Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 30, 2024

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

RE: CCN: 245560
Cycle Start Date: January 24, 2024

Dear Administrator:

On January 24, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 April 24, 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 July 24, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 01/24/2024

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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E 000	Initial Comments On 1/22/24 through 1/24/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		3/8/24

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

Electronically Signed | 02/09/2024

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.

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E 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

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E 039	Continued From page 2 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from	E 039		

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E 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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E 039	Continued From page 8 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 9 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure tabletop exercise included a documented scenario or analysis. This deficient practice had the potential to affect all 46 residents residing at the facility. Findings include: Review of the 2023, facility tabletop exercise identified a 2-page document titled Elopement (Missing Resident) Emergency Management Plan. The section marked Notification to the administrator, director of nursing, police and family were left blank. 61 staff were noted as attending this tabletop exercise, however, there were no details surrounding where the exercise was to take place, what staff responsibilities were, who responded, or if the facility had analyzed the information to identify if the exercise was successful. The facility only noted "Discussed elopement policy...did walk thru drill". There was no indication the facility met the requirement to have the exercise that was led by a facilitator and included a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan, nor	E 039	1. Edgebrook Care Center was tagged on E039 for failing to ensure tabletop exercise included a documented scenario or analysis. During our routine emergency plan drills we will include the drill scenario, any clinically-relevant emergency information and an analysis of the facilities response. 2. All residents in the facility have the potential to be affected by the deficient practice. As a result, our Safety Officer reviewed the tabletop drill that occurred on 11/16/23; a report was written to include the drill scenario with relevant details and analysis. This was completed on: 02/05/24. We will also hold another tabletop drill on armed intruder policy and procedure. All drill reports will be completed by 03/08/24. 3. To ensure systemic changes are sustained, we will add details to our future emergency preparedness exercises to include scenarios, clinical relevant details and analysis after the drills. This documentation will be maintained by the Safety Officer. The Safety Officer was educated on these requirements for emergency preparedness policy and	

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E 039	Continued From page 10 any analysis of the facility's response to the tabletop exercise. Interview on 1/23/24 at 3:59 p.m., with the safety officer identified she was not aware they needed to include a written scenario or analysis with a tabletop exercise. Interview on 1/24/23, with the administrator identified she would have expected the safety officer to include a scenario and documented analysis with the tabletop exercise.	E 039	procedure on: 2/05/24. 4. To monitor our performance and sustainability, the Quality Assurance Coordinator or designee will perform audits of routine drills reports. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting. Audits will be completed weekly x4, every other week x4. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits	
F 000	INITIAL COMMENTS On 1/22/24 through 1/24/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 with NO deficiencies cited: H55608883C (MN91289), H55608884C (MN98868), H55608885C (MN90827), H55608886C (MN93605), and H55608887C (MN93271). 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 substantial compliance with the	F 000		

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F 000	Continued From page 11 regulations has been attained.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly	F 640		2/9/24

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F 640	Continued From page 12 assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure timely submission of a Death in facility Minimum Data Set (MDS) for 1 of 1 resident (R9) who was reviewed for an MDS record over 120 days old. Findings include: R9's medical record identified last scheduled Minimum Data Set (MDS) assessment that had been completed and submitted was on 9/17/23. R9's death in facility MDS was signed by the responsible party on 10/2/23, and locked on 10/11/23. The death in facility MDS had not been successfully submitted and/or transmitted; as R9's electronic health record identified it had been completed rather than accepted under the status section, indicating it had not been submitted. Observation and Interview on 1/23/24 at 9:02 a.m., with registered nurse (RN)-A who revealed she was responsible for R9's MDS completion and submission. Her process was to submit	F 640	1. Edgebrook Care Center was tagged on F640 for failing to ensure timely submission of a death in facility MDS. During our weekly MDS batch submission, the MDS nurses will review the validation report to ensure all death in facility MDS s were submitted timely. The one death in facility MDS that we were tagged on was submitted on 01/23/24. 2. All residents in the facility have the potential to be affected by the deficient practice. Our center will review all weekly death in facility MDS submissions in the past 2 months to ensure complete transmission to CMS. This process was completed on: 02/05/2024. 3. To ensure timely death in facility MDS submission, the MDS nurses will review of all death in facility MDS submissions that are completed and compare what was submitted. The MDS nurses education on the policy for submission was completed on: 02/05/2024. 4. To monitor performance and	

