DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 2, 2022

CMS Certification Number (CCN): 245275

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 27, 2022 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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August 2, 2022

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

RE: CCN: 245275
Cycle Start Date: April 14, 2022

Dear Administrator:

On May 19, 2022, we notified you a remedy was imposed. On August 1, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 27, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 2, 2022 be discontinued as of July 27, 2022. (42 CFR 488.417 (b))

In our letter of June 2, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 2, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

May 19, 2022

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

RE: CCN: 245275
Cycle Start Date: April 14, 2022

Dear Administrator:

On April 19, 2022, we informed you that we may impose enforcement remedies.

On May 5, 2022, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 14, 2022

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 14, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 14, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of

payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 14, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Edenbrook Of Edina will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 14, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 14, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697
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
	245275	A. BUILDING _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF EDINA	**6200 XERXES AVENUE SOUTH MINNEAPOLIS, MN 55423**

(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
E 000	Initial Comments On 5/2/22, 5/3/22, 5/4/22, and 5/5/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/2/22, 5/3/22, 5/4/22, and 5/5/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H52751021C (MN83092), however, NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaint was found to be UNSUBSTANTIATED, however related deficiencies were cited. H5275200C (MN83059), with deficiencies cited at F609 and F610. The following complaint was found to be UNSUBSTANTIATED, however, un-related deficiences were cited H5275204C (MN80493), with deficiencies cited at F585 and F625. The following complaints were found to be	F 000		

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

Electronically Signed | 05/27/2022

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F 000	Continued From page 1 UNSUBSTANTIATED: H5275201C (MN83045), H5275202C (MN82875), H5275203C(MN82791), H5275205C (MN80162) and H5275206C (MN78466). 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 regulations has been attained.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583		6/10/22

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F 583	Continued From page 2 materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide privacy for 1 of 1 resident (R42) who was observed to receive wound care. Findings include: R42's admission Minimum Data Set (MDS) dated 3/21/22, indicated R42 had a mild cognitive impairment and diagnoses of Parkinson's disease and a penile wound. During an observation on 5/5/22, at 10:59 a.m. registered nurse (RN)-D cleaned R42's penile wound. RN-D shut R42's door, however, failed to close R42's privacy curtain. R42 was fully exposed from the waist down while RN-D performed cares. Physical therapy staff knocked on R42's door, however, RN-D did not respond. The physical therapist then entered R42's room, walked past the R42 and proceeded towards R42's roommate. The physical therapist then	F 583	¬¬¬R42's care plan has been updated to reflect providing privacy during personal cares/treatments. All residents have the potential to be affected by this deficient practice. Appropriate staff will be re-educated on ensuring the personal privacy of residents is provided. DON or designee will conduct audits to ensure each resident's right to privacy is maintained weekly times 4 weeks, then monthly times 1 month. Audits will be brought to QAPI for further review and recommendations.	

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F 583	Continued From page 3 assisted R42's roommate into a wheelchair and wheeled the resident past R42 who was still fully exposed. During an interview on 5/5/22, at 11:15 a.m. RN-D stated he had not realized there was a knock on the door and was unaware of any activity with R42's roommate. RN-D stated he was concentrating on R42's wound care and was just not paying attention. RN-D acknowledged R42's curtain was not closed and needed to be closed to protect privacy. During an interview on 5/5/22, at 4:45 p.m. the director of nursing (DON) stated his expectation was be to have the privacy curtain closed when completing cares to ensure privacy was provided. Facility policy titled Privacy and Dignity revised 1/10/22, directed privacy was to be provided during cares.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to	F 585		6/10/22

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F 585	Continued From page 4 resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those	F 585		

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F 585	Continued From page 5 grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 585		

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F 585	Continued From page 6 Based on interview and document review, the facility failed to ensure a written notice of a grievance resolution was provided to 1 of 1 resident (R68) reviewed for grievances. Findings include: R68's admission Minimum Data Set (MDS) dated 11/19/21, indicated R68 was moderately cognitively impaired. Five facility Grievance/Concern Forms all dated 1/3/22, completed by R68's family member (FM-B) included "written response requested" in the upper left corner. The forms also contained a field on page two of each document which indicated "The Resident/Resident Representative requested a written decision?" with a checkmark indicating "Yes." In addition, each form identified a written decision was provided on 2/3/22 (despite the resident being discharged prior to this date). During an interview on 5/5/22, at 9:40 a.m. (FM)-B stated she filed 17 grievances since R68's admission and the facility did not respond to any of them. She stated she requested written responses for many and never received a written response from the facility. During interview on 5/5/22, at 11:27 a.m. the social services director (SSD) stated grievances were addressed during daily interdisciplinary team meetings, until resolved, and resolutions were communicated to the resident and responsible party. She stated residents and their representatives had a right to request a written report. SSD reviewed nine grievances filed by FM-B and confirmed five of them included	F 585	R68 has been discharged from facility. R68's family has been provided copies of requested grievance resolutions. All residents have the potential to be affected by this deficient practice. Staff will be re-educated regarding making sure identified concerns, both voiced and in writing, are addressed with satisfaction in a timely manner and written responses delivered as requested. Social Services or designee will conduct grievance audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	

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(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 585	Continued From page 7 "written response requested" in the upper left of the forms. She stated she planned to provide written responses to FM-B at the next care conference scheduled for 2/3/22, but R68 was discharged in January. She stated resolutions were verbally communicated to FM-B, however, and written responses were not provided, as requested. During interview on 5/5/22, at 3:57 p.m. the administrator stated residents and their representatives received a response to any grievance in whatever form the family wished. SSD provided written responses to grievances when requested. She stated not all FM-B's grievances required written responses, but to her knowledge they were provided when requested. She stated her expectation was if a written response was requested it would be provided. The facility Policy and Procedure Grievance/Concerns dated 1/14/22, indicated the facility would make prompt efforts to resolve all grievances, and the grievance form included the date the grievance was received, a summary statement of the resident's grievance, the steps being taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents' concerns, whether the grievance was confirmed or not confirmed, corrective action taken, or to be taken, and the date the written decision was issued.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		6/10/22

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	245275	A. BUILDING _____ B. WING _____	C 05/05/2022

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F 609	Continued From page 8 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an injury of unknown origin to the state agency (SA) within 24-hours for 1 of 4 resident (R44) reviewed for abuse. Findings include: R44's quarterly Minimum Data Set (MDS) dated 2/13/22, indicated R44 had a severe cognitive impairment and diagnoses of dementia, chronic obstructive pulmonary disease (COPD) and anxiety.	F 609	R44's bruise has since resolved. TMA-A was re-educated on timely reporting of injuries of unknown origins. All residents have the potential to be affected by this deficient practice. Staff will be re-educated on timely reporting findings of injuries of unknown origins and related policies/procedures. The Administrator or designee will conduct incident audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further	

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F 609	Continued From page 9 R44's care plan dated 3/31/22, indicated R44 was vulnerable due to long-term placement and R44's safety would be protected. R44's progress note dated 4/25/22, at 10:33 a.m. indicated a bath aid performed shower and noticed a large bruise to the left side of R44's rib cage. A nursing home incident report (NHIR) dated 4/27/22, indicated R44's trained medication assistant (TMA)-A had documented a bruise of unknown origin in R44's medical record on 4/25/22 (two days prior to the report). During an interview on 5/5/22, at 4:45 p.m. the director of nursing (DON) confirmed R44's progress note was discovered days following the initial discovery of the bruise. The DON stated a licensed staff member should had been notified right away and he expected staff to report injuries of unknown origin immediately so a report could be filed. A facility policy dated Vulnerable Adult Abuse and Neglect Prevention revised 1/14/22, directed any suspicions of abuse must be reported to the Administrator immediately and the facility must report to the SA immediately.	F 609	review and recommendations.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		6/10/22

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F 610	Continued From page 10 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 4 residents (R44) reviewed for abuse. Findings include: R44's quarterly Minimum Data Set (MDS) dated 2/13/22, indicated R44 had a severe cognitive impairment and diagnoses of dementia, chronic obstructive pulmonary disease (COPD) and anxiety. R44's progress note dated 4/25/22, at 10:33 a.m. indicated a bath aid performed shower and noticed a large bruise to the left side of R44's rib cage. The facility's internal investigation dated 5/3/22, indicated trained medication assistant (TMA)-A and nursing assistant (NA)-I were interviewed. NA-A had identified the bruise on R44 and told TMA-A. TMA-A documented the bruise in a progress note. The investigation file lacked	F 610	R44's bruise has since resolved. All residents have the potential to be affected by this deficient practice. Appropriate staff will be re-educated on thoroughly investigating an injury of unknown origin and the Vulnerable Adult Abuse and Neglect Prevention Policy. Administrator or designee will conduct investigation audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	

