



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 24, 2024

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

RE: CCN: 245438
Cycle Start Date: April 23, 2024

Dear Administrator:

On May 14, 2024, 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, appearing to read 'Melissa Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 24, 2024

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

Re: Reinspection Results
Event ID: TLOF12

Dear Administrator:

On May 14, 2024 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 April 23, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2024

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

RE: CCN: 245438
Cycle Start Date: April 23, 2024

Dear Administrator:

On April 23, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

Edenbrook Of St Cloud

May 1, 2024

Page 2

- 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 July 23, 2024 (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 October 23, 2024 (six months after

Edenbrook Of St Cloud

May 1, 2024

Page 3

the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/23/2024
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 4/23/24, 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 complaint was reviewed: H54383274C (MN00102616) with deficiencies cited at F761 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		5/14/24	

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

TITLE

(X6) DATE

Electronically Signed

05/10/2024

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.

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 04/23/2024
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 761	<p>Continued From page 1</p> <p>Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to maintain safe storage of medications when the nurses left medication carts unlocked and unattended in 2 of 3 medication carts.</p> <p>Findings:</p> <p>On 4/23/24 at 11:48 a.m., licensed practical nurse (LPN)-A gathered supplies to check R2's blood glucose. LPN-A pressed the north medication cart lock partially into the cart. LPN-A walked away from the medication cart in the hall and into R2's room. LPN-A closed the door for privacy. Following the procedure, LPN-A returned to the cart and pulled the medication cart lock out with his fingers, and accessed the contents of the medication cart. LPN-A did not use a key to access the medication cart. LPN-A stated the importance of locking the medication cart when not in attendance was to make sure no medications were stolen. LPN-A stated he trusted the people and the residents at the facility. LPN-A</p>	F 761	<p>F761 Label/Store Drugs and Biologicals</p> <p>The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies.</p> <p>The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice: For all residents and others, The</p>	

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 04/23/2024
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 761	<p>Continued From page 2</p> <p>stated the lock on the medication was in working order. LPN-A stated leaving the medication cart unlocked and unattended was not a safe idea.</p> <p>On 4/23/24 at 12:01 p.m., LPN-B was observed from approximately 30 feet away, walking down the hall, approaching the west medication cart and pulling the lock out with her fingers to access the medication cart. LPN-B did not use a key to access the medication cart. LPN-B stated she had a key to the medication cart and the locking mechanism was in working order. LPN-B stated, "I guess I just do it that way," when asked why the medication cart was not locked.</p> <p>On 4/23/24 at 12:34 p.m., LPN-C stated the medication carts were to be locked if the nurse was not near the cart. CM-A stated the unlocked cart posed a danger that residents, staff or family could access the cart.</p> <p>On 4/23/24 at 2:12 p.m., the director of nursing (DON) stated the medication carts should be locked whenever the nurse was not in direct attendance of the cart. The DON stated the medication carts should not be left unattended and unlocked as anybody could get into the medication cart.</p> <p>A facility document Medication Storage dated 2/12/24, directed to ensure medications and biological are stored in a safe, secure storage and safe handling. Compartments containing medications should be locked when not in use. Trays or carts used to transport such items should not be left unattended. (Note: Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes).</p>	F 761	<p>Director of Nursing (DON) immediately provided review of Medication Storage policy and procedure, provided re-education to nurses on securing the medication in the medication cart(s). The medication carts are to be locked when not in use by the nurse. No medication cart is to be left unlocked when unattended. The medication carts were immediately locked/secured.</p> <p>R1/R2 had no negative outcome related to this deficiency</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice: For all residents and others, The Director of Nursing (DON) and/or designee immediately provided review of Medication Storage policy and procedure, provided re-education to nurses on securing the medication in the medication cart(s). The medication carts are to be locked when not in use by the nurse. No medication cart is to be left unlocked when unattended. The medication carts were immediately locked/secured.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Audits immediately in progress: Medication Cart security. All three medication carts were immediately audited for security.</p> <p>Indicate how the facility plans to monitor its performance to make sure that</p>	

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 04/23/2024	
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 761	Continued From page 3	F 761	solutions are sustained: Audit frequency and duration: 3 times per week for ONE month; 2 times per week for ONE month; 1 time per week for ONE month. Report provided to QAPI Committee for decision of duration for compliance attainment. Responsible person: Director of Nursing and/or designee Period for Correction is 21 days: Date certain of May 14, 2024	
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p>	F 880		5/14/24

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 04/23/2024
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 880	<p>Continued From page 4</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p>	F 880		