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F 640	Continued From page 13 completed MDS's each week. The electronic medical record program, Point Click Care (PCC) would create a batch of MDS's that were eligible for submission. Following submission of a batch of MDS's there would be a validation report for review that would confirm the submission date of each resident's MDS that had been submitted. After review of the validation reports with RN-A for batches that were submitted it was identified that the death in facility MDS had not generated in any of the MDS batches to be submitted. RN-A was unsure why R9's death in facility MDS did not generate as eligible for submission. Interview on 1/23/23 at 9:29 a.m., with regional consultant (RC) for the facility's MDS completion and submission process. She logged in remotely and confirmed that R9's death in facility MDS had not been submitted. The MDS had been locked during the final steps in PCC after completion. The system asked "yes" or "no" prompting staff if they wanted to submit. "It must have been accidentally check as "no" causing the MDS to be locked verses eligible for submission". Interview on 1/23/24 at 10:24 a.m., with administrator who identified her expectation was that all MDS assessments would be completed and submitted timely. A facility policy was requested but not provided.	F 640	sustainability, the Quality Assurance Coordinator or designee will perform audits of completed MDS submissions. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting. Audits will be completed weekly x4, every other week x4. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C	F 644		2/9/24

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F 644	Continued From page 14 of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the designated State Mental Health Authority (SMHA) when 1 of 2 residents (R14) had changes in mental health and/or had new-onset mental illness diagnoses. Findings include: R14's 1/23/24, face sheet identified she was admitted to the facility in June of 2022, with diagnosis of depression. R14's diagnosis list identified that upon admission, she had no diagnosis of mental illness or related condition. On 1/23/23, R14 had a new diagnosis added of psychotic disorder with delusions due to known physiological condition, and new onset anxiety disorder due to a known physiological condition. R14's medical record lacked any indication that the SMHA had been notified of the new diagnoses. R14's 5/16/23, annual Minimum Data Set (MDS)	F 644	1. Edgebrook Care Center was tagged on F644 for failing to notify the designated State Mental Health Authority (SMHA) when a resident has a change to mental health and/or new-onset of mental illness diagnosis. Our Social Services designee will notify the SMHA when a resident has a new mental health illness diagnosis for the PASARR level 2 assessment to be completed. 2. All residents with mental health diagnosis in the facility have the potential to be affected by the deficient practice. Our social services designee reviewed all resident with a mental health diagnosis and alerted the SMHA for PASARR level 2 assessment. This review was completed on: 02/02/2024. 3. To ensure this deficient practice does not occur again, our Social Services designee will review all new admissions, and the MDS nurses and social services	

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F 644	Continued From page 15 assessment identified R14 experienced delusions and verbal behaviors directed towards others and herself that put R14 at significant risk for injury. R14's 6/27/22, pre-admission screening (PAS) results identified she was being admitted with a primary diagnosis of cognitive impairment with no serious mental illness and no hallucinations or delusions within the past 6 months. R14's PAS identified she did not meet the criteria for mental illness at that time and did not require a level II (PASRR) Preadmission Screening and Resident Review to be completed. R14's 1/24/24, current medication administration record identified she was being administered quetiapine (antipsychotic) 75 mg, 2 x daily for delusions. Interview on 1/23/23 at 2:33 p.m., with the social service designee identified she thought that if a resident had a primary diagnosis of dementia, she did not have to notify the SMHA of a new onset mental illness. Interview on 1/24/23 at 1:30 p.m., administrator identified she had recently received training on PASRR and would have expected her social service designee to notify the SMHA of a new diagnosis of mental illness in this instance. A policy was requested, nothing was provided by end of the survey.	F 644	designee will review all diagnosis with quarter MDS review. If a PASARR level 2 assessments is needed, the social services designee will alert the SMHA. The social services designee was educated on the policy and procedure for PASARR level 2 reporting on: 02/05/2024. 4. To ensure sustainability the Quality Assurance Coordinator or designee will complete audits on new admissions. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting. Audits will be completed weekly x4, every other week x4. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits	
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	F 761		2/28/24

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F 761	Continued From page 16 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 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. §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. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to follow their policy and ensure discontinued medications were immediately removed from 1 of 1 resident's (R8) medication and not co-mingled with thier current medication supply located in the West medication cart, and secure them in a locked compartment in the medication room for final destruction. Findings include: R8's 11/29/23, Significant Minimum Data Set (MDS) assessment identified R8's cognition was intact, she required maximal assistance with daily	F 761	1. Edgebrook Care Center was tagged on F761 for failing to separate discontinued narcotic meds from current scheduled meds in the med cart. We will create a discontinue medication compartment in the narcotic medication box to keep discontinued medications in until two licensed nurses can destroy the narcotic. 2. Our nursing staff will ensure all current narcotics are separate from the discontinued narcotics. This will be completed by: 02/07/2024. 3. To ensure systemic changes are	

