



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 9, 2023

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

RE: CCN: 245275
Cycle Start Date: April 11, 2023

Dear Administrator:

On May 5, 2023, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

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



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June 9, 2023

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

Re: Reinspection Results
Event ID: E7M312

Dear Administrator:

On May 5, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

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



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April 20, 2023

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

RE: CCN: 245275
Cycle Start Date: April 11, 2023

Dear Administrator:

On April 11, 2023, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C 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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 11, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 11, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

Edenbrook Of Edina

April 20, 2023

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dates specified for compliance or the imposition of remedies.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Hagen". The signature is fluid and cursive, with a large initial "L" and "H".

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2023	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF EDINA				STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 000	INITIAL COMMENTS From 4/10/23 through 4/11/23, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued: H52751128C (MN92544) H52751130C (MN91540) H52751133C (MN88828) H52751180C (MN86865) H52751129C (MN86172) H52751132C (MN85502) H52751162C (MN84379) H52752868C (MN84484) H52751240C (MN92605 and MN92607), and The following complaints were reviewed: H52751141C (MN92549) with deficiencies issued at F677 and F760, H52751124C (MN92526) with deficiencies issued at F677 and F692, H52751131C (MN89330) with deficiencies issued at F677 and F698. Use this statement if deficiencies are issued on this survey 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			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2023

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

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F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure baths were provided for 3 of 3 residents (R3, R4, R6) reviewed for ADLs. Findings Include: R3's admission Minimum Data Set (MDS) dated 4/10/23, indicated R3 was moderately cognitively impaired, and required on person physical assistance for bathing and personal hygiene needs. Further, the MDS indicated R3 was always incontinent of bowel and bladder. R3's care plan dated 4/6/23, indicated R3 required one staff to assist with bathing. The posted bath schedule on the 2nd floor nurses' station cupboard indicated R3, was scheduled for baths Thursday evenings. R3's electronic health record (EHR) tasks	F 677			4/30/23

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F 677	Continued From page 2 documentation for baths lacked a preference for bath day, and had one documented bath on 4/10/23, in the last thirty days. During interview and observation on 4/10/23 at 12:19 p.m., family member (FM)-C stated often when family visits R3 had food on the face, body, and clothes, and was not getting baths. FM-C stated the family washed R3 and cleaned R3's dentures when they visit because the baths and denture care were not provided. FM-C stated she looked for evidence of toothpaste, toothbrush, and a denture cup, and there was none in the room. When observed, none of the denture supplies were present in the room. FM-C further stated family is frequently present, and had not seen R3 refuse baths. R4's quarterly MDS dated 2/28/23, indicated severely impaired cogitation, bathing had not occurred in the previous seven days, and R4 required extensive assistance of two staff for personal hygiene needs. Further, the MDS indicated R4 was always incontinent of bowel and bladder. R4's orders dated 9/29/21, indicated heel boots when in bed. R4's orders dated 6/2/22, indicated have R4 in bed by 4:00 p.m., per family request; another order dated 3/18/23, indicated have R4 in bed by 3:00 p.m., per family request. R4's care plan dated 8/30/22, indicated R4 required staff assistance for bathing and was incontinent of bowel and bladder. The posted bath schedule in the 2nd floor nurses' station indicated R4, was scheduled for baths on Friday evening shift.	F 677	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. All residents ☐ most recent bath date will be audited and all residents who remain out of compliance will receive a bath. All resident care plans have been updated with appropriate bath dates, the master bath schedule was updated and posted on all floors. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All admissions (new and re-admissions) will be reviewed for correct bath schedule in care plan and will be added to the master bath schedule. Nursing staff education to be completed on bathing schedule, importance of care plan adherence, bathing policy, and what to do when baths are not able to be completed. Nursing staff educated to post the updated bath schedules timely with all changes made to any residents bathing care plan. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator or designee will audit all admissions x 8 weeks to ensure bathing care plan matches master bath schedules and five additional residents per week x 8 weeks to ensure bath tasks are completed timely in the electronic medical record. Results of audits will be reported to Quarterly Quality Assurance and Improvement		