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 04/23/2024	
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 880	<p>Continued From page 5</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and document review, the facility failed to maintain infection control practices while conducting blood glucose checks for 2 of 3 residents (R2, R3) reviewed for medication administration.</p> <p>Findings include:</p> <p>R2's admission Minimum Data Set (MDS) dated 4/6/24 indicated R2 had a diagnosis of diabetes mellitus type 2.</p> <p>R2's Physician's Order dated 4/15/24, directed to check blood glucose three times daily.</p> <p>On 4/23/24 at 11:51 a.m., after checking R2's blood glucose, licensed practical nurse (LPN)-A was observed to place a contaminated lancet and cotton ball in the cover of the plastic container used to hold R2's glucometer, insulin pens, and blood glucose testing supplies. LPN-A carried the container to the medication cart, and placed the contaminated lancet (a pricking needle, used to obtain drops of blood for testing) in a plastic cup sitting on the top of the medication cart. There were a total of five used lancets in the cup. LPN-A closed the plastic container in the medication cart, and did not disinfecting the glucometer or the plastic container. LPN-A stated the sharps container was on the medication cart. The sharps container on the medication cart was observed to be full with lancets pressing out of the top of the container. The contents was approximately two inches above the full line. LPN-A stated glucometers were cleaned once weekly, unless</p>	F 880	<p>F880 Infection Control</p> <p>The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies.</p> <p>The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice: For affected residents R2, R3: The Director of Nursing (DON) immediately provided review of policies and procedures, provided re-education to nurses on donning and doffing gloves, handwashing, cleaning of blood glucose machines, disposal of used lancets, used alcohol wipes and ensuring cleanliness of plastic case for diabetic supplies. As well as sharp's container availability and when to change out the sharp's container.</p> <p>Address how the facility will identify other</p>	

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 04/23/2024	
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 880	<p>Continued From page 6</p> <p>they were used for another resident, then you would have to use the disinfectant wipe on it.</p> <p>R3's significant change MDS dated 3/20/24, indicated R3 had diagnosis of diabetes mellitus type 1 and end stage renal disease.</p> <p>R3's Physician's order dated 1/4/24, directed to check blood glucose four times per day.</p> <p>On 4/23/24 at 12:03 p.m., LPN-B was observed to gather supplies from the medication cart to test R3's blood glucose. LPN-A removed the plastic container from the medication cart. LPN-A inserted the test strip into the glucometer. She prepared R3's finger by wiping it, then pricked R3's finger with the lancet, and put pressure on R3's finger with both of her ungloved hands to produce a drop of blood. LPN-B stated gloves should be worn when handling bodily fluids such as vomit, urine, bowel movements, or blood. LPN-B stated she was never instructed to wear gloves when checking blood glucose. LPN-B stated glucometers were only cleaned once weekly, unless visibly dirty. LPN-B stated there was not a process for the day of the week the glucometers were cleaned.</p> <p>On 4/23/24 at 12:34 p.m., LPN-C stated gloves were to be worn for all glucometer testing. LPN-C stated the sharps containers were to be changed when the contents reached the fill line. LPN-C stated the nurses working on the medication carts were responsible to replace the sharps container and properly dispose of the full ones.</p> <p>On 4/23/24 at 1:49 p.m., CM-A stated the glucometers were to be properly disinfected after each use.</p>	F 880	<p>residents having the potential to be affected by the same deficient practice: For other residents with potential of being affected, The Director of Nursing (DON) and/or designee immediately provided review of policies and procedures, provided re-education to nurses on donning and doffing gloves, handwashing, cleaning of blood glucose machines, disposal of used lancets, used alcohol wipes and ensuring cleanliness of plastic case for diabetic supplies. As well as sharp's container availability and when to change out the sharp's container.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Audits immediately in progress: Donning and doffing of gloves; handwashing; cleaning blood glucose machines and diabetic supply case; sharp's container availability and when to change out sharp's container. Cleaning of blood glucose machines and diabetic supply cases was completed immediately. Sharps containers were checked for "full Line" and immediately replaced.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Audit frequency and duration: 3 times per week for ONE month; 2 times per week for ONE month; 1 time per week for ONE month. Report provided to QAPI Committee for decision of duration for compliance attainment.</p> <p>Responsible person: Director of Nursing</p>	

