



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 19, 2025

Administrator
Edenbrook of St. Cloud
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: December 19, 2024

Dear Administrator:

On February 14, 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 black ink that reads 'H. Zahler'.

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



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February 19, 2025

Administrator
Edenbrook of St. Cloud
1717 University Drive Southeast
Saint Cloud, MN 56304

Re: Reinspection Results
Event ID: 5P7W12

Dear Administrator:

On February 14, 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 December 19, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
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Protecting, Maintaining and Improving the Health of All Minnesotans

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January 10, 2025

Administrator
Edenbrook of St. Cloud
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: December 19, 2024

Dear Administrator:

On December 19, 2024, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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 St. Cloud

January 10, 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:

Annette Winters, Regional Supervisor, Federal Rapid Response

Health Regulation Division

Minnesota Department of Health

625 Robert Street N

P.O. Box 64975

Saint Paul, Minnesota 55164-0975

Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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 March 19, 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 June 19, 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 St. Cloud

January 10, 2025

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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 stylized with a large, looped "H" and a cursive "Zahler".

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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PO Box 64900
625 Robert Street North
St. Paul, MN 55155
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2024
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(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 12/17/24 through 12/19/24, 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 complaints were reviewed: H54382663C (MN00109058) H54382461C (MN00108882) with deficiencies cited at F550, and F804. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		2/3/25	

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

Electronically Signed

TITLE

(X6) DATE

01/20/2025

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 550	Continued From page 1 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure dignified and respectful maintain or promote their quality of life for 2 of 3 residents (R2, R4) reviewed when services were not provided to empty bedside urinals and bathing was not provided as scheduled.	F 550	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R2's full urinals were removed and clean urinals provided to resident.		

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F 550	Continued From page 2 Findings include: R2's admission Minimum Data Set (MDS) dated 11/6/24, identified he had moderate impaired cognition, sometimes socially isolated himself without behaviors. R2 had impaired mobility of one lower extremity and required partial to moderate assistance of staff for roll left/right, lying to sitting, sit to stand, chair/bed/chair/toilet transfers, and toileting hygiene. R2 was occasionally incontinent of bladder and continent of bowel. R2 used a walker and wheelchair for mobility. R2 had a diagnosis of benign prostatic hyperplasia (BPH) (enlargement of the prostate found just below the bladder and can block the flow of urine), diabetes mellitus, manic depression, and schizophrenia. R2's Kardex undated identified he required assistance with emptying urinal every shift, required assistance of one for shower every Friday evening (PM) shift, dressing and toileting. R2 required assist of one for bathing, uses urinal independently needs staff to empty. During interview/observation on 12/17/24 at 4:20 p.m. R2 stated the sign on the door "leave me alone" when the door was closed was the reason some staff told him they do not come into his room. R2 currently had three empty urinals located on his bedside table next to his bed. He wanted some privacy but still needed help with the urinals and staff to check on him. One week ago, a staff told him he was independent now and was able to empty his own urinals. During the night he had to urinate a lot, which was reason he had three full urinals sitting on his bedside table, the staff do not want to empty them especially during the night shift. When R2 uses his call light	F 550	R2's Task added to careplan to empty residents urinal, was also added to the careplan with directions to reapproach when resident refuses. R4 was bathed. Bathing schedule updated to include twice a week bathing schedule for R4. 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. Bathing schedule will be updated for all residents to ensure it accurately reflects resident plan for bathing frequency. All residents using a bedside urinal will be consulted to determine their preferences for managing urinal emptying. Care plans will be updated accordingly to ensure their preferences are respected and incorporated. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All nursing staff will be educated on facility policies: Activities of Daily Living and Resident Rights: Dignity. All nursing staff will be educated to ensure residents' bathing schedules are consistently maintained and urinals are emptied		

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F 550	Continued From page 3 on to get them emptied it takes up to one hour for staff to assist him. R2 stated he was able to use the urinals himself but had to have more than one because he was afraid if one had filled up and used it again, he would spill urine on himself. During an observation on 12/18/24 at 10:47 a.m. R2's room door was open and located on his bedside table was a urinal ¾ full of yellow colored urine visible from the hallway. R2 was not in his room. R2's care plan dated 12/19/24 identified R2 had a self-care deficit related to impaired mobility and pain. Staff were directed to have assisted with cleaning post incontinence. R2 used urinal independently and needed staff to empty urinal. During an interview on 12/19/24 at 8:30 a.m. licensed practical nurse (LPN)-A stated staff were expected to go into R2's room at least every two hours and check to see if his urinal should be emptied. LPN-A stated R2 was unable to empty the urinals (had three of them) himself and required staff assistance. LPN-A stated when the urinal filled up, sat on his bedside table for a length of time would be considered an infection problem and could have spilled onto the floor. LPN-A stated every resident should be checked on at least every two hours to make sure their needs were met. LPN-A stated for R2 it was a dignity issue made him not want to be here because he was not getting the care he needed, and he felt bad about it. LPN-A stated she had talked to R2 about his lack of help he had received, and he was very frustrated about it. LPN-A stated she had planned to provide that information to the facility social worker.	F 550	according to each resident's preference, to protect and promote their quality of life. The bathing schedule will be updated with all new admissions, discharges and changes to resident preference. Care plans will be updated with preferences for managing urinal emptying for all new admissions and changes to resident preference or use. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits will be completed twice weekly x 1 month, weekly x 1 month, every other week x 1 month, and monthly x 1 month to ensure bathing schedules and urinal emptying are being completed in a manner and in an environment that promotes maintenance or enhancement of the residents quality of life. Results and analysis of these audits will be brought to QAPI committee to review and determine frequency of ongoing audits. Date of compliance: 02/03/2025 Person responsible: Director of Nursing or designee		

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F 550	Continued From page 4 During an interview/observation on 12/19/24 at 8:50 a.m. R2's room door was open with television on. Three urinals were located on the bedside table visible from door. All three urinals had yellow urine in them: #1 urinal full (approximately 1000 milliliters (ml)), #2 was ¾ full (approximately 750 ml), #3 was ½ full (approximately 500 ml). R2 was in his wheelchair and stated my urinals were not emptied on nights and that was why there are three urinals almost full on my table. R2 stated staff had not checked on him this morning, been up since 5:00 a.m. and would have expected staff to empty the urinals before the night shift left. R2 place his call light on at 8:55 a.m. R2 stated he had urinary urgency problems, staff had scanned his bladder at times, saw a urologist, scheduled to see him again on January 14th, 2025, and still unable to urinate a lot at one time. He explained it was difficult for him to empty the urinals himself, unable to walk and carry the urinals, and a tight fit to get into to bathroom with his wheelchair. He has had urinary accidents because he was unable to get into the bathroom and that was why he has used urinals instead. When the urinals filled up, he had to ask to have them emptied and felt like a burden, wished he could go home because it was hard to see people walk by and see them on the bedside table full of urine, and he felt embarrassed. R2 stated he had placed his call light on waited up to 45 minutes, went out and smoked a cigarette, returned to his room 10 minutes later, the call light was turned off and urinals remained on the table by the bed full of urine. He placed the urinals on the table next to the bed so that it would be high enough up for staff to see and they would be emptied but has not worked. R2 stated he was upset, frustrated, and no longer wanted to live at this facility and just need to move out. He	F 550			

