Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 29, 2023

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

RE: CCN: 245560
Cycle Start Date: July 12, 2023

Dear Administrator:

On August 23, 2023, 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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 29, 2023

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

Re: Reinspection Results
Event ID: 0PQU12

Dear Administrator:

On August 23, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 12, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 24, 2023

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

RE: CCN: 245560
Cycle Start Date: July 12, 2023

Dear Administrator:

On July 12, 2023, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 12, 2023, (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 January 12, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 24, 2023

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

Re: State Nursing Home Licensing Orders
Event ID: 0PQU11

Dear Administrator:

The above facility was surveyed on July 11, 2023, through July 12, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

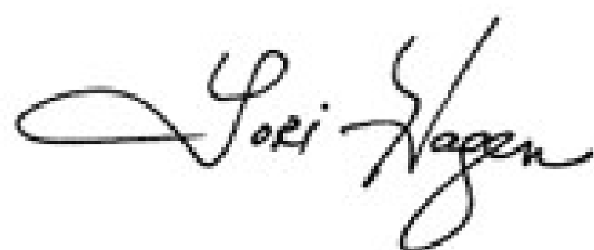
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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

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

Please contact me with any questions regarding this letter.

Sincerely,



Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING ______ B. WING ______	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 7/11/23 and 7/12/23, 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: H55603247 (MN00094764) with a deficiency issued at F690. 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 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		8/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/02/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING ______ B. WING ______	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST** **EDGERTON, MN 56128**

(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 690	Continued From page 1 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed complete a comprehensive assessment and develop and individualized toileting program to maintain or improve bowel/bladder continence for 1 of 1 resident (R2) reviewed for incontinence. Finding include: R2's significant change Material Data Set MDS dated 5/9/23, indicated R2 had severe cognitive impairment. R2's diagnoses included cerebral vascular accident (CVA or stroke), anxiety disorder, and overactive bladder (OAB). R2 required extensive assistance of one staff person	F 690	1. The resident (R-2) noted to be missing a bladder evaluation with corresponding toileting program. R-2 had a Bladder evaluation completed and care plan update on 7-13-23. A toileting program assessment was completed on 7-19-23 to monitor progress. 2. Edgebrook Care Center acknowledges this has the potential to affect other residents. We will review all current resident s medical records for bladder evaluation, if a resident has urinary incontinence; an updated bladder evaluation will be completed with updates	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING ______ B. WING ______	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 690	Continued From page 2 with toileting, personal hygiene, and ambulation. MDS further indicated that R2 did have a toileting program and was occassionally incontinent of bladder and always continent of bowel. R2's activities of daily living (ADL) care plan indicated the following interventions:. -toilet use limited assist of one staff to use toilet (dated 3/29/23). -staff to monitor for signs and symptoms of complications urgency, incontinence and signs and symptoms of urinary tract infection (UTI) (dated 3/20/23), -review bowel and bladder continence status and establish and/or review toileting plan based on resident's needs, receives Botox injections to bladder, (dated 5/4/23), R2's record did not include a comprehensive bowel and bladder assessment that identified history of incontinence, type of incontinence, voiding/bowel patterns, and modifiable risk factors in order to establish and individualized toileting schedule or program that prevents or reduces the risk of worsening incontinence and infections. R2's record identified R2 had fallen six times between 5/13/23 and 7/11/23, attempting to self-transfer to the bathroom. -5/13/23 at 1:20 p.m., R2 wheeled self into the bathroom, stood up to wash her hands and fell, no injury. Last toileted at 11:50 a.m. -5/25/23 at 7:45 a.m., R2 went to her room after breakfast, tried to take self to the bathroom, no injury. Last toileted at 6:00 a.m. New intervention was updated toileting schedule to include to offer toileting after meals as well. R2's care plan that was intiated on 3/29/23 that directed staff to toilet	F 690	to care plan and toileting program as indicated. 3. Bladder evaluation will be completed within 3 days after an admission, re-admission or change in condition if indicated. Staff will then start a toileting program, and update the care plan. Weekly Toileting program assessments will be completed until a satisfactory level of continence is met. Due date for reviewing all current residents records is by August 14, 2023. Education for bladder evaluation and toileting program requirements will be completed by Director of Nursing for all licensed nurses by August 14, 2023. 4. To monitor our performance and ensure our education was effective, focused audits will be completed by the Quality Assurance employee or designee. Focused audits will review up to 2 residents in each category; admission, re-admissions and change in condition. Schedule for audits: weekly x4, bi-weekly x2, monthly x2, then every other month x1. Results of these audits will be brought to the monthly QAPI meetings to ensure compliance is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