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F 761	Continued From page 17 cares, was identified as having pain and took pain medication. She had frequent pain that was severe and took an anti-anxiety, anti-depression, and opioid (narcotic used for pain) medication. R8 had identified diagnosis of anxiety and depression. Observation and interview on 1/24/24 at 10:37 a.m., with registered nurse (RN)-B of the West medication cart. The locked narcotic box located within the west medication cart contained 2 punch cards for R8 that had a yellow sticker on the punch card that identified it had been discontinued. The first punch card label identified lorazepam 0.5 milligrams (mg) take 1 tablet by mouth twice a day, with 14 doses remaining. The narcotic count book had d/c (discontinued) written on the page with no date. The second punch card label identified lorazepam 0.5 mg take 1 tablet at bedtime and 1 tablet 6 hours after scheduled dose as needed for anxiety, with 30 doses remaining. The narcotic count book had d/c written on the page with no date. RN-B was not certain when either order had been discontinued. The locked narcotic box also contained a punch card for R8 with a label that identified lorazepam 0.25 mg give 1/2 tablet at bedtime, with 23 doses. The narcotic count book identified on 1/17/24, the facility had received the lorazepam 0.25 mg doses. RN-B indicated that the facility used 2 licensed nurses to destroy controlled medications however, sometimes there were not 2 facility licensed nurses on duty, and they preferred to use the facility nurses' verses contracted nurses to destroy controlled medications. RN-B reported the process to destroy controlled medication would be to scan the bar code linked to the Omnicare system electronically. She acknowledged the lorazepam should have been	F 761	sustained, all licensed nurses and trained medical aids will be educated on the importance of keeping active and discontinued narcotics separated. Licensed nurses were educated policy and procedure. This education was completed by: 02/28/24. 4. To ensure compliance the Quality Assurance Coordinator or designee will complete audits on the discontinued narcotic medication separation. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting. Audits will be completed weekly x4, every other week x4. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits	

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F 761	Continued From page 18 destroyed by 2 licensed nurses after receiving the physician order to discontinue the medication. R8's physician orders identified an order was placed on: 1) 11/15/23, for lorazepam 0.5 mg by mouth twice a day for anxiety. 2) 11/29/23, to discontinue lorazepam 0.5 mg by mouth twice a day for anxiety. 3) 11/29/23, for 0.5 mg 1 tablet of lorazepam to be administered as needed twice a day for anxiety. 4) 12/20/23, to discontinue the Lorazepam 0.5 mg twice a day as needed for anxiety. 5) 12/20/23, for lorazepam 0.5 mg to be administered at bedtime for anxiety. 6) 1/3/24, to discontinue lorazepam 0.5 mg at bedtime for anxiety. 7) 1/3/24, for lorazepam 0.5 mg 1 tablet to be administered at bedtime and 1 tablet 6 hours after scheduled dose, as needed for anxiety. 8) 1/17/24, to discontinue the lorazepam 0.5 mg 1 tablet at bedtime and 1 tablet 6 hours after scheduled dose as needed for anxiety. 9) 1/17/24, for lorazepam 0.25 mg to be administered at bedtime for anxiety. Interview on 1/24/24 at 11:09 a.m., with RN-A identified controlled medication required 2 licensed nurses to destroy when medications are discontinued or when a resident discharges. Interview on 1/24/24 at 11:27 a.m., with RN-C identified controlled medications required 2 licensed nurses to destroy and that destruction should occur as soon as possible. Review of the 6/13/23 Medications: Controlled-R/S LTC policy identified controlled	F 761		

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F 761	Continued From page 19 medications that were discontinued should be placed in a lock box in the medication room as soon as they are discontinued and continued to be counted by 2 nurses until disposal was completed. There was no indication staff had followed the policy in the above observations and interviews and removed the medication from the medication cart as not to be co-mingled with in-use medication.	F 761		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:	F 851		2/13/24

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F 851	Continued From page 20 (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information at least quarterly or more often, including information for agency and contract staff, based on payroll and other verifiable and auditable data during 1 of 1 quarter	F 851	1. Edgebrook Care Center was tagged on F851 for failing to submit accurate or complete data for staffing information at least quarterly, including information for agency and contracted staff, based on payroll and other verifiable and auditable	