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F 550	Continued From page 5 had talked to the social worker and staff nurse about his concerns. At 9:05 a.m. (15 minutes later) nursing assistant (NA)-A entered the room, asked what R2 needed, applied gloves, emptied the urinals, removed gloves, washed hands, and exited the room. R4's admission MDS dated 11/7/24, identified intact cognition without behaviors. R4 had an impairment on upper extremity located on one side. R4 required partial to moderate assistance with personal hygiene, substantial to maximal assistance with roll left and right, sit to lying, lying to sit, sit to stand, chair/bed/chair and toilet transfers, and dependent for toileting hygiene and ambulation. R4 used a wheelchair for locomotion. R4 was frequently incontinent of bowel and bladder. R4's diagnoses included cancer, peripheral vascular disease (PVD), diabetes mellitus, and anxiety. R4's care plan dated 12/19/24 identified she had a self-care deficit, limited mobility, and directed staff to have provided assistance of one for personal hygiene and toileting, and transfers with front wheeled walker. R4 had an alternation in urinary elimination, overflow bladder incontinence, and directed staff to have provided incontinence cares after each incontinent bowel or bladder episode. R4 preferred to use bed side commode. R4's Kardex date 12/19/24 identified she required assistance of one for bathing on Tuesday and Friday morning (a.m.), dressing, transfers, personal hygiene, and offer and assist with toileting. R4's bath schedule dated 12/16/24 identified her	F 550			

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F 550	Continued From page 6 bath was scheduled for Tuesday morning (a.m.). R4's bath schedule undated, identified her bath times were changed to two days a week and scheduled for Tuesday and Friday a.m. R4's NA bathing documentation from 11/29/24 through 12/17/24 identified: -11/29/24 physical help required. -12/6/24 did not occur. -12/10/24 did not occur. -12/13/24 total dependence required. -12/17/24 did not occur. R4's urinary toileting record from 12/1/24 through 12/5/24 identified: 12/1/24 at 12:45 a.m. refused 12/1/24 at 1:53 p.m. continent 12/2/24 at 1:59 p.m. continent 12/2/24 at 9:59 p.m. incontinent 12/2/24 at 11:15 p.m. continent 12/3/24 at 1:59 p.m. continent 12/3/24 at 9:49 p.m. incontinent 12/4/24 at 2:56 a.m. continent 12/4/24 at 1:59 p.m. continent 12/4/24 at 8:46 p.m. incontinent 12/4/24 at 11:57 p.m. incontinent 12/5/24 at 1:55 p.m. incontinent 12/5/24 at 9:19 p.m. incontinent R4's Treatment Administration Record (TAR) for the month of November 2024, there was no order entered for bath/shower to be signed off that it was given. R4's TAR from 12/1/24 through 12/19/24, identified ensure resident received scheduled bath/shower every day shift every Tuesday and Friday. Order date 12/13/24 at 1:37 p.m. On	F 550			

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F 550	Continued From page 7 12/17/24 singed off No (N). During an interview on 12/18/24 at 11:19 a.m. R4 stated it was hard to get staff into her room for assistance to the bathroom and the long wait times frequently resulted in her having urinary incontinence, wetting herself in her pants. It made her feel awful, embarrassed. R4 stated she took water pills (a medication to excrete excess fluid from the body). About two weeks ago, she had to use the bathroom and could not wait any longer then had urinate in her pants. R4 stated a person should have not had to wait that long to get some help but was now able to take myself to the bathroom. There are still days when she is tired when staff need to help her to the bathroom though. R4 stated would have liked a shower twice a week but there were times when she was unable to get one shower a week. She was scheduled to have a shower yesterday; staff came and asked her if she was ready and was just going to have breakfast. She waited for someone to come after breakfast, but no one came back. She said her last shower was last Friday (5 days ago), her hair needed to be washed, and scalp felt itchy. R4's hair appeared unkept and uncombed. She was ok at times with one shower a week but then had to go two weeks without one in the past month, one of those days the facility had no hot water about two weeks ago. R4 stated her family had not assisted with her weekly bathes. During an interview on 12/18/24 at 2:16 p.m. NA-C stated he had transferred R4 on and off toilet in the a.m. and then therapy came in and worked with her around 11:00 a.m. R4 was supposed to have a assistance with bathing, did not offer to assist her with washing up, it did not	F 550			

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F 550	Continued From page 8 get done. NA-C stated it was staff responsibility to have helped R4 and to check back with her. NA-C identified on the shower/bath schedule located on a clip board dated 12/16/24, indicated R4 was scheduled for a shower one day a week on Tuesdays. NA-C stated if R4's frequency of a bath had changed staff was not aware of it, they followed the bath schedule. During an interview on 12/19/24 at 1:38 p.m. NA-B stated staff were expected to have checked on each resident at least hourly. Resident urinals should have been emptied at least on each walk around and/or as soon as you saw urine in them. It would be important to keep them empty, and not have them sitting around for an extended amount of time because it could cause infection, and the resident might be unable to use the urinal if it is full due to spillage of urine. NA-B stated the urinals should be emptied as soon as possible after use, dumped in the bathroom toilet, and rinsed out. NA-B stated a urinal with urine in it and visible to others can affect dignity and not pleasant for others to see and could embarrass a resident. On 12/17/24 NA-B charted no bath was given to R4 and verified she had not received her bath that day due to staff called in sick and they ran behind all day. When this happens, the evening (p.m.) shift should have done R4's bath and it was missed. NA-B stated he was not aware R4's bathes had increased to two times a week the bath schedule should have been updated to reflect that. During an interview on 12/19/24 at 1:55 p.m. floor manager LPN-B stated staff were expected to offer the resident a bath/shower once a week. R4's bathes were changed from one a week to two a week and should have started on 12/13/24.	F 550			

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F 550	Continued From page 9 LPN-B stated the bath/shower would have been important to monitor skin, general hygiene, to prevent skin breakdown and dignity in general. During an interview on 12/19/24 at 3:09 p.m. director of nursing (DON) staff was expected to complete hourly safety rounds, turn/reposition/toileting every 2 to 3 hours, and a.m. morning cares to have included: wash face/hands/all crevasses/abdominal folds, perineal cares, toileting, comb hair, and brush teeth. DON stated staff were expected to empty urinals if in the resident's room and saw it being used and for sure at the end of the shift as well. DON stated the urinals get smelly and bacteria grows when not emptied. During an interview on 12/19/24 at 3:30 p.m. administrator stated one of R2's interventions was for staff to empty his urinals but R2 was able to empty his own urinal and struggled with motivation to do it himself. The administrator stated a urinal full of urine located on the table could be a dignity issue when people walked by his room, and it was visible. Facility policy Activities of Daily Living (ADLS) dated 3/15/21, the facility must provide necessary care and services consistent to the resident's needs and choices and to maintain or improve his or his ability to carry out the activities of daily living. The facility will provide care and services such as hygiene: bathing, dressing, grooming and oral cares and elimination/toileting. Facility policy Resident Rights: Dignity dated 10/24/23, identified the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment	F 550			