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F 610	Continued From page 11 evidence of other interviews. During an interview on 5/5/22, at 4:45 p.m. the director of nursing (DON) acknowledged the only staff interviews were with TMA-A and NA-A. The DON stated he expected more staff to be interviewed to understand why or how the bruise may had occurred. The DON further stated the investigation did not meet his expectations and more should had been done. A facility policy dated Vulnerable Adult Abuse and Neglect Prevention revised 1/14/22, directed interviews will be conducted with all parties involved and staff who may be involved in the allegation.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a specialty mattress in a timely manner for 1 of 1 resident reviewed for accommodation of needs. Findings inlcude: R10's significant change Minimum Data Set	F 684	R10's replacement mattress was immediately placed on bed. All residents have the potential to be affected by this deficient practice. Staff will be re-educated on how to request for equipment exchange. Environmental Services Director or designee will conduct Maintenance	6/10/22

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F 684	Continued From page 12 (MDS) dated 2/9/22, indicated R10 had a severe cognitive impairment and diagnoses of chronic obstructive airway disease, Alzheimer's Disease, and anxiety. R10's care plan dated 4/25/22, indicated staff had to ensure R10 was centered on her bed to prevent falls. During an observation on 5/2/22, at 4:43 p.m. R10's replacement mattress was laying against the wall in R10's room. During an observation on 5/4/22, at 7:18 a.m. R10's replacement mattress was laying against the wall in R10's room. During an interview on 5/4/22, at 9:02 a.m. trained medical assistant (TMA)-B was not sure why a mattress was against R10's wall. TMA-B verified a packing slip on the mattress identified it was delivered on 4/30/22 and was intended for R10. During an interview on 5/4/22, at 10:23 a.m. a maintenance worker (M)-A stated for maintenance to change a mattress, a request had to placed by nursing staff. M-A verified no work order had been placed to change R10's mattress. During an observation on 5/5/22, at 8:05 a.m. R10's replacement mattress was laying against the wall of R10's room. During an interview on 5/5/22, at 1:53 p.m. registered nurse (RN)-E stated R10's perimeter mattress (creates a raised edges) was ordered on 4/25/22, via hospice, but was not sure when it arrived.	F 684	request audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	

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F 684	Continued From page 13 During an interview on 5/5/22, at 4:43 p.m. the director of nursing (DON) acknowledged the perimeter mattress should had been placed on R10's the bed when it arrived. The facility's maintenance log was reviewed and lacked indication a request for R10's mattress exchange was requested. A facility policy on how to request a bed exchange was requested, however, not received.	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide podiatry care for 1 of 1 resident (R44) reviewed for foot care. Findings include: R44's quarterly Minimum Data Set (MDS) dated 2/13/22, indicated R44 had a severe cognitive impairment and diagnoses of dementia, chronic	F 687	R44 was seen and treated by Podiatry the following day. All residents have the potential to be affected by this deficient practice. Direct care staff will be re-educated on the importance of offering and providing ancillary services to residents. DON or designee will assess residents foot care needs and/or resident	6/10/22

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F 687	Continued From page 14 obstructive pulmonary disease (COPD) and anxiety. R44's care plan dated 3/31/22, indicated R44 required one staff assist for personal hygiene care and bathing. R44's orders dated 8/6/20, indicated podiatry consult, as needed, per resident or family. During an observation on 5/4/22, at 8:01 a.m. R44's toenails were thick, long and yellow in color. The toenails on R44's big toes had curved and were growing sideways. R44's right second and third toenails showed some blackening near the nailbed. Nursing assistant (NA)-B had placed socks on R44 and attempted to place shoes. R44 requested not to wear shoes as they "don't fit." During an interview on 5/2/22, at 6:24 p.m. family member (FM)-A stated R44's toenails looked really long and like they had fungus. FM-A stated she asked about getting R44's toenails looked at by podiatry about a month ago, but was told it was hard to find someone to come to the facility. Further, R44 needed new shoes, as they did not fit anymore. During an interview on 5/4/22, at 2:50 p.m. licensed practical nurse (LPN)-A stated he had not been informed of R44's nails and upon assessment of R44's nails podiatry was needed. LPN-A also stated he did not know if a referral had been placed, but the health unit coordinator (HUC) would know. During an interview on 5/4/22, at 3:01 p.m. nursing assistant (NA)-B stated she worked in the facility both as a NA and as a HUC. NA-B stated	F 687	preferences for foot care and revise care plan based on the assessment and/or resident choice. HUC will ensure podiatry appointment and transportation arrangements are made in a timely manner after assessment identified the concern. DON or designee will conduct ancillary services audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	

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F 687	Continued From page 15 nobody informed her of R44 needing to see podiatry and no referral had been made. NA-B stated she planned to work on an appointment for R44 after she saw how long her nails were this morning. "No wonder she said her shoes were too small." R44's podiatry provider note dated 5/4/22, indicated R44 had bilateral foot pain, hypertrophic nails (abnormal thickening of nails) and required nail debridement of six or more nails. During an interview on 5/5/22, at 4:57 p.m. the director of nursing (DON) stated he expected staff to provide a referral to the unit coordinator when podiatry services were needed so care was not delayed. A facility policy titled Activities of Daily Living, dated 3/15/21, directed residents were given appropriate treatment and services to maintain or improve their activities of daily living.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement interim safety measures and complete timely root cause	F 689	R28's plan of care has been updated to reflect root cause of falls and interventions.	6/10/22

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F 689	Continued From page 16 analysis to prevent the likelihood of subsequent falls for 1 of 2 residents (R28) reviewed for falls. Findings include: R28's Admission Record dated 5/5/22, indicated R28 indicated diagnoses of unspecified dementia without behavioral disturbance and altered mental status. R28's admission Minimum Data Set (MDS) dated 3/2/22, indicated R28 was severely cognitively impaired and required total dependence of two staff for transfers and extensive assist of two staff for toileting. R28's care plan dated 2/25/22, indicated R28 had an activities of daily living (ADL) self-care performance deficit with an intervention of totally dependent on one staff for toilet use. Further, R28 had a history of falls with the following interventions: - 2/25/22 bed at wheelchair height and wheelchair at bedside when occupied. - 3/4/22 assist resident up in wheelchair when awake and encourage to sit in public areas as well as keep resident room door open for safety as resident allows. - 3/17/22 resident will be offered to be put in the dayroom during awake hours and resident will be redirected when possible when sitting on the floor. - 3/21/22 hospice to provide perimeter mattress. - 3/23/22 offer toileting before meals. - 4/29/22 treat underlying medical condition. - 5/2/22 soft-touch call light at hip when in bed. R28's risk management report dated 2/25/22, at 8:36 p.m. indicated R28 was on the floor in her	F 689	All residents have the potential to be affected by this deficient practice. DON or designee will educate appropriate staff on the policies and procedures related to falls, root cause analysis, and timely implementation of interventions. DON or designee will develop monitoring systems to ensure ongoing compliance. DON or designee to conduct fall audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	

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F 689	Continued From page 17	F 689		

room. When R28 was asked what happened, R28 explained she was attempting to sit on her wheelchair. The immediate intervention was to place the bed at wheelchair height and place the wheelchair at the bedside when R28 was in the bed. A subsequent progress note dated 2/28/22, at 8:16 a.m. indicated the interdisciplinary team (IDT) reviewed and discussed R28's fall from 2/25/22 (3-days later). No further interventions noted.

R28's risk management report dated 3/4/22, at 10:15 a.m. indicated R28 was on the floor mat kneeling next to her bed. R28 explained she was "getting out of here." No immediate intervention was implemented at the time of the fall. A subsequent progress note dated 3/9/22, at 2:40 p.m. indicated IDT reviewed the fall from 3/4/22 (5-days later). R28's care plan was updated to include R28 was to be up in her wheelchair when awake and placed in public areas.

R28's risk management report dated 3/17/22, at 6:49 p.m. indicated R28 was found on the floor beside her bed. R28 was in bed instead of in a public area in her wheelchair at the time of the fall. R28 was unable to explain how she fell. No immediate intervention implemented at the time of the fall. A subsequent progress note, dated 3/23/22, at 2:38 p.m. indicated the IDT reviewed the fall from 3/17/22 (6-days later). R28's care plan was updated to include R28 to be offered positioning in the day room during awake hours.

R28's risk management report dated 3/21/22, at 2:00 a.m. indicated R28 was found sitting on the floor in the hallway closet next to R28's room. R28 was unable to explain how she fell. No immediate intervention implemented at the time

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F 689	Continued From page 18	F 689		

of the fall. An additonal risk management report dated 3/23/22, at 11:06 a.m. indicated R28 was found on the floor in a kneeling position in her room. R28 was unable to explain what happened. R28 was in bed in her room instead of being in a public area in her wheelchair at the time of the fall. A progress note dated 3/30/22, at 2:09 p.m. the IDT reviewed the falls from 3/21/22 (9-days later) and 3/23/22 (7-days later) and updated the care plan for hospice to provide R28 with a perimeter mattress for safety as an intervention for both falls.

R28's risk management report dated 4/29/22, at 10:49 a.m. indicated R28 was found sitting on the bathroom floor in her room. Immediate intervention implemented to treat R28's underlying medical condition.