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 01/24/2024

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 851	Continued From page 21 reviewed (Quarter 4) to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705D identified the following dates triggered for review: 7/16/23, 7/23/23, 7/29/23, 7/30/23, 8/13/23, 8/26/23, 8/27/23, 9/09/23, 9/10/23, 9/16/23, 9/17/23, and 9/30/23 for failure to have licensed nurse coverage 24 hours per day. Review of staffing schedules identified the facility had 7 staff identified to have worked, registered nurses (RN)-D, RN-E, RN-F, RN-G, RN-H, RN-I and licensed practical nurse (LPN)-A. Review of staff's time cards on the above-mentioned dates identified licensed nursing staff had worked and the data submitted in the PBJ to CMS was inaccurate. Interview on 1/24/24 at 1:01 p.m., with the administrator (ADM) acknowledge the data submitted for the PBJ report for the infraction dates had been inaccurate due to excluding contracted agency nurse hours. She revealed her corporate office completed the PBJ submission from the data she took from the employee time punches, but received no documentation to support data had been submitted accurately, as it was triggered on the Casper 1705D report for Quarter 4, FY 2023. .Furthermore, there was no indication a Casper report 1702D or 1703D had been run by the facility, per CMS instructions to compare data submitted matched employee hours submitted.	F 851	data. The facility has gone through and reviewed payroll data and has updated the facility s PBJ reporting documentation to reflect an accurate reporting of all hours worked, for data yet to be submitted to CMS, per facility procedure. 2. All residents have the potential to be affected by this deficient practice. The facility has gone through and reviewed payroll data and has updated the facility s PBJ reporting documentation to reflect an accurate reporting of all hours worked, for data yet to be submitted to CMS, per facility procedure. This will be completed by 02/28/24. 3. To ensure systemic changes are sustained, education was provided to all staff responsible for reporting and tracking PBJ hours on the facility s procedure and hours that need manual entry into the location s tracking application. Monthly the administrator or designee will report hours manually updated, per the facility s PBJ procedure, to the Quality Assurance Committee. Education was completed on 02/05/24. 4. To ensure compliance the Quality Assurance Coordinator or designee will audit the PBJ nursing hours for accuracy. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting. Audits will be completed weekly for 6 weeks and reported to the Quality Assurance Committee for input on the need to increase, decrease or discontinue audits.	

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	245560	A. BUILDING _____ B. WING _____	C 01/24/2024

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F 851	Continued From page 22 There was no policy related to PBJ entries provided by the end of the survey.	F 851		

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	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/23/2024**

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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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/23/2024. At the time of this survey, Edgebrook Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 02/09/2024

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.

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EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST** **EDGERTON, MN 56128**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Edgebrook Care Center is one-story in height, has a partial basement, and is fully sprinklered. The original building was built in 1968, with building additions in 1992 and 1997. All were determined to be of Type II(111) construction. Building 02 consists of the 2003 building addition, which includes a meeting room and offices. Building 02 is one-story in height, has no	K 000		

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K 000	Continued From page 2 basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. Because the original building and the (3) addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility has a capacity of 52 beds and had a census of 48 at the time of the survey.	K 000		
K 353 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and	K 353	1. Edgebrook Care Center was tagged on	3/1/24

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K 353	Continued From page 3 staff interview, the facility failed to test and inspect the fire sprinkler system on a quarterly schedule per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/23/2024 at 11AM, it was revealed by a review of available documentation that there was no inspection records to review that showed that the fire sprinkler system had been inspected on a quarterly schedule in 2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	K353, failed to test and inspect the fire sprinkler system on a quarterly schedule. We did contact our Fire sprinkler inspection company (Midwestern Mechanical Inc) on 01/25/24 to schedule sprinkler testing and inspection every quarter. 2. Our Maintenance manager will ensure the sprinkler system is tested and inspected on a quarterly basis. The next inspection is scheduled to be completed by March 1st 2024. 3. To ensure systemic changes are sustained, the policy and procedure was reviewed by the Maintenance manager to ensure the sprinkler system is being audited and serviced on a quarterly basis. This education review was completed on 02/08/24. 4. To ensure ongoing compliance, the Quality Assurance Coordinator or designee will perform audits. Audits will be completed quarterly x2. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 3, 2024

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

RE: CCN: 245560
Cycle Start Date: January 24, 2024

Dear Administrator:

On March 13, 2024, the Minnesota Departments of Health and Public Safety, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us