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F 550	Continued From page 10	F 550			
F 804 SS=E	that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence and to be treated with respect, kindness, and dignity. Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 6 of 6 residents (R2, R3, R4, R5, R6, R7) reviewed who had food concerns. This deficient practice had the potential to affect all 63 residents residing in this facility. Findings included: Review of November 2024 grievances identified dinner was cold 11/11/24 and 11/12/24. Review of resident council meeting minutes dated 12/2/24 at 11:00 a.m. identified three officers and seven residents in attendance. Dietary: meals	F 804			2/3/25

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F 804	Continued From page 11 were still cold. The overview of action plan included a chart: current situation, what is our goal, what do we need to get there, who will help us get there, and status (resolved, not resolved/action needed, partially resolved/further steps needed) was left blank. During an interview on 12/17/24 at 9:30 a.m. family member (FM) stated sometimes the food was undercooked, chicken was pink, overcooked vegetables such as broccoli were mushy, and cold such as pizza, toast, and eggs. FM stated there were times when the biscuits and French toast were hard, and the residents could not bite into them. FM stated she had brought in food for her family member and warmed it up in the microwave. During an interview on 12/17/24 at 3:40 p.m. R3 stated this morning the temperature of food was cold. His French toast sticks and a tiny piece of ham steak was cold, hard, and tough to bite into. On other occasions when food was cold, he would tell staff and sometimes they offered to warm up his meal but then it became hard and unable to eat. Today R3's lunch included spaghetti and meatballs, broccoli, which were cold, and the sherbet was melted. He had seen the meal cart located in the hallway up to 30 minutes before the meal was served to residents. R3 stated we have the option of going to the dining room or stay in our rooms, and he had done both. During an interview on 12/17/24 at 4:21 p.m. R2 stated meals were frequently served late and the hot food was cold and overcooked most of the time. R2 stated pancakes edges were crispy, hard to cut with a knife and eat. R2 stated the	F 804	All dietary staff will be educated on the facility policy: Safe Food Temperatures. A temp log was updated with exact temperature safety ranges for all meals, diet textures and etc. A new plate warmer was ordered and is in use. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits will be completed twice weekly x 1 month, weekly x 1 month, every other week x 1 month, and monthly x 1 month to ensure food temperatures reach and maintain acceptable minimum temperatures. Results and analysis of these audits will be brought to QAPI committee to review and determine frequency of ongoing audits. Date of compliance: 02/03/2025 Person responsible: Administrator or designee		

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F 804	Continued From page 12 garlic bread was chewy and unsure why. R2 stated he had informed the manager of the kitchen of the concerns but was hard to talk to and things had not improved. Facility regular dinner menu dated 12/17/24, identified: Homemade vegetable beef soup Grilled cheese sandwich Marinated cucumbers Cinnamon applesauce Milk During a continuous observation on 12/17/24 at 5:16 p.m. located in main dining room 20 residents sat at tables and waited for supper to be served. At 5:20 p.m. noted from kitchen doorway two staff placed the food onto the plates with gloves on. The grilled cheese sandwiches were located in the steam table and when removed cut up in half or fourths with a large knife. The vegetable beef soup was located in a large metal pot located on the steam table and steam was seen coming from the top of the soup after it was placed into a bowl for each resident. At 5:40 p.m. R6 sat at table in dining room, yelled out twice can I get a sandwich that was not cold cannot eat this one. An unidentified staff went over to R6, removed her grilled cheese sandwich, brought it into the kitchen and at 5:42 p.m. returned with a grilled cheese sandwich. R6 stated thank you, took a bite and stated the sandwich was warm. R6 stated food was served cold frequently, wait time was long for meals to be served, and was frustrated, would have liked a hot meal once without requested to be warmed up. R6 stated the soup was too hot and blew on it until it was the temperature she wanted and ate the grilled cheese sandwich.	F 804			

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F 804	Continued From page 13 Review of the Food Temperature Log on 12/17/24 at approximately 5:45 p.m. identified dinner food temperatures were documented once at an undetermined time: Soup 180 degrees Fahrenheit (F.) Regular meat 175 degrees F. Ground meat 175 degrees F. Vegetable 180 degrees F. Pureed vegetable 180 degrees F. Starch 185 degrees F. Alternatives 165 degrees. F Dessert 35 degrees F. Milk/juice/coffee 35 degrees F. During an observation/interview on 12/17/24 at 5:48 p.m. cook (C)-A had placed a cut grilled cheese sandwich along with a bowl of soup on a plate and it was delivered by an unidentified staff to a resident in the dining room. C-A stated the foods that remained on the steam table she had just finished serving at 5:45 p.m. to residents were grilled cheese sandwiches and vegetable beef soup. C-A stated she had checked the temperature of the hot foods prior to when she started to serve the meals and entered the temperatures onto the log sheet. C-A stated she had never checked temperatures on the food during serving. C-A stated a female resident had complained the grill cheese sandwich was cold and her sandwich was replaced three times. At 5:52 p.m. C-A was asked to check the temperature on one of the grilled cheese sandwiches that remained in the steam table. Kitchen manager (KS) walked over to steam table and placed the thermometer into the center of a sandwich while it remained in the steam table and verified it was 124 degrees F. KS stated the temperature of the grilled cheese sandwich was	F 804			

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F 804	Continued From page 14 low, should have been above 130 degrees F. or higher, and verified the steam table remained turned on. KS stated they had been having issues with the steam table, sometimes warmed up but not hot enough, and waited on verification of a new steam table. KS stated in the meantime, staff were expected to have checked food temperatures to make sure they where they should be and served safely. KS wiped off end of thermometer and place the end of it into the large pot of vegetable soup and read 182 degrees F. stated should have been 135 to 160 degrees F. but 182 degrees F was fine. KS stated those foods were safe to have been served to the residents. Facility regular noon menu dated 12/18/24, identified: -pork chops -cream gravy -roasted butternut squash -French green beans -banana cream cheesecake -milk Facility Temperature Record for lunch dated 12/18/24, indicated all hot foods must be held at 140 degrees Fahrenheit (F) or higher. Recommended temperature for foods held on the serving line is 160 to 180 degrees F. Identified food temperatures were documented once at an undetermined time: - Regular meat 180 degrees F. - Ground meat 180 degrees F. - Vegetable 176 degrees F. - Starch 176 degrees F. - Gravy 168 degrees F. - Alternatives 177 degrees F. - Dessert 169 degrees F.	F 804			

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F 804	Continued From page 15 Milk/Juice/Coffee 169 degrees F. During an observation on 12/18/24 at 12:00 p.m. over 20 residents sat at tables in the large dining room while staff served them lunch. During an observation on 12/18/24 at 12:20 p.m. no residents remained in large dining room. At least 15 plates were observed on the tables with approximately up to 50 % of the food remained on the plates. During an observation on 12/18/24 at 12:25 p.m. two kitchen staff, C-B, and dietary aide (DA) prepared plates of food to be delivered to the resident rooms. The resident plates were stacked freely on the counter. C-B dished up hot foods (pork chops in sour cream gravy, squash, French green beans located in the steam table, the steel container of carrots was located outside of the steam table on top of steam table covers, placed the foods on a plate on top of a silver steel plate from a stack located on the counter. DA placed a cover that had a hole in the top of it over the plate of food and a piece of banana cream cake with whipped topping on each tray. DA placed each tray onto a shelf into a large brown colored cart. There were steel containers located on top of the steam table covers over the third and fourth well with foods in them: pureed meat, carrots, mashed potatoes, minced pork meat, squash, and boneless chicken breasts. At 12:40 p.m. all trays of food were loaded up into the brown cart and the doors were closed. C-B confirmed the stream table remained turned on (all four burners). C-B stated she had taken the temperature of all the foods when she cooked them and again prior to serving them to residents.	F 804			