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F 690	Continued From page 3 R2 at 6:00 a.m., 9:00 a.m., 11:00 a.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., 10:00 p.m., and as needed and after meals was discontinued on 5/31/23; the record did not include an evaluation for effectiveness. On 5/31/23 the care plan was revised to encourage R2 to rest in bed or recliner after meals, offer toileting after meals prior to laying down. -6/2/23 at 7:45 p.m., R2 found on floor, attempting to self-transfer. Last toileted at 5:00 p.m. -6/10/23 at 5:20 a.m., R2 attempted to self-transfer and fell, no injuries. Last toileted at 4:00 a.m. New intervention was to start a 72-hour bowel and bladder assessment. In review of R2's record it was not evident a 72-hour bowel and bladder assessment was completed. -7/1/23 at 3:40 a.m., R2 attempted to self-ambulate to the bathroom, no injuries, Last checked on at 3:00 a.m. -7/02/23 at 7:20 a.m., self-transferred to toilet, no injuries. Last toileted at 6:11 a.m. During an observation on 7/11/23 at 3:30 p.m., nursing assistant (NA)-C assisted R2 to use the toilet. NA-C assisted R2 to standup using a gait belt and removed R2's wet incontinent brief. At 3:44 p.m. R2 turned on her bathroom call light, NA-C assisted R2 with personal cares and placed a new brief on R2. During an interview on 7/11/23 at 2:48 p.m., NA-A indicated that R2 was anxious and impatient person. R2 was able to use call light and make needs known. NA-A explained staff took R2 to the bathroom as she requested, but R2 would not void everytime they took her. During an interview 7/12/23 at 10:55 a.m., NA-N	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING ______ B. WING ______	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 690	Continued From page 4 indicated R2 was not a toileting schedule. R2 used the call light to alert staff for when she needed to use the bathroom. During an interview on 7/12/23 at 3:55 p.m. director of nursing (DON) reviewed R2's record, and reported she was not able to find a comprehensive bowel and bladder assessment. DON stated she was able to see a 72-hour bowel and bladder monitoring was to be initiated on 6/14/23, but not able to find results or the evaluation of the information. DON stated that bowel and bladder assessments are completed at admission, new onset of incontinence or with a change in condition. Review of Facility policy titled, Bowel and Bladder: Evaluation Assessment, toileting Programs, dated 4/26/23, indicated that the program was based on the resident's comprehensive assessment. These assessments were to be completed on admission, documented on weekly and once a successful toileting program has been established, documentation is required to be done at least quarterly.	F 690		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00454	A. BUILDING: ______ B. WING ______	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****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 7/11/23 and 7/12/23, 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(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00454	A. BUILDING: ______ B. WING ______	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST EDGERTON, MN 56128**

(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 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H55603247C (MN00094764) with a licensing order issued at 0910. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00454	A. BUILDING: ____ B. WING ____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

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2 000	Continued From page 2 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		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed complete a comprehensive assessment and develop and individualized toileting program to maintain or improve bowel/bladder continence for 1 of 1 resident (R2) reviewed for incontinence.	2 910	1. The resident (R-2) noted to be missing a bladder evaluation with corresponding toileting program. R-2 had a Bladder evaluation completed and care plan update on 7-13-23. A toileting program assessment was completed on 7-19-23 to monitor progress.	8/14/23

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	00454	A. BUILDING: ______ B. WING ______	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