R28's risk management report dated 5/2/22, at 3:07 p.m. indicated R28 was found sitting on the floor on the floor mat beside the bed. Immediate intervention implemented to place a soft-touch call light at hip height when R28 in bed.

R28's medical record lacked any evidence of an IDT review/discussion of R28's falls on 4/29/22 and 5/2/22 or any interventions implemented.

During an interview on 5/5/22, at 1:42 p.m. registered nurse (RN)-A stated when a resident falls a risk management report was completed and an immediate intervention should be implemented.

During an interview on 5/5/22, at 2:20 p.m. the director of nursing (DON) stated after a fall an immediate intervention should be implemented and a root cause should be determined. The

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F 689	Continued From page 19 DON verified R28 did not have an immediate intervention implemented after each fall and the root cause was not completed in a timely manner. The facility post fall policy dated 3/23/20, indicated a risk management report should be completed after each fall and an immediate intervention put in place. Further, indicated the staff were to identify the underlying causes and risk factors of the fall and update the plan of care with new interventions.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 692	R27's weight order was changed from	6/10/22

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F 692	Continued From page 20 review, the facility failed to obtain daily weights as ordered for 1 of 4 residents (R27) reviewed for nutrition. Findings include: R27's Admission Record dated 5/4/22, indicated she was admitted to the facility on 11/18/21 and had diagnoses of arm fracture, perforated intestine and colostomy, muscle weakness, and osteoporosis. R27's significant change Minimum Data Set (MDS) dated 3/1/22, indicated R27 was moderately cognitively impaired, independent with eating, required extensive assist of one staff for bed mobility, locomotion, and personal hygiene, and extensive assist of two staff for toileting, dressing, and transfers. R27's care plan dated 1/27/22 included R27 had potential for unplanned weight loss with an intervention to weigh resident per facility policy or as ordered. R27's dietary Care Area Assessment (CAA) dated 3/8/22, identified R27's body mass index (BMI) was too low as indicated by BMI of 16.1. Review of R27's Weights and Vitals Summary dated 5/4/22, indicated on 11/20/21, R27 weighed 99.6 lbs. A subsequent weight taken on 4/14/22, indicated R27 weighed 89.1 pounds; a -10.54 % loss over a five-month period. R27's Order Summary Report dated 5/4/22, included a physician order for daily weights for unplanned weight loss starting 3/17/22.	F 692	daily to weekly per Registered Dietician. All residents have the potential to be affected by this deficient practice. Direct care staff will be re-educated on the importance of obtaining weights as indicated in the resident's medical record. DON or designee will conduct weight audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	

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F 692	Continued From page 21 Subsequent review of R27's Weights and Vitals Summary dated 5/4/22, lacked documented weights for 42 of 48 days (87.5%) from 3/17/22, through 5/3/22. During interview on 5/4/22, at 11:47 a.m. nursing assistant (NA)-I stated sometimes nurses took weights, but usually the computer let the NA's know which residents needed weights taken. She stated if a resident refused, she documented the refusal and informed the nurse. She stated she was unaware R27 required daily weights, reviewed R27's record, and stated R27 was not scheduled for daily weights. During interview on 5/4/22, at 11:52 a.m. NA-G stated if a resident needed a weight checked it appeared on his documentation screen in the care plan. He stated some residents had daily weights and he tried to get them before breakfast and documented the weight in the electronic record right away. He stated he had not obtained a weight on R27 as he was not prompted to weight her by the documentation system. During interview on 5/4/22, at 12:03 p.m. registered nurse (RN)-H stated the need for weights appeared on the medication administration record (MAR) in the electronic chart. She stated she could assign an aide to take the weight or take it herself, but the nurse was ultimately responsible for making sure they were done. She stated when she documented a weight the value appeared in the Vitals section of the electronic record. She stated if a resident had an order for daily weights, it should be evident in the computer, and R27 popped up for her in the computer that morning. RN-H confirmed R27 had an order for daily weights and stated the last one	F 692		

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F 692	Continued From page 22 was completed 4/14/22. She stated it was not happening, and that wasn't good because R27 needed weights due to unplanned weight loss. Staff should be monitoring weights so that they were aware of what was going on with her nutritional status. She stated any refusal of weights should be documented, but R27 generally did not refuse. During interview on 5/4/22, at 12:46 p.m. the director of nursing (DON) stated residents were weighed at least weekly for four weeks upon admission or per physician order. He stated his expectation was if a resident had an order for daily weights they should be taken daily, and the doctor notified of any concerns. He stated lack of weight monitoring could lead to functional decline and any resident refusal should be documented. The policy Resident Heights and Weights (undated) indicated upon day of admission and two days following, the nursing department staff will weight resident on the appropriate scale weekly thereafter for four weeks and then monthly unless otherwise ordered by the physician, recommended by the dietician or medical condition requires.	F 692		
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced	F 730		6/10/22

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F 730	Continued From page 23 by: Based on interview and document review, the facility failed to complete annual performance reviews for 4 of 4 nursing assistants (NA-C, NA-D, NA-E, NA-F) whose employee files were reviewed. This had the potential to affect all 61 residents who resided at the facility. Findings include: A facility provided document which was unnamed (undated) identified the following staff hire dates: -NA-C was hired on 12/29/19. -NA-D was hired on 12/5/18. -NA-E was hired on 12/2/20. -NA-F was hired on 1/10/18. The personnel files for NA-C, NA-D, NA-E, NA-F were reviewed and all lacked performance reviews since hire. During an interview on 5/5/22, at 4:45 p.m. the director of nursing (DON) acknowledged the performance reviews were not completed and stated nursing leadership was in the process of starting them. The DON further stated evaluation of staff was important to understand as it impacted how resident cares were provided. A facility policy titled Performance Evaluations (no date), directed employee performance reviews are conducted on an annual cycle.	F 730	NA-C, NA-D, NA-E, and NA-F have all received annual performance reviews. All staff have the potential to be affected by this deficient practice. Staff will be re-educated on required annual performance reviews. DON or designee will review applicable procedure and policies to ensure the timely completion of nursing assistant performance reviews. DON or designee will conduct performance review audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		5/27/22

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F 761	Continued From page 24 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, interview, and document review, the facility failed to ensure medications were stored securely for 1 of 3 residents (R49) reviewed for medication administration and storage. In addition, the facility failed to ensure 1 of 1 medication carts were locked when unsupervised on the dementia unit. This had the potential to affect all residents who could access unsecured medications. Findings include: During medication administration observation on 5/4/22, at approximately 8:03 a.m. registered nurse (RN)-D assembled R49's 8:00 a.m.	F 761	R49's medications were all reviewed and accounted for. All residents have the potential to be affected by this deficient practice. Appropriate staff will be re-educated on proper storage of medications and ensuring the med carts are secured when left unsupervised. DON or designee will conduct med storage audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	

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F 761	Continued From page 25	F 761		

medications and placed the appropriate doses in a medication cup. RN-D left a partially filled bottle of acetaminophen 500 milligrams (mg), a medication card containing 21 doses of apixaban 2.5 mg (used for atrial fibrillation, an irregular fast heartbeat), and a medication card containing 14 doses of digoxin 125 micrograms (mcg) (used for atrial fibrillation) on top of the medication cart. At 8:09 a.m. RN-D entered R49's room, closing the door partway behind him leaving the cart and its contents out of view. RN-D exited the room at 8:13 a.m.

During interview on 5/4/22, at 8:13 a.m. RN-D stated he accidentally left the medications on top of the cart because they were face down of the left side of the cart and he was working on the right. He stated he didn't see them, and it was "bad" to leave them on top. He stated it was a simple mistake, but someone could have taken them and overdosed, especially since some residents were cognitively impaired.

During interview on 5/5/22, at 8:34 a.m. director of nursing (DON) stated medications were stored in the medication cart, and it was not okay to leave medications on top of the medication cart and walk away. He stated his expectation was all medications should be secured to prevent residents from taking another resident's medications.