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F 804	Continued From page 16 C-B stated she had entered the temperatures into the log sheet. C-B stated the steam table was turned on hours before the food was placed in there at 6:00 a.m. C-B stated there were four knobs one for each part of the steam table to total four knobs. Four sections in the steam table were observed. C-B stated she had set the first knob and turned it one click to the right and the same with knob three and four. C-B stated there were no makings on the knobs that indicated what each one was set at. C-B stated the second knob was the only one out of the four that had a silver plate with markings on it so that she knew to set it just below high. C-B verified three of the four dials were missing the silver plate and each dial was for a separate section of the steam table. At 12:45 p.m. C-B completed a temperature check on the following foods: Pork chops in sour cream gravy (no meat remained in the large metal container located in the steam table first section) Large amount of sour cream gravy remained in the metal tray located in the steam table section one and was temped at 167 degrees F. French green beans (located in the steam table first section) 162 degrees F. Food that was located out of the steamer and on top of the metal covers that were placed on top of the steam table section three and four: Chicken boneless 127.0 degrees F. C-B stated she had placed in steamer and just removed it prior to when surveyor came into the kitchen. Sliced carrots (approx. four inches of carrots in bottom of metal container) 101.4 (stated should	F 804			

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F 804	Continued From page 17 be at least 150 degrees F. or higher) were not located in the steam table and C-B stated they were just served to residents. C-B stated the temperature of the carrots was not up to 150 or higher and should have not been served to the residents. Pureed pork chops 92.0 degrees F. C-B stated they should have been at least 160 degrees F. and not sure why they were so cold, had not been that long since they were served, and the steam table should have kept these hot. On 12/18/24 at 12:55 p.m. kitchen manger (KM) entered the large kitchen and walked over to the steam table. Foods were not placed in the steam table and located on to top of the metal covers that were placed over the steam table. The following foods were checked by KM for temperatures: Pureed pork 101.0 degrees F. Mashed potatoes 135.0 degrees F. Minced pork meat 104.0 degrees F. Squash 90.0 degrees F. French green beans 100.0 degrees F. located in the steam table. Previous observation identified the green beans were served /delivered to more than 10 residents until 12:40 p.m. KM stated the steam table should have maintained the expected temperature for all the hot foods and where the temperatures should presently be at so that the temperatures were kept at where it would be servable. KM stated not sure why would have collected temperatures of these foods now that they were done serving.	F 804			

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F 804	Continued From page 18 On 12/18/24 at 1:00 p.m. while steam table remained turned on surveyor requested a scoop of gravy from pork chop pan located in first section of steam table, French green beans located in the steam table and sliced carrots located in a metal container on top of the metal covers over the steam table be placed on a plate to sample. KM and surveyor sampled the carrots, and both agreed they were not hot, and KM stated just warm, and surveyor identified them as cold. Surveyor sampled the gravy and green beans and were warm. KM stated unsure why the food needed to be sampled now, the residents had already been served their meal. During the interview on 12/18/24 at 1:01 p.m. KM stated all food for the facility and assisted living was made in this large kitchen. Once the cook has made the food they are expected to check all the temperatures, divide it up and place in holding ovens set at 225 degrees F. KM stated one hour prior to serving the steam tables should have been turned on and one to two inches of water added to the bottom of each well, there were four wells in the steam table on the mainline. KM stated the mainstream table had four dials only one had numbers and the other three did not. KM stated it was an old piece of equipment and he instructed his staff to turn the unmarked dials one click to the right when there was steam it was working properly. KM stated the water in the steam table wells could have been tested for the temperature but had not been done. KM stated was not aware or been told by kitchen staff the steam table had not been working properly. KM stated when water was steaming would guarantee it was over 200 degrees F. KM verified C-B would have been expected to have used a perforated pan placed in the steamer for the	F 804			

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F 804	Continued From page 19 pureed foods and carrots to have maintained correct temperatures. Those foods that we temped were not servable due to low temperatures that should have been maintained throughout the serving of the meal. KM stated none of the pureed food or the carrots were placed in the team table as expected. KM stated he was aware of resident complaints of cold food during the resident council meeting and completed an audit. KM stated the audit showed the food stayed hot only if the steel plate warmers and a lid were used and served in a timely manner before 12:30 p.m. (copy of two audits were received and dated 10/10/24 and 10/11/24). KM stated would have expected staff to have turned on the plate warmer and those plates used to keep the food hot. KM stated staff would be expected to re-temp foods that no longer seemed warm enough. KM stated residents could have gotten sick if the pork they served was under 165 degrees F. and should have been thrown out. KM stated the vegetables and gravy should have been maintained at to at least 165 degrees F. to have been safe to be served and eaten. KM stated he assumed the pureed meat temperature were taken to meet the requirements for safety to eat and should have been entered on the log form, but the temperatures were not on the form. KM stated all foods are to be expected to be temped and meet the recommended temperature guidelines prior to serving otherwise service would have to wait until the correct temperature has been reached. KM stated the log form required adjustments so that all foods temped were documented. On 12/18/24, DM provided surveyor an untitled dietary log form that listed all three meals (breakfast, lunch, and supper) for one week with	F 804			

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NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
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F 804	Continued From page 20 each type of food to have been served during that meal with the acceptable temperature(s) required. DM stated this was the log form the cooks were required to use when they served meals, and they were currently using the wrong form. Each section at the top listed the day of the week with three boxes located below that labeled beginning, middle and end and included a column below each one for the meal. Lunch section identified: Meat/entrée 160 to 180 degrees F. Ground Meat/Entrée 160 to 180 degrees F. Pureed Meat/Entrée 160 to 180 degrees F. Alternative Entrée 160 to 180 degrees F. Gravy 180 degrees F. Potato/Starch 160 to 180 degrees F. Pureed Potato 160 to 180 degrees F. Main Vegetable 160 degrees F. 2nd Vegetable 160 degrees F. Pureed Vegetable 160 degrees F. Soup 170 to 190 degrees F. Alternative Soup 170 to 190 degrees F. Cold Entrée/Vegetable 40 degrees F. During a follow up interview on 12/18/24 at 10:55 a.m. R3 stated he had gone to the dining room for supper last night. R3 stated the grilled cheese sandwich was cold and hard. R3 stated was unable to eat the sandwich and had not requested anything different. During an interview on 12/18/24 at 11:15 a.m. R4 stated has had cold food and/or that was barely warm. R4 stated went to the dining room last night for supper. R4 stated the cheese on the grilled cheese sandwiches was not melted and cold. R4 stated staff offered to warm up food when requested.	F 804			