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F 677	Continued From page 3 R4's electronic health record (EHR) bath task documentation indicated a preference for Friday evening baths and as needed, but R4 received no baths on Friday evenings. The task documentation indicated R4 had a bath 3/19/23, and then not again until 4/6/23. During interview and observation on 4/10/23 at 9:53 a.m., nursing assistant (NA)-B stated there was not enough NA help to complete work some days. NA-B stated sometimes R4 sits in her chair for long periods of time, up to six or seven hours, and does not get checked for incontinence and/or have the incontinence brief changed often enough. NA-B stated many residents required two staff for cares, and the aides had to run between floors to help each other or ask nurses for help. NA-B stated residents miss showers, and NAs did not have enough time to do rounds to check on residents more than once a shift. Further, NA-B stated some residents required range of motion exercises, and were not getting those either and said, "We have to pick our battles." NA-B stated if baths for residents were not done, it was because staff did not have time to do them. When interviewed on 4/10/23 at 10:11 a.m. NA-C stated she was required to work between two floors twice in the previous week. NA-C stated most days there was only one NA per floor, and there was not enough time or staff to provide evening cares, baths, and put residents to bed. During interview and observation on 4/11/23 at 10:21 a.m., in R4's room, NA-A stated two staff called in for morning shift, and she did not did not know what care each resident required and did	F 677	committee X1 for further problem resolution if needed. DON is responsible for compliance.		

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F 677	Continued From page 4 not have time to review resident care sheets on the Kardex in the EHR. Further, NA-A stated when the facility is short-staffed, residents did not get up on time, and did not get incontinence briefs checked and/or changed timely, or baths as scheduled. During observation on 4/11/23 at 10:25 a.m., NA-A walked down the hall and told staff sitting at the desk, "I'm tired. [expletive]," and then NA-A walked down the stairs off the unit. R6's significant change MDS dated 4/8/23, indicated R6 was cognitively intact, required dialysis, and bathing had not occurred in the previous seven days, and required extensive assistance of two staff for personal hygiene needs. Further, the MDS indicated R6 was occasionally incontinent of bladder, and frequently incontinent of bowel. R6's orders dated 3/1/23, indicated R4 was scheduled for dialysis on Mondays, Wednesday, and Friday mornings. R6's care plan revised 3/30/23, indicated R6 required extensive assistance of one person for bathing. The posted bath schedule in the 2nd floor nurses' station indicated R4 was scheduled for baths on Tuesday evening shift. R6's electronic health record (EHR) tasks documentation for baths indicated a preference for Friday morning shift baths. The task documentation indicated R6 was not available for a bath on 3/17/23 at 11:47 a.m., and 3/31/23 at 1:59 p.m., which were dates/times R6 was	F 677			

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F 677	Continued From page 5 scheduled to be out of the building for dialysis. R6 received a bath on 4/1/23, and had none since 4/1/23. During interview and observation on 4/10/23 at 1:46 p.m., R6's hair appeared greasy, uncombed, and she wore pants soaked with liquid on the front. R6 recalled one bath in the past two months, and reportedly would never refuse a bath. R6 stated her pants were wet from washing her face because after dialysis she got sweaty, and because she does not get a bath, at least wanted a clean face. R6 inquired if she had a body odor. During interview on 4/11/23 at 12:52 p.m., registered nurse (RN)-B stated the facility did not have enough NAs and as a result weights and baths were not getting done as ordered. RN-B acknowledged R6's baths were scheduled when she was out of the facility for dialysis. During interview on 4/11/23 2:32 p.m., the director of nursing (DON) stated she expected residents would have baths as scheduled, and that baths were scheduled when residents were available. The Activities of Daily Living policy dated 3/15/21, indicated the facility must provide the necessary care and services including oral hygiene and bathing.	F 677			
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	F 692			4/30/23

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F 692	Continued From page 6 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 interview, observation, and document review the facility failed to ensure tube feedings were administered for 1 of 2 residents (R4) reviewed for tube feeding administration. Findings include: R4's quarterly MDS dated 2/28/23, indicated severely impaired cognition, and R4 required tube feeding. R4's orders dated 5/6/20, indicated nothing by mouth for food. Orders dated 2/22/23, indicated enteral (tube) feed three times a day via gravity, and an order dated 12/20/22, indicated Jevity three times a day. R4's care plan dated 8/30/22, indicated R4 required tube feeding per provider orders.			F 692	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R4's physician updated regarding		