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 04/23/2024
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 880	<p>Continued From page 7</p> <p>On 4/23/24 at 2:12 p.m., the director of nursing (DON) stated glucometers were expected to be cleaned after each use. The DON stated gloves should be worn with all glucometer checks. The DON stated sharps containers should be replaced when the contents reached the full line. The DON stated it was unacceptable to place five contaminated lancets on top of the medication cart in a plastic cup. She stated the lancets should be discarded promptly after each use.</p> <p>A facility document Care of the Diabetic Resident dated 8/22/23, directed blood glucose monitoring procedure: Wash your hands or use hand sanitizer to clean hands Put on gloves Discard test strip when finished Clean the glucometer per facility policy Remove and discard gloves; wash hands Store the glucometer in a clean and dry location</p> <p>A facility document Cleaning and Disinfection of a Glucometer dated 3/8/23, directed: 1. Gather necessary equipment for procedure. 2. Perform hand hygiene and apply gloves. 3. Wipe all external surfaces, including top, bottom and sides, using the approved cleaning solution or commercially prepared EPA germicidal wipe; avoid allowing the solution to penetrate the test strip and/or key code ports of the meter. 4. Ensure the meter remains wet for the time recommended by the manufacturer of the wipe and allow to air dry for an additional minute before using on the next resident. 5. If blood is visibly present on the meter, the procedure should be repeated a second time. 6. Discard soiled items in approved containers.</p>	F 880	<p>and/or designee</p> <p>Period for Correction is 21 days: Date certain of May 14, 2024</p>	

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 04/23/2024
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 880	Continued From page 8 7. Remove gloves and perform hand hygiene.	F 880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: TLOF11

Dear Administrator:

The above facility was surveyed on April 23, 2024 through April 23, 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

May 1, 2024

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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.



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

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 04/23/2024
--	--	---	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 4/23/24, 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 reviewed these orders and identify the date</p>	2 000		
-------	---	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/10/24
--	-------	------------------------------

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 04/23/2024
--	--	---	---

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) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>when they will be completed.</p> <p>The following complaint was reviewed: H54383274C (MN00102616) with a licensing order issued at 4658.0800 Subp 1 and 4658.1340 Subp1.</p> <p>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.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of</p>	2 000		

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 04/23/2024
--	--	---	---

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) COMPLETE DATE
2 000	Continued From page 2 state form.	2 000		
21375	<p>MN Rule 4658.0800 Subp. 1 Infection Control; Program</p> <p>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain infection control practices while conducting blood glucose checks for 2 of 3 residents (R2, R3) reviewed for medication administration.</p> <p>Findings include:</p> <p>R2's admission Minimum Data Set (MDS) dated 4/6/24 indicated R2 had a diagnosis of diabetes mellitus type 2.</p> <p>R2's Physician's Order dated 4/15/24, directed to check blood glucose three times daily.</p> <p>On 4/23/24 at 11:51 a.m., after checking R2's blood glucose, licensed practical nurse (LPN)-A was observed to place a contaminated lancet and cotton ball in the cover of the plastic container used to hold R2's glucometer, insulin pens, and</p>	21375	Corrected	5/14/24

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 04/23/2024
--	--	---	---

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) COMPLETE DATE
21375	<p>Continued From page 3</p> <p>blood glucose testing supplies. LPN-A carried the container to the medication cart, and placed the contaminated lancet (a pricking needle, used to obtain drops of blood for testing) in a plastic cup sitting on the top of the medication cart. There were a total of five used lancets in the cup. LPN-A closed the plastic container in the medication cart, and did not disinfecting the glucometer or the plastic container. LPN-A stated the sharps container was on the medication cart. The sharps container on the medication cart was observed to be full with lancets pressing out of the top of the container. The contents was approximately two inches above the full line. LPN-A stated glucometers were cleaned once weekly, unless they were used for another resident, then you would have to use the disinfectant wipe on it.</p> <p>R3's significant change MDS dated 3/20/24, indicated R3 had diagnosis of diabetes mellitus type 1 and end stage renal disease.</p> <p>R3's Physician's order dated 1/4/24, directed to check blood glucose four times per day.</p> <p>On 4/23/24 at 12:03 p.m., LPN-B was observed to gather supplies from the medication cart to test R3's blood glucose. LPN-A removed the plastic container from the medication cart. LPN-A inserted the test strip into the glucometer. She prepared R3's finger by wiping it, then pricked R3's finger with the lancet, and put pressure on R3's finger with both of her ungloved hands to produce a drop of blood. LPN-B stated gloves should be worn when handling bodily fluids such as vomit, urine, bowel movements, or blood. LPN-B stated she was never instructed to wear gloves when checking blood glucose. LPN-B stated glucometers were only cleaned once weekly, unless visibly dirty. LPN-B stated there</p>	21375		