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F 804	Continued From page 21 During an interview on 12/18/24 at 4:40 p.m. R7 stated the food during meals was occasionally cold such as sandwiches. R7 stated when she had chosen to eat in her room the food arrived lukewarm and usually colder than what she had received in the dining room. R7 stated there were many times she had made her own sandwich out of her refrigerator located in the room. R7 stated she had not told anyone but felt she should have. During an interview on 12/19/24 at 9:35 a.m. R5 stated usually went to dining room for meals. R5 stated food was good except the hot food was cold, especially the eggs. R5 stated there had been discussion at resident counsel and there were concerns about cold food. R5 stated food was cold the same for all meals, no specific one and this really should not have been happening. Facility policy titled Safe Food Temperatures dated 3/2023, identified foods are to be maintained at a safe a palatable temperature during meal service. Safe food temperatures conform to Hazard Analysis Critical Control Points (HACCP) principles (an internationally recognized method of identifying and managing food safety related to risk and can provide assurance to customers that a food safety program is well managed). All hot foods were to be held at 150 degrees F. or above. Staff were directed to have taken temperature on all foods on the steam table prior to serving and at the end of the serving. If serving had taken longer than 30 minutes, temperatures would also be expected to be taken during the middle of the serving to ensure food were at their optimum holding temperatures. Food temperatures which fail to reach or maintain acceptable minimum temperatures would be	F 804			

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F 804	Continued From page 22 required to have received corrective action such as reheated until the acceptable temperature was reached. Completed temperature records would be kept on file.	F 804			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 10, 2025

Administrator
Edenbrook of St. Cloud
1717 University Drive Southeast
Saint Cloud, MN 56304

Re: State Nursing Home Licensing Orders
Event ID: 5P7W11

Dear Administrator:

The above facility was surveyed on December 17, 2024, through December 19, 2024, 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 St. Cloud

January 10, 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:

Annette Winters, Regional Supervisor, Federal Rapid Response

Health Regulation Division

Minnesota Department of Health

625 Robert Street N

P.O. Box 64975

Saint Paul, Minnesota 55164-0975

Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

PO Box 64900

625 Robert Street North

St. Paul, MN 55155

Office: 651-201-4384

Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2024
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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 12/17/24 through 12/19/24, 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 order was issued. Please indicate in your electronic plan of correction you have	2 000		

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

01/20/25

Minnesota Department of Health

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2 000	Continued From page 1 reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54382663C (MN00109058) H54382461C (MN00108882) with licensing orders issued at 1025, 1805. 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	2 000			

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2 000	Continued From page 2 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 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		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 6 of 6 residents (R2, R3, R4, R5, R6, R7) who had food concerns. This deficient practice had the potential to affect all 63 residents residing in this facility. Findings included: Review of November 2024 grievances identified dinner was cold 11/11/24 and 11/12/24. Review of resident council meeting minutes dated	21025	Aknowledged	2/3/25

Minnesota Department of Health

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21025	Continued From page 3 12/2/24 at 11:00 a.m. identified three officers and seven residents in attendance. Dietary: meals were still cold. The overview of action plan included a chart: current situation, what is our goal, what do we need to get there, who will help us get there, and status (resolved, not resolved/action needed, partially resolved/further steps needed) was left blank. During an interview on 12/17/24 at 9:30 a.m. family member (FM) stated sometimes the food was undercooked, chicken was pink, overcooked vegetables such as broccoli were mushy, and cold such as pizza, toast, and eggs. FM stated there were times when the biscuits and French toast were hard, and the residents could not bite into them. FM stated she had brought in food for her family member and warmed it up in the microwave. During an interview on 12/17/24 at 3:40 p.m. R3 stated this morning the temperature of food was cold. His French toast sticks and a tiny piece of ham steak was cold, hard, and tough to bite into. On other occasions when food was cold, he would tell staff and sometimes they offered to warm up his meal but then it became hard and unable to eat. Today R3's lunch included spaghetti and meatballs, broccoli, which were cold, and the sherbet was melted. He had seen the meal cart located in the hallway up to 30 minutes before the meal was served to residents. R3 stated we have the option of going to the dining room or stay in our rooms, and he had done both. During an interview on 12/17/24 at 4:21 p.m. R2 stated meals were frequently served late and the hot food was cold and overcooked most of the time. R2 stated pancakes edges were crispy,	21025			

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21025	Continued From page 4 hard to cut with a knife and eat. R2 stated the garlic bread was chewy and unsure why. R2 stated he had informed the manager of the kitchen of the concerns but was hard to talk to and things had not improved. Facility regular dinner menu dated 12/17/24, identified: Homemade vegetable beef soup Grilled cheese sandwich Marinated cucumbers Cinnamon applesauce Milk During a continuous observation on 12/17/24 at 5:16 p.m. located in main dining room 20 residents sat at tables and waited for supper to be served. At 5:20 p.m. noted from kitchen doorway two staff placed the food onto the plates with gloves on. The grilled cheese sandwiches were located in the steam table and when removed cut up in half or fourths with a large knife. The vegetable beef soup was located in a large metal pot located on the steam table and steam was seen coming from the top of the soup after it was placed into a bowl for each resident. At 5:40 p.m. R6 sat at table in dining room, yelled out twice can I get a sandwich that was not cold cannot eat this one. An unidentified staff went over to R6, removed her grilled cheese sandwich, brought it into the kitchen and at 5:42 p.m. returned with a grilled cheese sandwich. R6 stated thank you, took a bite and stated the sandwich was warm. R6 stated food was served cold frequently, wait time was long for meals to be served, and was frustrated, would have liked a hot meal once without requested to be warmed up. R6 stated the soup was too hot and blew on it until it was the temperature she wanted and ate the grilled cheese sandwich.	21025			

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21025	Continued From page 5 Review of the Food Temperature Log on 12/17/24 at approximately 5:45 p.m. identified dinner food temperatures were documented once at an undetermined time: Soup 180 degrees Fahrenheit (F.) Regular meat 175 degrees F. Ground meat 175 degrees F. Vegetable 180 degrees F. Pureed vegetable 180 degrees F. Starch 185 degrees F. Alternatives 165 degrees. F Dessert 35 degrees F. Milk/juice/coffee 35 degrees F. During an observation/interview on 12/17/24 at 5:48 p.m. cook (C)-A had placed a cut grilled cheese sandwich along with a bowl of soup on a plate and it was delivered by an unidentified staff to a resident in the dining room. C-A stated the foods that remained on the steam table she had just finished serving at 5:45 p.m. to residents were grilled cheese sandwiches and vegetable beef soup. C-A stated she had checked the temperature of the hot foods prior to when she started to serve the meals and entered the temperatures onto the log sheet. C-A stated she had never checked temperatures on the food during serving. C-A stated a female resident had complained the grill cheese sandwich was cold and her sandwich was replaced three times. At 5:52 p.m. C-A was asked to check the temperature on one of the grilled cheese sandwiches that remained in the stream table. Kitchen manager (KS) walked over to steam table and placed the thermometer into the center of a sandwich while it remained in the steam table and verified it was 124 degrees F. KS stated the temperature of the grilled cheese sandwich was low, should have been above 130 degrees F. or	21025			