During observation on 5/5/22, at 10:34 a.m. trained medication aide (TMA)-B walked from the nurse's office to an unlocked medication cart in the dining area where ambulatory residents with dementia were present and unsupervised. At 10:37 a.m. TMA-B walked away from the unlocked cart with a resident, leaving the cart

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F 761	Continued From page 26 open and unsupervised in the presence of another resident. TMA-B returned at 10:40 a.m. and locked the cart. The facility policy Medication Storage dated 9/21/19, indicated compartments containing medications should be locked when not in use. Trays or carts used to transport such items should not [be] left unattended. Further, medication will be stored in an orderly manner in cabinets, drawers, or carts.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a method to consistently monitor dish machine temperatures	F 812	A technician from Sunburst was out the following day to service the dishwasher. All unlabeled and expired foods were	6/10/22

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F 812	Continued From page 27 to ensure proper sanitation of dishware. In addition, the facility failed to date opened containers of food stored in the kitchen refrigerator. These practices had the potential for food-borne illness and could affect 62 of 62 residents who utilized facility supplied dishware and/or received meals prepared and served by the facility. Findings include: TEMPERATURE MONITORING On 5/3/22, at 10:16 a.m. the Dishmachine Temperature Log (high temp machine) dated 4/22, contained dish machine temperature documentation for 42 of 93 (43.8%) opportunities. The form included fields for weekly recording of plate surface temperatures, however, the fields lacked documentation. During the kitchen tour with the dietary director (DD) on 5/03/22, at 10:19 a.m. DD stated the dish machine used hot water to sanitize and temperatures were recorded during the middle of a load each meal by the dietary aides. Upon review of the Dishmachine Temperature Log (high temp machine) dated 4/22, DD stated it had been a while since the temperatures were taken. He stated the kitchen had been short staffed lately, especially on the afternoon shift, which was why some of the temperatures were missing. DD stated the wash temperature should be above 160 degrees Fahrenheit (°F) and the rinse temperature should be above 180°F. During observation of dish machine temperatures with DD, the wash temperature was noted as 150°F and the rinse temperature was 196°F. DD initiated a second run which resulted in a wash	F 812	immediately disposed of. All residents have the potential to be affected by these deficient practices. Appropriate staff will be re-educated on acceptable dishwasher temps, completing of temp logs. Appropriate staff will be re-educated on importance of dating and labeling foods once opened and proper disposal. Culinary Director or designee will complete dishwasher temp and food labeling audits weekly times 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	

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F 812	Continued From page 28	F 812		

temperature of 148°F and rinse temperature of 192°F. DD stated the temperature dropped from the first to the second load, and that it was "not okay." He stated staff needed to use alternate means of sanitizing dishes until it was fixed. He stated it was important to take the temperatures of the dishwasher wash and rinse cycles to make sure the machine sanitized the dishes so they were not spreading germs. DD stated the last time he knew the dish machine was at the appropriate temperature was 4/28/22, when the last temperature was documented.

During observation on 5/3/22, at 10:19 a.m. the label on the dish machine identified it was a DiverseyLever ADC44 Dishwasher. The NSF (National Sanitation Foundation) Data Plate affixed to the side of the dish machine indicated a required wash temperature minimum of 160°F and a final hot water sanitizing rinse minimum temperature of 180°F.

The American Dish Service Models ADC44 and ADC66 Conveyor Dishwashers Service Manual dated 10/7/13, indicated the incoming water temperature for hot water sanitizing should be 160°F and the final rinse temperature should be a minimum of 180°F.

During interview on 5/3/22, at 11:57 a.m. director of maintenance (DM) stated he had just run the dish machine and the wash temperature was above 160°F. He stated if he ran it multiple times the temperature dropped to 150°F, but if he waited and let it sit between loads it went up to 170°F. He stated the booster heater should have kept the temperature up, but it was not maintaining heat over multiple cycles and he needed to call the contracted repair company to

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F 812	Continued From page 29 come out to fix it. During interview on 5/3/22, at 12:52 p.m. the administrator stated the maintenance director was supposed to check to dishwasher when a work order was placed and as needed for preventative maintenance. She stated staff were supposed to check temperatures either at each meal or when they turn it on, and her expectation was it should have been completed per policy to ensure dishes were sanitized appropriately to avoid contamination and spread of bacteria. FOOD STORAGE During a kitchen tour with the dietary director (DD) on 5/3/22, at 10:19 a.m. the following items were observed in the refrigerator: -5 quarts chicken stock, undated -3 cups canned pineapple, undated -Approximately 4 pounds of strawberries in a plastic tub, undated, covered on the top with 1/8 to ¼ inch of greenish gray fuzzy mold-like substance -Two ounces cheddar cheese, undated -1 pound of roast beef and ham sandwich meat in a metal container covered in foil, undated -A container of beef base, undated During interview on 5/3/22, at 10:43 a.m. dietary director (DD) stated the aforementioned items should have been dated so staff knew when to throw them away and not serve them to avoid foodborne illness. During interview on 5/3/22, at 12:52 p.m. administrator stated she expected food items to be rotated in the kitchen and dated upon being opened. She stated anything that was opened	F 812		

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F 812	Continued From page 30 and not dated should have been thrown out since its age could not be determined there could be a risk of bacterial contamination. The facility policy Sanitation and Cleaning Schedule dated 2/25/21, indicated the "Dish Machine Temperature Log, including plate surface temperature at least once/week for high temp machines, must be completed per policy and reviewed daily to ensure compliance." The policy indicated any temperatures on the log that are out of compliance must be addressed immediately. Further, the policy indicated all food items must be dated upon receiving and dated and sealed when opened.	F 812		
F 921 SS=B	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the walls were kept in good repair. Further, the facility failed to ensure bed rails were clean and sanitary for 1 of 1 residents (R34) reviewed for environment. This deficient practice had the potential to affect all residents who utilized these areas. Findings include: WALL REPAIR On 5/2/22, at 6:56 p.m. the wall and ceiling above the first-floor A1 shower room across from room	F 921	R34's grab bars were cleaned and disinfected by housekeeping staff. Facility wall and ceiling tiles have been replaced and/or repaired. All residents have the potential to be affected by these deficient practices. Appropriate staff will be re-educated on cleaning and preventive maintenance. The Environmental Services Director or designee will ensure a preventative maintenance and cleaning program is developed to accurately reflect ongoing preventative maintenance/cleaning scheduled or needed in the facility on a	6/10/22

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F 921	Continued From page 31 111 was observed to have water damage with open and crumbling sheet rock and a black mold-like substance spotting throughout. On 5/2/22, at 7:01 p.m. multiple layers of wallpaper and sheeting to the lower left of the second-floor spa/massage room entrance were observed pulled away from the wall due to water damage. On 5/2/22, at 7:15 p.m. a ceiling tile on the north side of the third-floor dining room adjacent to the wall was observed to have water damage and had a visible black mold-like substance on the lower edge. During interview and facility tour on 5/5/22, at 1:53 p.m. director of maintenance (DM) stated there must have been a pipe leak in the wall at some time in the past and estimated the water-damaged area above the first-floor shower door to be 4.5 feet in overall width and ranged from 2 inches to 2.5 feet in height. The area consisted of bubbled paint and exposed, cracked, and crumbled sheetrock partially covered with a black mold-like or mildew-like substance. DM confirmed an area of ceiling tiles above the door approximately 2.5 feet long by and 7 inches wide also had water damage. He stated the area was dry to the touch, so he did not think there was active mold. During observation of the ceiling on the north side in the third-floor dining area DM stated he had not noticed the damage to the ceiling tiles. He stated it was "definitely water damage", but it probably was not wet. He stated it was hard to say if it was mold or not without going up on a ladder to get to it. He estimated the area to be 4 feet wide by 18	F 921	routine basis. The Environmental Services Director or designee will conduct weekly preventive maintenance/cleaning audits weekly time 4 weeks, then monthly times 1 month. Audit results will be brought to QAPI for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 32 inches high and stated the whole tile needed to be replaced. During observation of the wall outside of the second-floor spa/massage room, DM stated he was unsure where the water was coming from and estimated the water-damaged area to be approximately 30 inches high by 20 inches wide. DM confirmed there were no current work orders placed for repairs to the three areas of concern. During interview on 5/5/22, at 2:39 p.m. registered nurse (RN)-F stated she was on the first floor and noticed damage above the resident shower room door and placed a work order to have it fixed a few months prior. She stated she did not know if it was mold or mildew on the wall and described it as "Ew." RN-F reviewed the electronic list of work order requests and noted it was marked as completed by the previous maintenance staff. The facility Work Order Report dated 5/5/22, lacked evidence open work orders were in place for the three concerns. During interview on 5/5/22, at 3:57 p.m. the administrator stated her expectation was maintenance staff should be rounding on the facility and completing audits on the building. She stated the staff used an electronic system to generate work orders, and the maintenance team had standard, routine, and scheduled work and should be completing preventative maintenance as it came up. She stated it was important to keep up on maintenance and for the physical plant to be in good condition for residents, visitors, and staff who worked in the facility.	F 921		

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F 921	Continued From page 33 A policy regarding maintenance of environment was requested but not provided. BED RAILS R34's significant change Minimum Data Set (MDS) dated 4/15/22, indicated R34 had a severe cognitive impairment and diagnoses of dementia and failure to thrive. During an observation on 5/3/22, at 12:01 p.m. R34's left bedrail had red and brown dried material on it. During an observation on 5/4/22, at 11:51 a.m. R34's left bedrail had red and brown, dried material on it. During an observation on 5/4/22, at 1:49 p.m. a wet floor sign had been placed outside the door of R34's room. R34's left bedrail still had red and brown dried material on it. During an interview on 5/5/22, at 2:24 p.m. family member (FM)-B stated R34's bedrail was dirty and it had been for several weeks. FM-B stated it was bothersome as R34 frequently reached for the bedrail and touched it often. During an interview on 5/5/22, at 2:24 p.m. the director of maintenance stated the expectation was for housekeeping to clean all high contact surfaces daily. This included side tables, remotes, call lights and bedrails. During an interview on 5/5/22, at 2:53 p.m. housekeeper (HK)-A stated R34's room had been cleaned already. HK-A acknowledged R34's bedrail was dirty and needed cleaning.	F 921		