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2 910	Continued From page 3 Finding include: R2's significant change Material Data Set MDS dated 5/9/23, indicated R2 had severe cognitive impairment. R2's diagnoses included cerebral vascular accident (CVA or stroke), anxiety disorder, and overactive bladder (OAB). R2 required extensive assistance of one staff person with toileting, personal hygiene, and ambulation. MDS further indicated that R2 did have a toileting program and was occassionally incontinent of bladder and always continent of bowel. R2's activities of daily living (ADL) care plan indicated the following interventions:. -toilet use limited assist of one staff to use toilet (dated 3/29/23). -staff to monitor for signs and symptoms of complications urgency, incontinence and signs and symptoms of urinary tract infection (UTI) (dated 3/20/23), -review bowel and bladder continence status and establish and/or review toileting plan based on resident's needs, receives Botox injections to bladder, (dated 5/4/23), R2's record did not include a comprehensive bowel and bladder assessment that identified history of incontinence, type of incontinence, voiding/bowel patterns, and modifiable risk factors in order to establish and individualized toileting schedule or program that prevents or reduces the risk of worsening incontinence and infections. R2's record identified R2 had fallen six times between 5/13/23 and 7/11/23, attempting to self-transfer to the bathroom. -5/13/23 at 1:20 p.m., R2 wheeled self into the bathroom, stood up to wash her hands and fell,	2 910	2. Edgebrook Care Center acknowledges this has the potential to affect other residents. We will review all current resident s medical records for bladder evaluation, if a resident has urinary incontinence; an updated bladder evaluation will be completed with updates to care plan and toileting program as indicated. 3. Bladder evaluation will be completed within 3 days after an admission, re-admission or change in condition if indicated. Staff will then start a toileting program, and update the care plan. Weekly Toileting program assessments will be completed until a satisfactory level of continence is met. Due date for reviewing all current residents records is by August 14, 2023. Education for bladder evaluation and toileting program requirements will be completed by Director of Nursing for all licensed nurses by August 14, 2023. 4. To monitor our performance and ensure our education was effective, focused audits will be completed by the Quality Assurance employee or designee. Focused audits will review up to 2 residents in each category; admission, re-admissions and change in condition. Schedule for audits: weekly x4, bi-weekly x2, monthly x2, then every other month x1. Results of these audits will be brought to the monthly QAPI meetings to ensure compliance is sustained.	

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2 910	Continued From page 4	2 910		

no injury. Last toileted at 11:50 a.m.
-5/25/23 at 7:45 a.m., R2 went to her room after breakfast, tried to take self to the bathroom, no injury. Last toileted at 6:00 a.m. New intervention was updated toileting schedule to include to offer toileting after meals as well. R2's care plan that was intiated on 3/29/23 that directed staff to toilet R2 at 6:00 a.m., 9:00 a.m., 11:00 a.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., 10:00 p.m., and as needed and after meals was discontinued on 5/31/23; the record did not include an evaluation for effectiveness. On 5/31/23 the care plan was revised to encourage R2 to rest in bed or recliner after meals, offer toileting after meals prior to laying down.
-6/2/23 at 7:45 p.m., R2 found on floor, attempting to self-transfer. Last toileted at 5:00 p.m.
-6/10/23 at 5:20 a.m., R2 attempted to self-transfer and fell, no injuries. Last toileted at 4:00 a.m. New intervention was to start a 72-hour bowel and bladder assessment. In review of R2's record it was not evident a 72-hour bowel and bladder assessment was completed.
-7/1/23 at 3:40 a.m., R2 attempted to self-ambulate to the bathroom, no injuries, Last checked on at 3:00 a.m.
-7/02/23 at 7:20 a.m., self-transferred to toilet, no injuries. Last toileted at 6:11 a.m.

During an observation on 7/11/23 at 3:30 p.m., nursing assistant (NA)-C assisted R2 to use the toilet. NA-C assisted R2 to standup using a gait belt and removed R2's wet incontinent brief. At 3:44 p.m. R2 turned on her bathroom call light, NA-C assisted R2 with personal cares and placed a new brief on R2.

During an interview on 7/11/23 at 2:48 p.m., NA-A indicated that R2 was anxious and impatient

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2 910	Continued From page 5	2 910		

person. R2 was able to use call light and make needs known. NA-A explained staff took R2 to the bathroom as she requested, but R2 would not void everytime they took her.

During an interview 7/12/23 at 10:55 a.m., NA-N indicated R2 was not a toileting schedule. R2 used the call light to alert staff for when she needed to use the bathroom.

During an interview on 7/12/23 at 3:55 p.m. director of nursing (DON) reviewed R2's record, and reported she was not able to find a comprehensive bowel and bladder assessment. DON stated she was able to see a 72-hour bowel and bladder monitoring was to be initiated on 6/14/23, but not able to find results or the evaluation of the information. DON stated that bowel and bladder assessments are completed at admission, new onset of incontinence or with a change in condition.

Review of Facility policy titled, Bowel and Bladder: Evaluation Assessment, toileting Programs, dated 4/26/23, indicated that the program was based on the resident's comprehensive assessment. These assessments were to be completed on admission, documented on weekly and once a successful toileting program has been established, documentation is required to be done at least quarterly.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents chart for bladder assessments and ensure care plans reflect these assessments. The director of nursing or designee, could conduct random audits of care plans to ensure appropriate care and services are implemented.

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2 910	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		