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F 692	Continued From page 7 R4's treatment administration record (TAR) indicated feedings were missed 4/5/23 at 8:00 a.m., 4/5/23 at 1:00 p.m., and 4/10/23, at 1:00 p.m. R4's progress notes lacked indication the provider was notified of the missed tube feedings. During interview on 4/11/23 at 12:52 p.m., registered nurse (RN)-B stated R4's tube feedings were missed because there was only a TMA working on 2nd floor the shifts the feedings were missed and not nurse. RN-B stated TMAs could not administer tube feedings. Also, RN-B stated if the IV for R3 was missed on 4/4/23, it may not have been delivered on time, but did not know why two doses were missed after they were delivered, but acknowledged R3 missed the first three doses of IV antibiotic upon admission. RN-B stated the facility is short of nurses, especially on the morning shift. RN-B stated missed doses of IV medications could cause an infection to get worse, and acknowledged the provider was not notified of the missed doses. During interview on 4/11/23 at 2:21 p.m., family member (FM)-E stated there are cameras in R4's room and on 4/10/23, R4 was fed at 8:00 a.m., 8:00 p.m. and the 1:00 p.m. feeding was missed. RM-E stated they called the facility around 6:00 p.m. to remind staff about the tube feeding and was told the next feeding could be administered at 8:00 p.m. when staff had time to do it. During interview on 4/11/23 at 2:32 p.m., the director of nursing (DON) stated the expectation was for tube feedings to be administered as ordered, and providers would be notified if they were not.			F 692	missed tube feeding. Audit completed, no other medications or feedings were missed. Per surveyor recommendation during this site visit, review of care plan and orders to identify if continuous would be appropriate for R4. It has been determined that resident is appropriate for bolus and not continuous. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving enteral nutrition have the potential to be affected. All residents with tube feeding will be audited for the past 30 days and any missed administrations will be reported to the physician and resident/responsible party. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All nurses will be educated on the importance of timely tube feeding administration along with the tube feeding policies and procedure. TMAs will be educated on the importance of notifying a nurse when tube feeding is due. All nurses and TMAs to be educated to report to the Director of Nursing or designee anytime a tube feeding is not completed for appropriate follow up. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator or designee will audit tube feeding completion for all residents on tube feeding 2x weekly x4 weeks then 1x weekly x8 weeks. Results of audits will be reported to Quarterly Quality Assurance		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2023
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F 692	Continued From page 8	F 692	and Improvement committee X1 for further problem resolution if needed. DON is responsible for compliance.		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to provide dialysis care assessments for 3 of 3 residents (R6, R20, R21) reviewed for dialysis. Findings include: R6's significant change Minimum Data Set (MDS) dated 4/8/23, indicated R6 was cognitively intact, required dialysis, and bathing had not occurred in the previous seven days. Further, the MDS indicated R6 required extensive assistance of two staff for personal hygiene needs and was occasionally incontinent of bladder, and frequently incontinent of bowel. R6's orders dated 3/1/23, indicated dialysis on Mondays, Wednesdays, and Fridays. Orders dated 2/16/23, indicated check for bruit (a rumbling sound heard with stethoscope that indicates good blood flow) and thrill (a rumbling sensation felt on the fistula that indicates good	F 698			4/30/23

