revised 2/18/25 identified a focus related to renal failure due to end stage renal disease and had fistula created, waiting for fistula to mature, no start date for dialysis, does not want dialysis initiated. Intervention dated 7/2/24 identified to use enhanced barrier precautions. Care plan does not identify what cares identify the need for EBP nor does the foley catheter identify the need for EBP.	21390			

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21390	Continued From page 17 During an observation and interview on 3/11/25 at 1:16 p.m., upon entrance to R1's room a paper sign was hung on the wall to the right side of R2's door. Two, "STOP" signs noted at the top on either side. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person." The sign also had color pictures of hand cleanser, gloves, and gown. During an interview on 3/11/25 at 1:23 p.m., licensed practical nurse (LPN)-A verified R1's catheter was lying on the floor and should not be related to infection control concerns. During an observation on 3/12/25 at 10:10 a.m., R1 was lying in bed and his catheter bag was hooked to the bed control cord and the bottom of the catheter bag was lying on the floor. At 2:17 p.m., NA-A verified the catheter bag was lying on the floor and should not be. NA-A stated he would have to find a catheter bag covering to put it in. At 10:19 a.m., LPN-A verified the catheter bag was lying on the floor, walked into R1's room with washing his hands and picked up the catheter bag without applying EBP per the room signage and hooked the catheter to the bed. LPN-A then picked up R1's breakfast tray and walked out of the room without washing his hands, walked	21390			

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21390	Continued From page 18 down the hall, set the breakfast tray on the cart in between the east and west hallways, then proceeded to walk down the hall. LPN-A stated R1 should be on EBP precautions due to his Foley catheter and fistula and stated he should have used them in addition to washing his hands before and after entering/leaving the room. During an interview on 3/12/25 at 10:26 a.m., director of nursing DON stated staff should be using EBP's when touching R1's catheter bag. All residents with EBP have a sign clearly posted outside their room and staff should be looking for that and following our policy for EBP to help prevent the spread of infection. DON further stated staff should be washing hands prior to entrance of a room, after leaving a resident's room and between glove changes. DON stated not following EBP would be an infection control issue. Facility policy, "enhance Barrier Precautions," dated 3/6/24, identified it is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with chronic wounds requiring a dressing, indwelling medical devices or residents with "infection or colonization with an MDRO" 1. "Enhanced Barrier Precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Enhanced Barrier Precautions will not only focus on residents with infection or colonization with MDRO's but will also address residents at risk for developing or	21390			

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21390	Continued From page 19 becoming colonized. Enhanced Barrier Precautions are precautions that are between Standard Precautions and Contact Precautions. Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities. Novel or Targeted MDROs include: "Pan-resistant organisms Carbapenem's-producing carbapenem-resistant Enterobacter ales, carbapenems-producing carbapenem-resistant Pseudomonas spp., carbapenems-producing carbapenem-resistant Acinetobacter baumannii, and Candida auris"1Additional MDROs that are epidemiologically important include: "Methicillin-resistant Staphylococcus aureus (MRSA), ESBL-producing Enterobacterales, Vancomycin-resistant Enterococci (VRE),Multidrug-resistant Pseudomonas aeruginosa, Drug-resistant Streptococcus pneumoniae. "The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-Contact Resident Care Activities include1: Policy & Procedure: Enhanced Barrier Precautions: Dressing, Bathing/showering, Transferring, providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care: any skin opening requiring a dressing"1. Standard Precautions should be applied to all residents at all times. 2. Transmission-based precautions should be applied to all residents when standard precautions alone do not prevent pathogen transmission. 3. EBP are used in conjunction with standard precautions and expand the use of PPE	21390			

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21390	Continued From page 20 to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A. EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. b. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. c. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. d. EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. 4. Post clear signage on the door/wall outside resident room a. Type of precautions i. Contact Link: Contact Precaution sign ii. Droplet Link: Droplet Precaution sign iii. Airborne Link: Airborne Precaution sign iv. Enhanced Barrier Precautions Link: EBP Sign 5. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: 1. Dressing 2. Bathing/showering 3. Transferring 4. Providing hygiene 5. Changing linens 6. Changing briefs or assisting with toileting 7. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator 8. Wound care: any skin opening requiring a dressing" 1 ii. In general, gowns and gloves would not be recommended	21390			

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21390	Continued From page 21 when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. Outside the resident's room, EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. iii. Residents are not restricted to their rooms or limited from participation in group activities. Because EBP do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 6. Facility will ensure PPE and alcohol-based hand rub are readily accessible to staff. 7. Communication and education will be provided to all staff caring for or entering resident room for directions. 8. The Infection Preventionist may consult Public Health when needed for additional decisions regarding practices to prevent the spread of MDROs. Requested a handwashing policy and was not received. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to include hand hygiene practices to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform hand hygiene audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance	21390			

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21390	Continued From page 22 Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390			