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21025	Continued From page 6 higher, and verified the steam table remained turned on. KS stated they had been having issues with the steam table, sometimes warmed up but not hot enough, and waited on verification of a new steam table. KS stated in the meantime, staff were expected to have checked food temperatures to make sure they where they should be and served safely. KS wiped off end of thermometer and place the end of it into the large pot of vegetable soup and read 182 degrees F. stated should have been 135 to 160 degrees F. but 182 degrees F was fine. KS stated those foods were safe to have been served to the residents. Facility regular noon menu dated 12/18/24, identified: -pork chops -cream gravy -roasted butternut squash -French green beans -banana cream cheesecake -milk Facility Temperature Record for lunch dated 12/18/24, indicated all hot foods must be held at 140 degrees Fahrenheit (F) or higher. Recommended temperature for foods held on the serving line is 160 to 180 degrees F. Identified food temperatures were documented once at an undetermined time: - Regular meat 180 degrees F. - Ground meat 180 degrees F. - Vegetable 176 degrees F. - Starch 176 degrees F. - Gravy 168 degrees F. - Alternatives 177 degrees F. - Dessert 169 degrees F. - Milk/Juice/Coffee 169 degrees F.	21025			

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21025	Continued From page 7 During an observation on 12/18/24 at 12:00 p.m. over 20 residents sat at tables in the large dining room while staff served them lunch. During an observation on 12/18/24 at 12:20 p.m. no residents remained in large dining room. At least 15 plates were observed on the tables with approximately up to 50 % of the food remained on the plates. During an observation on 12/18/24 at 12:25 p.m. two kitchen staff, C-B, and dietary aide (DA) prepared plates of food to be delivered to the resident rooms. The resident plates were stacked freely on the counter. C-B dished up hot foods (pork chops in sour cream gravy, squash, French green beans located in the steam table, the steel container of carrots was located outside of the steam table on top of steam table covers, placed the foods on a plate on top of a silver steel plate from a stack located on the counter. DA placed a cover that had a hole in the top of it over the plate of food and a piece of banana cream cake with whipped topping on each tray. DA placed each tray onto a shelf into a large brown colored cart. There were steel containers located on top of the steam table covers over the third and fourth well with foods in them: pureed meat, carrots, mashed potatoes, minced pork meat, squash, and boneless chicken breasts. At 12:40 p.m. all trays of food were loaded up into the brown cart and the doors were closed. C-B confirmed the stream table remained turned on (all four burners). C-B stated she had taken the temperature of all the foods when she cooked them and again prior to serving them to residents. C-B stated she had entered the temperatures into the log sheet. C-B stated the steam table was turned on hours before the food was placed in	21025			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21025	Continued From page 8 there at 6:00 a.m. C-B stated there were four knobs one for each part of the steam table to total four knobs. Four sections in the steam table were observed. C-B stated she had set the first knob and turned it one click to the right and the same with knob three and four. C-B stated there were no makings on the knobs that indicated what each one was set at. C-B stated the second knob was the only one out of the four that had a silver plate with markings on it so that she knew to set it just below high. C-B verified three of the four dials were missing the silver plate and each dial was for a separate section of the steam table. At 12:45 p.m. C-B completed a temperature check on the following foods: Pork chops in sour cream gravy (no meat remained in the large metal container located in the steam table first section) Large amount of sour cream gravy remained in the metal tray located in the steam table section one and was temped at 167 degrees F. French green beans (located in the steam table first section) 162 degrees F. Food that was located out of the steamer and on top of the metal covers that were placed on top of the steam table section three and four: Chicken boneless 127.0 degrees F. C-B stated she had placed in steamer and just removed it prior to when surveyor came into the kitchen. Sliced carrots (approx. four inches of carrots in bottom of metal container) 101.4 (stated should be at least 150 degrees F. or higher) were not located in the steam table and C-B stated they were just served to residents. C-B stated the temperature of the carrots was not up to 150 or	21025		

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21025	Continued From page 9 higher and should have not been served to the residents. Pureed pork chops 92.0 degrees F. C-B stated they should have been at least 160 degrees F. and not sure why they were so cold, had not been that long since they were served, and the steam table should have kept these hot. On 12/18/24 at 12:55 p.m. kitchen manger (KM) entered the large kitchen and walked over to the steam table. Foods were not placed in the steam table and located on to top of the metal covers that were placed over the steam table. The following foods were checked by KM for temperatures: Pureed pork 101.0 degrees F. Mashed potatoes 135.0 degrees F. Minced pork meat 104.0 degrees F. Squash 90.0 degrees F. French green beans 100.0 degrees F. located in the steam table. Previous observation identified the green beans were served /delivered to more than 10 residents until 12:40 p.m. KM stated the steam table should have maintained the expected temperature for all the hot foods and where the temperatures should presently be at so that the temperatures were kept at where it would be servable. KM stated not sure why would have collected temperatures of these foods now that they were done serving. On 12/18/24 at 1:00 p.m. while steam table remained turned on surveyor requested a scoop of gravy from pork chop pan located in first section of steam table, French green beans located in the steam table and sliced carrots	21025			

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21025	Continued From page 10 located in a metal container on top of the metal covers over the steam table be placed on a plate to sample. KM and surveyor sampled the carrots, and both agreed they were not hot, and KM stated just warm, and surveyor identified them as cold. Surveyor sampled the gravy and green beans and were warm. KM stated unsure why the food needed to be sampled now, the residents had already been served their meal. During the interview on 12/18/24 at 1:01 p.m. KM stated all food for the facility and assisted living was made in this large kitchen. Once the cook has made the food they are expected to check all the temperatures, divide it up and place in holding ovens set at 225 degrees F. KM stated one hour prior to serving the steam tables should have been turned on and one to two inches of water added to the bottom of each well, there were four wells in the steam table on the mainline. KM stated the mainstream table had four dials only one had numbers and the other three did not. KM stated it was an old piece of equipment and he instructed his staff to turn the unmarked dials one click to the right when there was steam it was working properly. KM stated the water in the steam table wells could have been tested for the temperature but had not been done. KM stated was not aware or been told by kitchen staff the steam table had not been working properly. KM stated when water was steaming would guarantee it was over 200 degrees F. KM verified C-B would have been expected to have used a perforated pan placed in the steamer for the pureed foods and carrots to have maintained correct temperatures. Those foods that we temped were not servable due to low temperatures that should have been maintained throughout the serving of the meal. KM stated none of the pureed food or the carrots were	21025			

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21025	Continued From page 11 placed in the team table as expected. KM stated he was aware of resident complaints of cold food during the resident council meeting and completed an audit. KM stated the audit showed the food stayed hot only if the steel plate warmers and a lid were used and served in a timely manner before 12:30 p.m. (copy of two audits were received and dated 10/10/24 and 10/11/24). KM stated would have expected staff to have turned on the plate warmer and those plates used to keep the food hot. KM stated staff would be expected to re-temp foods that no longer seemed warm enough. KM stated residents could have gotten sick if the pork they served was under 165 degrees F. and should have been thrown out. KM stated the vegetables and gravy should have been maintained at to at least 165 degrees F. to have been safe to be served and eaten. KM stated he assumed the pureed meat temperature were taken to meet the requirements for safety to eat and should have been entered on the log form, but the temperatures were not on the form. KM stated all foods are to be expected to be temped and meet the recommended temperature guidelines prior to serving otherwise service would have to wait until the correct temperature has been reached. KM stated the log form required adjustments so that all foods temped were documented. On 12/18/24, DM provided surveyor an untitled dietary log form that listed all three meals (breakfast, lunch, and supper) for one week with each type of food to have been served during that meal with the acceptable temperature(s) required. DM stated this was the log form the cooks were required to use when they served meals, and they were currently using the wrong form. Each section at the top listed the day of the week with three boxes located below that labeled	21025		