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F 921	Continued From page 34 A policy for cleaning was requested, but not received.	F 921		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 19, 2022

Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

Re: State Nursing Home Licensing Orders
Event ID: VWZ511

Dear Administrator:

The above facility was surveyed on May 2, 2022 through May 5, 2022 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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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
	00740	A. BUILDING: _____ B. WING _____	C 05/05/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/2/22, 5/3/22, 5/4/22, and 5/5/22 , a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 0285, 0830, 0860, 1015, 1426, 1610,	2 000		

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2 000	Continued From page 1 1685, 1855, 1880, and 1942. The following complaint was found to be SUBSTANTIATED: H52751021C (MN83092). NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5275201C (MN83045), H5275202C (MN82875), H5275203C(MN82791), H5275205C (MN80162) and H5275206C (MN78466). The following complaints were found to be UNSUBSTANTIATED: H5275204C (MN80493), however, a related licensing order was issued at 1810. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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	2 000		

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2 000	Continued From page 2 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of 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		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of	2 285		6/10/22

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2 285	Continued From page 3 incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance reviews for 4 of 4 nursing assistants (NA-C, NA-D, NA-E, NA-F) whose employee files were reviewed. This had the potential to affect all 61 residents who resided at the facility. Findings include: A facility provided document which was unnamed (undated) identified the following staff hire dates: -NA-C was hired on 12/29/19. -NA-D was hired on 12/5/18. -NA-E was hired on 12/2/20. -NA-F was hired on 1/10/18. The personnel files for NA-C, NA-D, NA-E, NA-F were reviewed and all lacked performance reviews since hire. During an interview on 5/5/22, at 4:45 p.m. the director of nursing (DON) acknowledged the performance reviews were not completed and stated nursing leadership was in the process of starting them. The DON further stated evaluation of staff was important to understand as it impacted how resident cares were provided. A facility policy titled Performance Evaluations (no date), directed employee performance reviews are conducted on an annual cycle. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable procedures and policies to ensure the timely completion of nursing assistant	2 285	Corrected.	

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2 285	Continued From page 4 performance reviews; educate staff on applicable policy revision; and, audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement interim safety measures and complete timely root cause analysis to prevent the likelihood of subsequent falls for 1 of 2 residents (R28) reviewed for falls. Findings include: R28's Admission Record dated 5/5/22, indicated R28 indicated diagnoses of unspecified dementia without behavioral disturbance and altered mental status.	2 830	Corrected.	6/10/22

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2 830	Continued From page 5 R28's admission Minimum Data Set (MDS) dated 3/2/22, indicated R28 was severely cognitively impaired and required total dependence of two staff for transfers and extensive assist of two staff for toileting. R28's care plan dated 2/25/22, indicated R28 had an activities of daily living (ADL) self-care performance deficit with an intervention of totally dependent on one staff for toilet use. Further, R28 had a history of falls with the following interventions: - 2/25/22 bed at wheelchair height and wheelchair at bedside when occupied. - 3/4/22 assist resident up in wheelchair when awake and encourage to sit in public areas as well as keep resident room door open for safety as resident allows. - 3/17/22 resident will be offered to be put in the dayroom during awake hours and resident will be redirected when possible when sitting on the floor. - 3/21/22 hospice to provide perimeter mattress. - 3/23/22 offer toileting before meals. - 4/29/22 treat underlying medical condition. - 5/2/22 soft-touch call light at hip when in bed. R28's risk management report dated 2/25/22, at 8:36 p.m. indicated R28 was on the floor in her room. When R28 was asked what happened, R28 explained she was attempting to sit on her wheelchair. The immediate intervention was to place the bed at wheelchair height and place the wheelchair at the bedside when R28 was in the bed. A subsequent progress note dated 2/28/22, at 8:16 a.m. indicated the interdisciplinary team (IDT) reviewed and discussed R28's fall from 2/25/22 (3-days later). No further interventions noted.	2 830		

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2 830	Continued From page 6 R28's risk management report dated 3/4/22, at 10:15 a.m. indicated R28 was on the floor mat kneeling next to her bed. R28 explained she was "getting out of here." No immediate intervention was implemented at the time of the fall. A subsequent progress note dated 3/9/22, at 2:40 p.m. indicated IDT reviewed the fall from 3/4/22 (5-days later). R28's care plan was updated to include R28 was to be up in her wheelchair when awake and placed in public areas. R28's risk management report dated 3/17/22, at 6:49 p.m. indicated R28 was found on the floor beside her bed. R28 was in bed instead of in a public area in her wheelchair at the time of the fall. R28 was unable to explain how she fell. No immediate intervention implemented at the time of the fall. A subsequent progress note, dated 3/23/22, at 2:38 p.m. indicated the IDT reviewed the fall from 3/17/22 (6-days later). R28's care plan was updated to include R28 to be offered positioning in the day room during awake hours. R28's risk management report dated 3/21/22, at 2:00 a.m. indicated R28 was found sitting on the floor in the hallway closet next to R28's room. R28 was unable to explain how she fell. No immediate intervention implemented at the time of the fall. An additonal risk management report dated 3/23/22, at 11:06 a.m. indicated R28 was found on the floor in a kneeling position in her room. R28 was unable to explain what happened. R28 was in bed in her room instead of being in a public area in her wheelchair at the time of the fall. A progress note dated 3/30/22, at 2:09 p.m. the IDT reviewed the falls from 3/21/22 (9-days later) and 3/23/22 (7-days later) and updated the care plan for hospice to provide R28 with a perimeter mattress for safety as an intervention for both falls.	2 830		

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2 830	Continued From page 7 R28's risk management report dated 4/29/22, at 10:49 a.m. indicated R28 was found sitting on the bathroom floor in her room. Immediate intervention implemented to treat R28's underlying medical condition. R28's risk management report dated 5/2/22, at 3:07 p.m. indicated R28 was found sitting on the floor on the floor mat beside the bed. Immediate intervention implemented to place a soft-touch call light at hip height when R28 in bed. R28's medical record lacked any evidence of an IDT review/discussion of R28's falls on 4/29/22 and 5/2/22 or any interventions implemented. During an interview on 5/5/22, at 1:42 p.m. registered nurse (RN)-A stated when a resident falls a risk management report was completed and an immediate intervention should be implemented. During an interview on 5/5/22, at 2:20 p.m. the director of nursing (DON) stated after a fall an immediate intervention should be implemented and a root cause should be determined. The DON verified R28 did not have an immediate intervention implemented after each fall and the root cause was not completed in a timely manner. The facility post fall policy dated 3/23/20, indicated a risk management report should be completed after each fall and an immediate intervention put in place. Further, indicated the staff were to identify the underlying causes and risk factors of the fall and update the plan of care with new interventions. SUGGESTED MEHTOD OF CORRECTION:	2 830		

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(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
2 830	Continued From page 8 The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures related to performing a timely comprehensive root cause analysis. he DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide podiatry care for 1 of 1 resident (R44) reviewed for foot care. Findings include: R44's quarterly Minimum Data Set (MDS) dated 2/13/22, indicated R44 had a severe cognitive impairment and diagnoses of dementia, chronic obstructive pulmonary disease (COPD) and anxiety. R44's care plan dated 3/31/22, indicated R44 required one staff assist for personal hygiene	2 860	Corrected.	6/10/22

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	00740	A. BUILDING: _____ B. WING _____	C 05/05/2022

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2 860	Continued From page 9 care and bathing. R44's orders dated 8/6/20, indicated podiatry consult, as needed, per resident or family. During an observation on 5/4/22, at 8:01 a.m. R44's toenails were thick, long and yellow in color. The toenails on R44's big toes had curved and were growing sideways. R44's right second and third toenails showed some blackening near the nailbed. Nursing assistant (NA)-B had placed socks on R44 and attempted to place shoes. R44 requested not to wear shoes as they "don't fit." During an interview on 5/2/22, at 6:24 p.m. family member (FM)-A stated R44's toenails looked really long and like they had fungus. FM-A stated she asked about getting R44's toenails looked at by podiatry about a month ago, but was told it was hard to find someone to come to the facility. Further, R44 needed new shoes, as they did not fit anymore. During an interview on 5/4/22, at 2:50 p.m. licensed practical nurse (LPN)-A stated he had not been informed of R44's nails and upon assessment of R44's nails podiatry was needed. LPN-A also stated he did not know if a referral had been placed, but the health unit coordinator (HUC) would know. During an interview on 5/4/22, at 3:01 p.m. nursing assistant (NA)-B stated she worked in the facility both as a NA and as a HUC. NA-B stated nobody informed her of R44 needing to see podiatry and no referral had been made. NA-B stated she planned to work on an appointment for R44 after she saw how long her nails were this morning. "No wonder she said her shoes were too small."	2 860		