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 04/23/2024
--	--	---	---

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) COMPLETE DATE
21375	<p>Continued From page 4</p> <p>was not a process for the day of the week the glucometers were cleaned.</p> <p>On 4/23/24 at 12:34 p.m., LPN-C stated gloves were to be worn for all glucometer testing. LPN-C stated the sharps containers were to be changed when the contents reached the fill line. LPN-C stated the nurses working on the medication carts were responsible to replace the sharps container and properly dispose of the full ones.</p> <p>On 4/23/24 at 1:49 p.m., CM-A stated the glucometers were to be properly disinfected after each use.</p> <p>On 4/23/24 at 2:12 p.m., the director of nursing (DON) stated glucometers were expected to be cleaned after each use. The DON stated gloves should be worn with all glucometer checks. The DON stated sharps containers should be replaced when the contents reached the full line. The DON stated it was unacceptable to place five contaminated lancets on top of the medication cart in a plastic cup. She stated the lancets should be discarded promptly after each use.</p> <p>A facility document Care of the Diabetic Resident dated 8/22/23, directed blood glucose monitoring procedure: Wash your hands or use hand sanitizer to clean hands Put on gloves Discard test strip when finished Clean the glucometer per facility policy Remove and discard gloves; wash hands Store the glucometer in a clean and dry location</p> <p>A facility document Cleaning and Disinfection of a Glucometer dated 3/8/23, directed: 1. Gather necessary equipment for procedure.</p>	21375		

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 04/23/2024
--	--	---	---

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) COMPLETE DATE
21375	<p>Continued From page 5</p> <ol style="list-style-type: none"> 2. Perform hand hygiene and apply gloves. 3. Wipe all external surfaces, including top, bottom and sides, using the approved cleaning solution or commercially prepared EPA germicidal wipe; avoid allowing the solution to penetrate the test strip and/or key code ports of the meter. 4. Ensure the meter remains wet for the time recommended by the manufacturer of the wipe and allow to air dry for an additional minute before using on the next resident. 5. If blood is visibly present on the meter, the procedure should be repeated a second time. 6. Discard soiled items in approved containers. 7. Remove gloves and perform hand hygiene. <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures regarding blood glucose checks. The DON or designee could provide education on these policies and procedures to all staff who perform blood glucose checks. The DON or designee could and establish a system to monitor the nurses for infection control practices with glucometer checks, including, but not limited to glove use, sharps safety, and disinfecting of the glucometers, and report the results of these audits to the Quality Assessment Performance Improvement (QAPI) committee.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21375		
21610	<p>MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage</p> <p>Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit</p>	21610		5/14/24

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 04/23/2024
--	--	---	---

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) COMPLETE DATE
21610	<p>Continued From page 6</p> <p>only authorized nursing personnel to have access to the keys.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain safe storage of medications when the nurses left medication carts unlocked and unattended in 2 of 3 medication carts.</p> <p>Findings:</p> <p>On 4/23/24 at 11:48 a.m., licensed practical nurse (LPN)-A gathered supplies to check R2's blood glucose. LPN-A pressed the north medication cart lock partially into the cart. LPN-A walked away from the medication cart in the hall and into R2's room. LPN-A closed the door for privacy. Following the procedure, LPN-A returned to the cart and pulled the medication cart lock out with his fingers, and accessed the contents of the medication cart. LPN-A did not use a key to access the medication cart. LPN-A stated the importance of locking the medication cart when not in attendance was to make sure no medications were stolen. LPN-A stated he trusted the people and the residents at the facility. LPN-A stated the lock on the medication was in working order. LPN-A stated leaving the medication cart unlocked and unattended was not a safe idea.</p> <p>On 4/23/24 at 12:01 p.m., LPN-B was observed from approximately 30 feet away, walking down the hall, approaching the west medication cart and pulling the lock out with her fingers to access the medication cart. LPN-B did not use a key to access the medication cart. LPN-B stated she had a key to the medication cart and the locking mechanism was in working order. LPN-B stated,</p>	21610	Corrected	

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 04/23/2024
--	--	---	---

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) COMPLETE DATE
21610	<p>Continued From page 7</p> <p>"I guess I just do it that way," when asked why the medication cart was not locked.</p> <p>On 4/23/24 at 12:34 p.m., LPN-C stated the medication carts were to be locked if the nurse was not near the cart. CM-A stated the unlocked cart posed a danger that residents, staff or family could access the cart.</p> <p>On 4/23/24 at 2:12 p.m., the director of nursing (DON) stated the medication carts should be locked whenever the nurse was not in direct attendance of the cart. The DON stated the medication carts should not be left unattended and unlocked as anybody could get into the medication cart.</p> <p>A facility document Medication Storage dated 2/12/24, directed to ensure medications and biological are stored in a safe, secure storage and safe handling. Compartments containing medications should be locked when not in use. Trays or carts used to transport such items should not be left unattended. (Note: Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes).</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures regarding medication cart security. The DON or designee could educate all licensed nursing staff on these policies and procedures. The DON or designee could conduct audits of medication carts security, and report the reesults of these ausits to the Quality Assessment Performance Improvement (QAPI) committee.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one</p>	21610		

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 04/23/2024
--	--	---	---

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) COMPLETE DATE
21610	Continued From page 8 (21) days.	21610		