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21025	Continued From page 12 beginning, middle and end and included a column below each one for the meal. Lunch section identified: Meat/entrée 160 to 180 degrees F. Ground Meat/Entrée 160 to 180 degrees F. Pureed Meat/Entrée 160 to 180 degrees F. Alternative Entrée 160 to 180 degrees F. Gravy 180 degrees F. Potato/Starch 160 to 180 degrees F. Pureed Potato 160 to 180 degrees F. Main Vegetable 160 degrees F. 2nd Vegetable 160 degrees F. Pureed Vegetable 160 degrees F. Soup 170 to 190 degrees F. Alternative Soup 170 to 190 degrees F. Cold Entrée/Vegetable 40 degrees F. During a follow up interview on 12/18/24 at 10:55 a.m. R3 stated he had gone to the dining room for supper last night. R3 stated the grilled cheese sandwich was cold and hard. R3 stated was unable to eat the sandwich and had not requested anything different. During an interview on 12/18/24 at 11:15 a.m. R4 stated has had cold food and/or that was barely warm. R4 stated went to the dining room last night for supper. R4 stated the cheese on the grilled cheese sandwiches was not melted and cold. R4 stated staff offered to warm up food when requested. During an interview on 12/18/24 at 4:40 p.m. R7 stated the food during meals was occasionally cold such as sandwiches. R7 stated when she had chosen to eat in her room the food arrived lukewarm and usually colder than what she had received in the dining room. R7 stated there were many times she had made her own sandwich out	21025			

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21025	Continued From page 13 of her refrigerator located in the room. R7 stated she had not told anyone but felt she should have. During an interview on 12/19/24 at 9:35 a.m. R5 stated usually went to dining room for meals. R5 stated food was good except the hot food was cold, especially the eggs. R5 stated there had been discussion at resident counsel and there were concerns about cold food. R5 stated food was cold the same for all meals, no specific one and this really should not have been happening. Facility policy titled Safe Food Temperatures dated 3/2023, identified foods are to be maintained at a safe a palatable temperature during meal service. Safe food temperatures conform to Hazard Analysis Critical Control Points (HACCP) principles (an internationally recognized method of identifying and managing food safety related to risk and can provide assurance to customers that a food safety program is well managed). All hot foods were to be held at 150 degrees F. or above. Staff were directed to have taken temperature on all foods on the steam table prior to serving and at the end of the serving. If serving had taken longer than 30 minutes, temperatures would also be expected to be taken during the middle of the serving to ensure food were at their optimum holding temperatures. Food temperatures which fail to reach or maintain acceptable minimum temperatures would be required to have received corrective action such as reheated until the acceptable temperature was reached. Completed temperature records would be kept on file. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could inservice staff regarding proper holding procedures of foods for resident consumption, and audit for compliance.	21025			

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21025	Continued From page 14	21025		
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure dignified and respectful maintain or promote their quality of life for 2 of 3 residents (R2, R4) reviewed when services were not provided to empty bedside urinals and bathing was not provided as scheduled. Findings include: R2's admission Minimum Data Set (MDS) dated 11/6/24, identified he had moderate impaired cognition, sometimes socially isolated himself without behaviors. R2 had impaired mobility of one lower extremity and required partial to moderate assistance of staff for roll left/right, lying to sitting, sit to stand, chair/bed/chair/toilet transfers, and toileting hygiene. R2 was occasionally incontinent of bladder and continent of bowel. R2 used a walker and wheelchair for mobility. R2 had a diagnosis of benign prostatic hyperplasia (BPH) (enlargement of the prostate found just below the bladder and can block the flow of urine), diabetes mellitus, manic	21805	Acknowledged	2/3/25

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21805	Continued From page 15 depression, and schizophrenia. R2's Kardex undated identified he required assistance with emptying urinal every shift, required assistance of one for shower every Friday evening (PM) shift, dressing and toileting. R2 required assist of one for bathing, uses urinal independently needs staff to empty. During interview/observation on 12/17/24 at 4:20 p.m. R2 stated the sign on the door "leave me alone" when the door was closed was the reason some staff told him they do not come into his room. R2 currently had three empty urinals located on his bedside table next to his bed. He wanted some privacy but still needed help with the urinals and staff to check on him. One week ago, a staff told him he was independent now and was able to empty his own urinals. During the night he had to urinate a lot, which was reason he had three full urinals sitting on his bedside table, the staff do not want to empty them especially during the night shift. When R2 uses his call light on to get them emptied it takes up to one hour for staff to assist him. R2 stated he was able to use the urinals himself but had to have more than one because he was afraid if one had filled up and used it again, he would spill urine on himself. During an observation on 12/18/24 at 10:47 a.m. R2's room door was open and located on his bedside table was a urinal ¾ full of yellow colored urine visible from the hallway. R2 was not in his room. R2's care plan dated 12/19/24 identified R2 had a self-care deficit related to impaired mobility and pain. Staff were directed to have assisted with cleaning post incontinence. R2 used urinal independently and needed staff to empty urinal.	21805			

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21805	Continued From page 16 During an interview on 12/19/24 at 8:30 a.m. licensed practical nurse (LPN)-A stated staff were expected to go into R2's room at least every two hours and check to see if his urinal should be emptied. LPN-A stated R2 was unable to empty the urinals (had three of them) himself and required staff assistance. LPN-A stated when the urinal filled up, sat on his bedside table for a length of time would be considered an infection problem and could have spilled onto the floor. LPN-A stated every resident should be checked on at least every two hours to make sure their needs were met. LPN-A stated for R2 it was a dignity issue made him not want to be here because he was not getting the care he needed, and he felt bad about it. LPN-A stated she had talked to R2 about his lack of help he had received, and he was very frustrated about it. LPN-A stated she had planned to provide that information to the facility social worker. During an interview/observation on 12/19/24 at 8:50 a.m. R2's room door was open with television on. Three urinals were located on the bedside table visible from door. All three urinals had yellow urine in them: #1 urinal full (approximately 1000 milliliters (ml)), #2 was ¾ full (approximately 750 ml), #3 was ½ full (approximately 500 ml). R2 was in his wheelchair and stated my urinals were not emptied on nights and that was why there are three urinals almost full on my table. R2 stated staff had not checked on him this morning, been up since 5:00 a.m. and would have expected staff to empty the urinals before the night shift left. R2 place his call light on at 8:55 a.m. R2 stated he had urinary urgency problems, staff had scanned his bladder at times, saw a urologist, scheduled to see him again on January 14th, 2025, and still unable to urinate a	21805			