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2 860	Continued From page 10 R44's podiatry provider note dated 5/4/22, indicated R44 had bilateral foot pain, hypertrophic nails (abnormal thickening of nails) and required nail debridement of six or more nails. During an interview on 5/5/22, at 4:57 p.m. the director of nursing (DON) stated he expected staff to provide a referral to the unit coordinator when podiatry services were needed so care was not delayed. A facility policy titled Activities of Daily Living, dated 3/15/21, directed residents were given appropriate treatment and services to maintain or improve their activities of daily living. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could assess residents foot care needs and/or resident preferences for foot care and revise care plan based on the assessment and/or resident choice; then designate staff members to ensure podiatry appointment and transportation arrangements are made in a timely manner after assessment identified the concern; then develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		6/10/22

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21015	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a method to consistently monitor dish machine temperatures to ensure proper sanitation of dishware. In addition, the facility failed to date opened containers of food stored in the kitchen refrigerator. These practices had the potential for food-borne illness and could affect 62 of 62 residents who utilized facility supplied dishware and/or received meals prepared and served by the facility. Findings include: TEMPERATURE MONITORING On 5/3/22, at 10:16 a.m. the Dishmachine Temperature Log (high temp machine) dated 4/22, contained dish machine temperature documentation for 42 of 93 (43.8%) opportunities. The form included fields for weekly recording of plate surface temperatures, however, the fields lacked documentation. During the kitchen tour with the dietary director (DD) on 5/03/22, at 10:19 a.m. DD stated the dish machine used hot water to sanitize and temperatures were recorded during the middle of a load each meal by the dietary aides. Upon review of the Dishmachine Temperature Log (high temp machine) dated 4/22, DD stated it had been a while since the temperatures were taken. He stated the kitchen had been short staffed lately, especially on the afternoon shift, which was why some of the temperatures were missing. DD stated the wash temperature should be above 160 degrees Fahrenheit (°F) and the rinse	21015	Corrected.	

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21015	Continued From page 12	21015		

temperature should be above 180°F. During observation of dish machine temperatures with DD, the wash temperature was noted as 150°F and the rinse temperature was 196°F. DD initiated a second run which resulted in a wash temperature of 148°F and rinse temperature of 192°F. DD stated the temperature dropped from the first to the second load, and that it was "not okay." He stated staff needed to use alternate means of sanitizing dishes until it was fixed. He stated it was important to take the temperatures of the dishwasher wash and rinse cycles to make sure the machine sanitized the dishes so they were not spreading germs. DD stated the last time he knew the dish machine was at the appropriate temperature was 4/28/22, when the last temperature was documented.

During observation on 5/3/22, at 10:19 a.m. the label on the dish machine identified it was a DiverseyLever ADC44 Dishwasher. The NSF (National Sanitation Foundation) Data Plate affixed to the side of the dish machine indicated a required wash temperature minimum of 160°F and a final hot water sanitizing rinse minimum temperature of 180°F.

The American Dish Service Models ADC44 and ADC66 Conveyor Dishwashers Service Manual dated 10/7/13, indicated the incoming water temperature for hot water sanitizing should be 160°F and the final rinse temperature should be a minimum of 180°F.

During interview on 5/3/22, at 11:57 a.m. director of maintenance (DM) stated he had just run the dish machine and the wash temperature was above 160°F. He stated if he ran it multiple times the temperature dropped to 150°F, but if he waited and let it sit between loads it went up to

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21015	Continued From page 13 170°F. He stated the booster heater should have kept the temperature up, but it was not maintaining heat over multiple cycles and he needed to call the contracted repair company to come out to fix it. During interview on 5/3/22, at 12:52 p.m. the administrator stated the maintenance director was supposed to check to dishwasher when a work order was placed and as needed for preventative maintenance. She stated staff were supposed to check temperatures either at each meal or when they turn it on, and her expectation was it should have been completed per policy to ensure dishes were sanitized appropriately to avoid contamination and spread of bacteria. FOOD STORAGE During a kitchen tour with the dietary director (DD) on 5/3/22, at 10:19 a.m. the following items were observed in the refrigerator: -5 quarts chicken stock, undated -3 cups canned pineapple, undated -Approximately 4 pounds of strawberries in a plastic tub, undated, covered on the top with 1/8 to ¼ inch of greenish gray fuzzy mold-like substance -Two ounces cheddar cheese, undated -1 pound of roast beef and ham sandwich meat in a metal container covered in foil, undated -A container of beef base, undated During interview on 5/3/22, at 10:43 a.m. dietary director (DD) stated the aforementioned items should have been dated so staff knew when to throw them away and not serve them to avoid foodborne illness. During interview on 5/3/22, at 12:52 p.m.	21015		

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21015	Continued From page 14 administrator stated she expected food items to be rotated in the kitchen and dated upon being opened. She stated anything that was opened and not dated should have been thrown out since its age could not be determined there could be a risk of bacterial contamination. The facility policy Sanitation and Cleaning Schedule dated 2/25/21, indicated the "Dish Machine Temperature Log, including plate surface temperature at least once/week for high temp machines, must be completed per policy and reviewed daily to ensure compliance." The policy indicated any temperatures on the log that are out of compliance must be addressed immediately. Further, the policy indicated all food items must be dated upon receiving and dated and sealed when opened. SUGGESTED METHOD OF CORRECTION: The administrator, director of dietary services, or designee, could review and revise as necessary the policies and procedures regarding kitchen sanitation and food storage. The director of dietary services, or designee, could provide training for all appropriate staff on these policies and procedures. The director of dietary, or designee, could audit to ensure policies and procedures are followed and report findings of the audits to the Quality Assurance and Performance Improvement (QAPI) committee for recommendations to ensure ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21015		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		6/10/22

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21426	Continued From page 15 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive tuberculosis program. Further, the facility failed to screen and/or test for exposure to tuberculosis (TB) of 3 of 5 employees (assistant director (AD)-A, nursing assistant (NA)-G, and NA-H), and 2 of 5 residents (R5, R42) who were reviewed. Findings include: The facility TB Risk Assessment dated 2020, had not been completed in it's entirety and lacked information about screening, record keeping, and staff education.	21426	Corrected.	

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21426	Continued From page 16 STAFF A facility provided document which was unnamed (undated) identified AD's hire date was 1/10/22. AD's TB screen and record of Mantoux test, chest x-ray, or blood test to screen for exposure was requested, but was not received. A facility provided document which was unnamed (undated) identified NA-G's hire date was 3/29/22. NA-G's TB screen and record of Mantoux test, chest x-ray, or blood test to screen for exposure was requested, but was not received. A facility provided document which was unnamed (undated) identified NA-H's hire date was 4/5/22. NA-H's TB screen and record of Mantoux test, chest x-ray, or blood test to screen for exposure was requested, but was not received. RESIDENTS R5 was admitted to the facility October 2020. R5 's medical record lacked a symptom screening. R42 was admitted to the facility in March 2022. R42's medical record identified a first step Mantoux was completed on 3/24/22. R42 's medical record lacked a symptom screening and a second step Mantoux. During an interview on 5/58/22, at 5:32 p.m. the director of nursing (DON) stated there was a sweep done of all residents to see who needed TB screening or a Mantoux. The facility was focusing on who needed them to get caught up. The DON verified there was not a facility TB risk assessment completed. Furthermore, the DON	21426		

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21426	Continued From page 17 stated a facility assessment completed was important to help determine what assessments are needed and how often to prevent TB within the facility. A TB facility policy was requested however was not received. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON), or designee, could develop TB policies and procedures to ensure all residents and staff are screened for physical signs and symptoms of active TB and are tested appropriately; then educate the appropriate staff on the policies/procedures; then develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were stored securely for 1 of 3 residents (R49) reviewed for medication administration and storage. In addition, the facility failed to ensure 1 of 1 medication carts were locked when unsupervised on the dementia unit. This had the potential to affect all residents who could access	21610	Corrected.	6/10/22

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21610	Continued From page 18 unsecured medications. Findings include: During medication administration observation on 5/4/22, at approximately 8:03 a.m. registered nurse (RN)-D assembled R49's 8:00 a.m. medications and placed the appropriate doses in a medication cup. RN-D left a partially filled bottle of acetaminophen 500 milligrams (mg), a medication card containing 21 doses of apixaban 2.5 mg (used for atrial fibrillation, an irregular fast heartbeat), and a medication card containing 14 doses of digoxin 125 micrograms (mcg) (used for atrial fibrillation) on top of the medication cart. At 8:09 a.m. RN-D entered R49's room, closing the door partway behind him leaving the cart and its contents out of view. RN-D exited the room at 8:13 a.m. During interview on 5/4/22, at 8:13 a.m. RN-D stated he accidentally left the medications on top of the cart because they were face down of the left side of the cart and he was working on the right. He stated he didn't see them, and it was "bad" to leave them on top. He stated it was a simple mistake, but someone could have taken them and overdosed, especially since some residents were cognitively impaired. During interview on 5/5/22, at 8:34 a.m. director of nursing (DON) stated medications were stored in the medication cart, and it was not okay to leave medications on top of the medication cart and walk away. He stated his expectation was all medications should be secured to prevent residents from taking another resident's medications. During observation on 5/5/22, at 10:34 a.m.	21610		