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21805	Continued From page 17 lot at one time. He explained it was difficult for him to empty the urinals himself, unable to walk and carry the urinals, and a tight fit to get into to bathroom with his wheelchair. He has had urinary accidents because he was unable to get into the bathroom and that was why he has used urinals instead. When the urinals filled up, he had to ask to have them emptied and felt like a burden, wished he could go home because it was hard to see people walk by and see them on the bedside table full of urine, and he felt embarrassed. R2 stated he had placed his call light on waited up to 45 minutes, went out and smoked a cigarette, returned to his room 10 minutes later, the call light was turned off and urinals remained on the table by the bed full of urine. He placed the urinals on the table next to the bed so that it would be high enough up for staff to see and they would be emptied but has not worked. R2 stated he was upset, frustrated, and no longer wanted to live at this facility and just need to move out. He had talked to the social worker and staff nurse about his concerns. At 9:05 a.m. (15 minutes later) nursing assistant (NA)-A entered the room, asked what R2 needed, applied gloves, emptied the urinals, removed gloves, washed hands, and exited the room. R4's admission MDS dated 11/7/24, identified intact cognition without behaviors. R4 had an impairment on upper extremity located on one side. R4 required partial to moderate assistance with personal hygiene, substantial to maximal assistance with roll left and right, sit to lying, lying to sit, sit to stand, chair/bed/chair and toilet transfers, and dependent for toileting hygiene and ambulation. R4 used a wheelchair for locomotion. R4 was frequently incontinent of bowel and bladder. R4's diagnoses included cancer, peripheral vascular disease (PVD), diabetes	21805			

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21805	Continued From page 18 mellitus, and anxiety. R4's care plan dated 12/19/24 identified she had a self-care deficit, limited mobility, and directed staff to have provided assistance of one for personal hygiene and toileting, and transfers with front wheeled walker. R4 had an alternation in urinary elimination, overflow bladder incontinence, and directed staff to have provided incontinence cares after each incontinent bowel or bladder episode. R4 preferred to use bed side commode. R4's Kardex date 12/19/24 identified she required assistance of one for bathing on Tuesday and Friday morning (a.m.), dressing, transfers, personal hygiene, and offer and assist with toileting. R4's bath schedule dated 12/16/24 identified her bath was scheduled for Tuesday morning (a.m.). R4's bath schedule undated, identified her bath times were changed to two days a week and scheduled for Tuesday and Friday a.m. R4's NA bathing documentation from 11/29/24 through 12/17/24 identified: -11/29/24 physical help required. -12/6/24 did not occur. -12/10/24 did not occur. -12/13/24 total dependence required. -12/17/24 did not occur. R4's urinary toileting record from 12/1/24 through 12/5/24 identified: 12/1/24 at 12:45 a.m. refused 12/1/24 at 1:53 p.m. continent 12/2/24 at 1:59 p.m. continent 12/2/24 at 9:59 p.m. incontinent	21805			

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21805	Continued From page 19 12/2/24 at 11:15 p.m. continent 12/3/24 at 1:59 p.m. continent 12/3/24 at 9:49 p.m. incontinent 12/4/24 at 2:56 a.m. continent 12/4/24 at 1:59 p.m. continent 12/4/24 at 8:46 p.m. incontinent 12/4/24 at 11:57 p.m. incontinent 12/5/24 at 1:55 p.m. incontinent 12/5/24 at 9:19 p.m. incontinent R4's Treatment Administration Record (TAR) for the month of November 2024, there was no order entered for bath/shower to be signed off that it was given. R4's TAR from 12/1/24 through 12/19/24, identified ensure resident received scheduled bath/shower every day shift every Tuesday and Friday. Order date 12/13/24 at 1:37 p.m. On 12/17/24 singed off No (N). During an interview on 12/18/24 at 11:19 a.m. R4 stated it was hard to get staff into her room for assistance to the bathroom and the long wait times frequently resulted in her having urinary incontinence, wetting herself in her pants. It made her feel awful, embarrassed. R4 stated she took water pills (a medication to excrete excess fluid from the body). About two weeks ago, she had to use the bathroom and could not wait any longer then had urinate in her pants. R4 stated a person should have not had to wait that long to get some help but was now able to take myself to the bathroom. There are still days when she is tired when staff need to help her to the bathroom though. R4 stated would have liked a shower twice a week but there were times when she was unable to get one shower a week. She was scheduled to have a shower yesterday; staff came and asked her if she was ready and was	21805		

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21805	Continued From page 20 just going to have breakfast. She waited for someone to come after breakfast, but no one came back. She said her last shower was last Friday (5 days ago), her hair needed to be washed, and scalp felt itchy. R4's hair appeared unkept and uncombed. She was ok at times with one shower a week but then had to go two weeks without one in the past month, one of those days the facility had no hot water about two weeks ago. R4 stated her family had not assisted with her weekly bathes. During an interview on 12/18/24 at 2:16 p.m. NA-C stated he had transferred R4 on and off toilet in the a.m. and then therapy came in and worked with her around 11:00 a.m. R4 was supposed to have a assistance with bathing, did not offer to assist her with washing up, it did not get done. NA-C stated it was staff responsibility to have helped R4 and to check back with her. NA-C identified on the shower/bath schedule located on a clip board dated 12/16/24, indicated R4 was scheduled for a shower one day a week on Tuesdays. NA-C stated if R4's frequency of a bath had changed staff was not aware of it, they followed the bath schedule. During an interview on 12/19/24 at 1:38 p.m. NA-B stated staff were expected to have checked on each resident at least hourly. Resident urinals should have been emptied at least on each walk around and/or as soon as you saw urine in them. It would be important to keep them empty, and not have them sitting around for an extended amount of time because it could cause infection, and the resident might be unable to use the urinal if it is full due to spillage of urine. NA-B stated the urinals should be emptied as soon as possible after use, dumped in the bathroom toilet, and rinsed out. NA-B stated a urinal with urine in it	21805			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2024
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304			
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21805	Continued From page 21 and visible to others can affect dignity and not pleasant for others to see and could embarrass a resident. On 12/17/24 NA-B charted no bath was given to R4 and verified she had not received her bath that day due to staff called in sick and they ran behind all day. When this happens, the evening (p.m.) shift should have done R4's bath and it was missed. NA-B stated he was not aware R4's bathes had increased to two times a week the bath schedule should have been updated to reflect that. During an interview on 12/19/24 at 1:55 p.m. floor manager LPN-B stated staff were expected to offer the resident a bath/shower once a week. R4's bathes were changed from one a week to two a week and should have started on 12/13/24. LPN-B stated the bath/shower would have been important to monitor skin, general hygiene, to prevent skin breakdown and dignity in general. During an interview on 12/19/24 at 3:09 p.m. director of nursing (DON) staff was expected to complete hourly safety rounds, turn/reposition/toileting every 2 to 3 hours, and a.m. morning cares to have included: wash face/hands/all crevasses/abdominal folds, perineal cares, toileting, comb hair, and brush teeth. DON stated staff were expected to empty urinals if in the resident's room and saw it being used and for sure at the end of the shift as well. DON stated the urinals get smelly and bacteria grows when not emptied. During an interview on 12/19/24 at 3:30 p.m. administrator stated one of R2's interventions was for staff to empty his urinals but R2 was able to empty his own urinal and struggled with motivation to do it himself. The administrator stated a urinal full of urine located on the table	21805			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2024
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21805	Continued From page 22 could be a dignity issue when people walked by his room, and it was visible. Facility policy Activities of Daily Living (ADLS) dated 3/15/21, the facility must provide necessary care and services consistent to the resident's needs and choices and to maintain or improve his or his ability to carry out the activities of daily living. The facility will provide care and services such as hygiene: bathing, dressing, grooming and oral cares and elimination/toileting. Facility policy Resident Rights: Dignity dated 10/24/23, identified the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence and to be treated with respect, kindness, and dignity. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee to provide staff inservice regarding dignified resident treatment, and maintain record of inservice provided and staff attendance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805			