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21610	Continued From page 19 trained medication aide (TMA)-B walked from the nurse's office to an unlocked medication cart in the dining area where ambulatory residents with dementia were present and unsupervised. At 10:37 a.m. TMA-B walked away from the unlocked cart with a resident, leaving the cart open and unsupervised in the presence of another resident. TMA-B returned at 10:40 a.m. and locked the cart. The facility policy Medication Storage dated 9/21/19, indicated compartments containing medications should be locked when not in use. Trays or carts used to transport such items should not [be] left unattended. Further, medication will be stored in an orderly manner in cabinets, drawers, or carts. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures for proper storage of medications; educate all appropriate staff on the policies and procedures, and conduct audits on a regular basis to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		6/10/22

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21695	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the walls were kept in good repair. Further, the facility failed to ensure bed rails were clean and sanitary for 1 of 1 residents (R34) reviewed for environment. This deficient practice had the potential to affect all residents who utilized these areas. Findings include: WALL REPAIR On 5/2/22, at 6:56 p.m. the wall and ceiling above the first-floor A1 shower room across from room 111 was observed to have water damage with open and crumbling sheet rock and a black mold-like substance spotting throughout. On 5/2/22, at 7:01 p.m. multiple layers of wallpaper and sheeting to the lower left of the second-floor spa/massage room entrance were observed pulled away from the wall due to water damage. On 5/2/22, at 7:15 p.m. a ceiling tile on the north side of the third-floor dining room adjacent to the wall was observed to have water damage and had a visible black mold-like substance on the lower edge. During interview and facility tour on 5/5/22, at 1:53 p.m. director of maintenance (DM) stated there must have been a pipe leak in the wall at some time in the past and estimated the water-damaged area above the first-floor shower door to be 4.5 feet in overall width and ranged from 2 inches to 2.5 feet in height. The area	21695	Corrected.	

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21695	Continued From page 21	21695		

consisted of bubbled paint and exposed, cracked, and crumbled sheetrock partially covered with a black mold-like or mildew-like substance. DM confirmed an area of ceiling tiles above the door approximately 2.5 feet long by and 7 inches wide also had water damage. He stated the area was dry to the touch, so he did not think there was active mold.

During observation of the ceiling on the north side in the third-floor dining area DM stated he had not noticed the damage to the ceiling tiles. He stated it was "definitely water damage", but it probably was not wet. He stated it was hard to say if it was mold or not without going up on a ladder to get to it. He estimated the area to be 4 feet wide by 18 inches high and stated the whole tile needed to be replaced.

During observation of the wall outside of the second-floor spa/massage room, DM stated he was unsure where the water was coming from and estimated the water-damaged area to be approximately 30 inches high by 20 inches wide. DM confirmed there were no current work orders placed for repairs to the three areas of concern.

During interview on 5/5/22, at 2:39 p.m. registered nurse (RN)-F stated she was on the first floor and noticed damage above the resident shower room door and placed a work order to have it fixed a few months prior. She stated she did not know if it was mold or mildew on the wall and described it as "Ew." RN-F reviewed the electronic list of work order requests and noted it was marked as completed by the previous maintenance staff.

The facility Work Order Report dated 5/5/22, lacked evidence open work orders were in place

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	00740	A. BUILDING: _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF EDINA	6200 XERXES AVENUE SOUTH MINNEAPOLIS, MN 55423

(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
21695	Continued From page 22 for the three concerns. During interview on 5/5/22, at 3:57 p.m. the administrator stated her expectation was maintenance staff should be rounding on the facility and completing audits on the building. She stated the staff used an electronic system to generate work orders, and the maintenance team had standard, routine, and scheduled work and should be completing preventative maintenance as it came up. She stated it was important to keep up on maintenance and for the physical plant to be in good condition for residents, visitors, and staff who worked in the facility. A policy regarding maintenance of environment was requested but not provided. BED RAILS R34's significant change Minimum Data Set (MDS) dated 4/15/22, indicated R34 had a severe cognitive impairment and diagnoses of dementia and failure to thrive. During an observation on 5/3/22, at 12:01 p.m. R34's left bedrail had red and brown dried material on it. During an observation on 5/4/22, at 11:51 a.m. R34's left bedrail had red and brown, dried material on it. During an observation on 5/4/22, at 1:49 p.m. a wet floor sign had been placed outside the door of R34's room. R34's left bedrail still had red and brown dried material on it. During an interview on 5/5/22, at 2:24 p.m. family member (FM)-B stated R34's bedrail was dirty	21695		

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21695	Continued From page 23 and it had been for several weeks. FM-B stated it was bothersome as R34 frequently reached for the bedrail and touched it often. During an interview on 5/5/22, at 2:24 p.m. the director of maintenance stated the expectation was for housekeeping to clean all high contact surfaces daily. This included side tables, remotes, call lights and bedrails. During an interview on 5/5/22, at 2:53 p.m. housekeeper (HK)-A stated R34's room had been cleaned already. HK-A acknowledged R34's bedrail was dirty and needed cleaning. A policy for cleaning was requested, but not received. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee, could ensure a preventative maintenance and cleaning program was developed to accurately reflect ongoing preventative maintenance/cleaning scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance/cleaning is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

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21855	Continued From page 24	21855		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide privacy for 1 of 1 resident (R42) who was observed to receive wound care. Findings include: R42's admission Minimum Data Set (MDS) dated 3/21/22, indicated R42 had a mild cognitive impairment and diagnoses of Parkinson's disease and a penile wound. During an observation on 5/5/22, at 10:59 a.m. registered nurse (RN)-D cleaned R42's penile wound. RN-D shut R42's door, however, failed to close R42's privacy curtain. R42 was fully exposed from the waist down while RN-D performed cares. Physical therapy staff knocked on R42's door, however, RN-D did not respond. The physical therapist then entered R42's room, walked past the R42 and proceeded towards R42's roommate. The physical therapist then assisted R42's roommate into a wheelchair and	21855	Corrected.	6/10/22

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21855	Continued From page 25 wheeled the resident past R42 who was still fully exposed. During an interview on 5/5/22, at 11:15 a.m. RN-D stated he had not realized there was a knock on the door and was unaware of any activity with R42's roommate. RN-D stated he was concentrating on R42's wound care and was just not paying attention. RN-D acknowledged R42's curtain was not closed and needed to be closed to protect privacy. During an interview on 5/5/22, at 4:45 p.m. the director of nursing (DON) stated his expectation was be to have the privacy curtain closed when completing cares to ensure privacy was provided. Facility policy titled Privacy and Dignity revised 1/10/22, directed privacy was to be provided during cares. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could train staff to ensure the personal privacy of residents, and then perform audits to ensure each resident's right to privacy is maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend	21880		6/10/22

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21880	Continued From page 26 changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21880	Corrected.	

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21880	Continued From page 27 facility failed to ensure a written notice of a grievance resolution was provided to 1 of 1 resident (R68) reviewed for grievances. Findings include: R68's admission Minimum Data Set (MDS) dated 11/19/21, indicated R68 was moderately cognitively impaired. Five facility Grievance/Concern Forms all dated 1/3/22, completed by R68's family member (FM-B) included "written response requested" in the upper left corner. The forms also contained a field on page two of each document which indicated "The Resident/Resident Representative requested a written decision?" with a checkmark indicating "Yes." In addition, each form identified a written decision was provided on 2/3/22 (despite the resident being discharged prior to this date). During an interview on 5/5/22, at 9:40 a.m. (FM)-B stated she filed 17 grievances since R68's admission and the facility did not respond to any of them. She stated she requested written responses for many and never received a written response from the facility. During interview on 5/5/22, at 11:27 a.m. the social services director (SSD) stated grievances were addressed during daily interdisciplinary team meetings, until resolved, and resolutions were communicated to the resident and responsible party. She stated residents and their representatives had a right to request a written report. SSD reviewed nine grievances filed by FM-B and confirmed five of them included "written response requested" in the upper left of the forms. She stated she planned to provide	21880		

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21880	Continued From page 28	21880		

written responses to FM-B at the next care conference scheduled for 2/3/22, but R68 was discharged in January. She stated resolutions were verbally communicated to FM-B, however, and written responses were not provided, as requested.

During interview on 5/5/22, at 3:57 p.m. the administrator stated residents and their representatives received a response to any grievance in whatever form the family wished. SSD provided written responses to grievances when requested. She stated not all FM-B's grievances required written responses, but to her knowledge they were provided when requested. She stated her expectation was if a written response was requested it would be provided.

The facility Policy and Procedure Grievance/Concerns dated 1/14/22, indicated the facility would make prompt efforts to resolve all grievances, and the grievance form included the date the grievance was received, a summary statement of the resident's grievance, the steps being taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents' concerns, whether the grievance was confirmed or not confirmed, corrective action taken, or to be taken, and the date the written decision was issued.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could inservice staff regarding making sure identified concerns, both voiced and in writing, are addressed with satisfaction in a timely manner and written responses delivered as requested; then audit to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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21880	Continued From page 29 (21) days.	21880		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council within the past 12-months. This had the potential to affect all 62 residents residing in the facility. Findings include: During interview on 5/4/22, at 1:44 p.m. social services director (SSD) stated the facility had not attempted to facilitate a family council meeting since 2019, and presented a facility flier (undated) which indicated the last family council meeting was held 9/24/19. The facility policy Family Council dated 10/12/21, indicated the facility will provide residents and their families with the opportunity to air any	21942	Corrected.	6/10/22

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21942	Continued From page 30 grievances that they many have and to give suggestions on what they would like, along with and changes they think should be made. The policy lacked indication of meeting frequency. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee, could review or revise policies and communicate with the residents and/or families concerning the establishment of family council. A letter could be sent to discover if any family members are interested in the establishment of the committees. The administrator, DON or designee could attempt at least once each calendar year and provide education for staff regarding formulation of a Family Council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		

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	245275	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

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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 05/04/2022. At the time of this survey, Edenbrook Of Edina 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 | 05/27/2022

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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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. This 3-story building was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 65 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress per NFPA 101 (2012 edition), Life Safety Code section 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/04/2022, between 09:00 AM and 12:00 PM, it was revealed by observation that storage was in the path of egress out of the Equipment Room (B-1) secondary emergency exit. An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 211	Hallway outside of boiler room no path of egress. 1. The hallway outside of the boiler room (B-1) was cleared of trash and debris. 2. Signs were hung stating that the area is not to be used for storage. 3. This will be monitored on a weekly basis when building rounds are being completed. 4. The environmental service director is responsible for ensuring that the hall remains clear and free from debris. 5. This project was completed on 5-6-2022.	6/10/22
K 233 SS=F	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the	K 233		6/30/22

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K 233	Continued From page 3 swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear width in exit access doors and exit doors system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.3.6 and 19.2.3.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/04/2022, between 09:00 AM and 12:30 PM, it was revealed by observation that resident rooms throughout the facility did not have the required clear width of 32-inch exit access due to interference of the bathroom door. An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 233	Bathroom door clearance. 1. The building was walked and inspected to determine the number of bathroom doors were not in compliance. It was found that 7 bathrooms on first floor, 4 bathrooms on second floor and 2 bathrooms on third floor were not in compliance. It has been decided that a single spring door chain will be attached to the bathroom door to prevent the door from swinging into the entrance door and creating an entrapment area. 2. Per company policy a weekly door check is required throughout the facility and these bathroom doors will be closely inspected each week to ensure that the overlap is not occurring. 3. The company online Tels system requires a weekly door log for any doors that are not meeting the standard requirements. Any issues with these doors will be logged in the weekly Tels and then fixed immediately. 4. The environmental service director is responsible for ensuring that these door and chain assemblies are set to the right position and are working properly each week. 5. The spring assemblies have been ordered but are waiting on delivery. This project will be completed no later than	

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(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
K 233	Continued From page 4	K 233	June 30, 2022.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 2 hazardous storage rooms per NFPA 101 (2012 edition), Life Safety	K 321	B8 storage room door. 1. An automatic door closer was installed on the B8 storage room door.	6/10/22

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	245275	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

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K 321	Continued From page 5 Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/04/2022 between 09:00 AM and 12:00 PM, it was revealed by observation that combustible storage room B8 did not have a self-closing device. 2. On 05/04/2022 between 09:00 AM and 12:00 PM, it was revealed by observation the self-closing door to the boiler room was propped open. An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 321	2. This deficiency can not reoccur because the closer is installed on the door. 3. Part of the maintenance weekly checklist is to check door closures and this door will be a part of the checks. 4. The environmental service director is responsible for maintaining the door and ensuring that the closer is functioning properly. 5. This project was completed on 5-6-2022. Boiler room door propped. 1. The bucket that was propping the door was removed along with any other materials that could be used to prop the door were taken off the landing. 2. Signs were hung on the door stating that the door must not be propped open. 3. Maintenance is the only department with keys to the boiler room door. Staff has been educated on the importance of keeping that door closed. Environmental service director will ensure the door is closed when doing daily walkthroughs of the boiler room. 4. The environmental service director is responsible for ensuring that the door is not propped. This will be monitored during the daily walkthroughs. 5. This project was completed on 5-6-2022.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping	K 511		6/10/22

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K 511	Continued From page 6 complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the electrical system per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70 (2011 edition), Life Safety Code, section 314.25. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/04/2022 between 09:00 AM and 12:00 PM, it was revealed by observation that there was an electrical junction box with exposed wires on the ceiling of the memory care dining room. An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 511	Exposed wires in junction box memory care dining room. 1. The exposed wires in the memory care dining room were contained by putting a cover on the junction box. 2. Maintenance staff was educated on the importance of not leaving exposed wires. 3. After any new electrical projects are completed the Environmental service director must check the completed work to ensure there are no exposed wires. 4. The environmental service director is responsible for ensuring that no wires are left exposed after electrical projects are completed. 5. This task was completed on 5-6-2022.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at	K 712		6/10/22

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K 712	Continued From page 7 least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/04/2022 between 09:00 AM and 12:30 PM, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: 1. First shift 04/14/2021 at 01:00 PM, 07/15/2022 at 01:20 PM, and 10/19/21 at 01:30 PM. 2. Second shift 02/20/2022 at 2:00 PM, 05/12/2021 at 3:00 PM, and 08/22/2021 at 3:06 PM. 3. Third shift 06/08/2021 at 01:30 AM and 12/13/2021 at 02:00 AM. An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 712	No variation in times 1. An annual fire drill schedule was created with the month and time of day that each drill should be performed was created to help ensure that fire drills are performed at staggered times of the day. 2. The schedule was put into the life safety book at the front of the drills tabs so that it is easy to see and reference when getting ready to perform a fire drill. 3. Environmental service director will follow the scheduled times to ensure that drills are taking place at different times of the day. 4. The Environmental Service Director is responsible for ensuring that the times of the fire drill are staggered throughout the year. 5. The annual fire drill schedule was made on 5-23-2022.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations	K 741		6/10/22

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K 741	Continued From page 8 Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to implement a staff smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/04/2022 between 09:00 AM and 12:00 PM,	K 741	No staff smoking policy- smoking by back door. 1. A staff smoking policy was located and revised to meet the standards set by the building. 2. Staff was educated about the smoking policy and informed of the importance of not smoking near the building. Staff was required to sign an acknowledgement form stating that they had been given training on the smoking	

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K 741	Continued From page 9 it was revealed by observation and a review of available documentation that the smoking policy did not cover staff smoking, and the staff were smoking directly outside the employee exit door and there was evidence of cigarette butts on the ground. An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 741	policy. 3. Moving forward the staff smoking policy will be incorporated into new hire orientation. It is a part of the orientation packet that staff is required to sign and acknowledge upon being hired. 4. The HR manager is responsible for ensuring that the orientation packet is signed. The environmental service director is responsible for discussing the smoking policy during new hire orientation. 5. The smoking policy was updated and staff were educated on 5-6-2022	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K 914		6/10/22

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K 914	Continued From page 10 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical receptacle testing and maintenance in resident sleeping rooms per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 and 6.3.4.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/04/2022, between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that the required annual receptacle inspection documentation was not available at the time of the survey. An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 914	No documentation of electrical receptacle test from 2021. 1. Receptacle testing is being done throughout the building; project started on 05/24/2022. 2. The annual date of inspection has been added to the inspections checklist that is updated each year when a task is complete. 3. The environmental service director is responsible for ensuring that this task is being completed every year. This task is also in the Tels maintenance tasks and it is part of the checklist on an annual basis. 4. The environmental service director is responsible for keeping the building l compliance with annual electrical receptacle tests in all resident rooms. 5. The project was started on 5/24/2022 and will be completed no later than 6/10/2022.	
K 930 SS=D	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities	K 930	Two oxygen reservoirs in one room. 1. The oxygen cylinder that was not in use was removed from the room and staff	6/10/22

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K 930	Continued From page 11 Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/04/2021 between 09:00 AM and 12:00 PM, it was revealed by observation that room 302 had two liquid oxygen reservoirs inside one was in use and the other was being stored. An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 930	was informed that no more than one oxygen tank is to be stored in the room at one time. 2. The oxygen storage procedure was then reviewed and revised to ensure that the proper storage procedures were in the document. Staff training was then performed and staff attending were then required to sign an acknowledgement of training. 3. Proper oxygen storage is a part of the new hire orientation training. During the building tour the oxygen storage room is shown to all new staff and proper handling and storage is covered. 4. The environmental service director is responsible for ensuring that oxygen is stored properly in the oxygen storage closet and not in any common areas throughout the building. It is the responsibility of the nurse on duty to ensure that there are no extra oxygen reservoirs being stored in resident areas where they are not in use. 5. Staff was educated on the oxygen storage policy and the extra oxygen tank was removed on 5-6-2022.	