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F 698	Continued From page 9 blood flow) every shift and as needed. Also, orders dated 4/10/23, indicated nursing to monitor site to assure dressing remains clean, dry, and intact, every shift. Orders dated 2/18/23, indicated check vital signs (VS) before and after dialysis on Tuesday, Thursday, and Saturday. An order dated 2/17/23, indicated check weights on shower and bath days (once weekly). R6's care plan, revised 3/20/23, indicated R6 was dependent upon kidney dialysis. The care plan included interventions to check bruit and thrill, and to monitor the fistula site but did not include a frequency for either. Additionally, the care plan indicated monitor VS as ordered. R6's weights recorded in the electronic health record (EHR) indicated two weights recorded in April on Saturday 4/1/23, and Monday 4/3/23, and five weights recorded in March on Thursday 3/2/23, Friday 3/3/23, Tuesday 3/7/23, Saturday 3/18/23, and Tuesday 3/28/23. R6's April treatment administration record (TAR) indicated check for bruit and thrill every shift and as needed. From 4/1/23, to 4/10/23, the thrill and bruit assessment, and site dressing assessments were missed four of thirty times, and was signed off by a trained medication assistant (TMA)-A twice. The TAR indicated R6 goes to dialysis Mondays, Wednesdays, and Fridays. R6's TAR lacked documentation of weights before and after dialysis. During interview and observation on 4/10/23 at 1:46 p.m., R6 stated dialysis was scheduled on Tuesdays, Thursday, and Saturdays, but due to inability to schedule rides on Saturdays, was changed to Mondays, Wednesdays, and Fridays.			F 698	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving dialysis have the potential to be affected. There are no other residents currently in-house who receive dialysis. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nurse management educated on importance of ensuring all residents receiving dialysis have orders and care plans in place to include monitoring of bruit and thrill, fistula site, and vitals, with frequency. Education to nursing staff on importance of completing dialysis care assessments, including review the Care of a Hemodialysis Patient Policy and the Dialysis Communication Sheet. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator or designee will audit to ensure dialysis care assessments are completed timely and appropriately 2x weekly x4 weeks then 1x weekly x8 weeks. Results of audits will be reported to Quarterly Quality Assurance and Improvement committee X1 for further problem resolution if needed. DON is responsible for compliance.		

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F 698	Continued From page 10 R6 was wearing a bandage on her left upper arm over her dialysis fistula (a connection made between an artery and vein for dialysis access). R6 stated staff, "Sometimes," assessed the site and bandage after dialysis and, "Sometimes not." R6 stated she did not know what kind of care the site required. R6 further stated she was not weighed, and vital signs were not assessed before and after dialysis. R20's 5-Day MDS dated 3/23/23, indicated R20 was admitted 3/17/23, was cognitively intact, and required dialysis. R20 lacked orders to assess for bruit and thrill, assess VS and weights before and after dialysis, perform dialysis fistula monitoring and site, and assess the dressings after dialysis. R20's care plan lacked focus area for dialysis or interventions for dialysis care. R21's admission MDS dated 1/24/23, indicated R21 was admitted 1/18/23, was cognitively intact, and required dialysis. R21 lacked orders to assess for bruit and thrill, assess weights before and after dialysis, perform dialysis fistula monitoring and site, and assess the dressings after dialysis. R21's care plan dated 3/2/23, indicated R20 had potential for altered nutrition related to dialysis but lacked any other focus area for dialysis or interventions for dialysis care. During interview on 4/11/23 at 10:49 a.m. TMA-A stated TMAs were not allowed to check for bruit	F 698			

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F 698	Continued From page 11 and thrill or assess fistula dressings. TMA-A stated they did not know what the terms bruit and thrill meant, and did not know why some bruit and thrill assessments were signed off with the TMA's initials. TMA-A stated if the assessments were signed off by a TMA, then nurses would not do the assessments as it would appear they had been completed. During interview on 4/11/23 at 12:52 p.m., registered nurse (RN)-B stated the expectation for residents who have dialysis was to check VS, the port, weights, bruit and thrill before and after dialysis treatment. RN-B stated R20 had a central line port and not a fistula and did not require some of the same care as someone with a fistula. RN-B reviewed R20's medical record and acknowledged R20 had a fistula and not a port, and had no orders or care plan for dialysis care. RN-B reviewed R21's medical record and acknowledged R21 had no orders or care plan for dialysis care. Upon review of R6's medical record, RN-B acknowledged R6's weights were not performed as ordered, and were ordered for the wrong days of the week. RN-B stated the orders for R21's VS were entered wrong, and as a result the vital signs were not done. Additionally, RN-B stated the expectations was to assess the residents who have dialysis so they don't become more ill, get fluid overload, or infections. When interviewed on 4/11/23 at 2:32 p.m. the director of nursing (DON) stated she expected nursing staff to use the order set for dialysis, each resident on dialysis would have a comprehensive care plan for dialysis, and only nurses would chart dialysis care.			F 698			

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F 698	Continued From page 12 The Care of Hemodialysis Resident Policy dated 8/1/15, indicated check for bruit and thrill daily, take vital signs daily or per physician order, check for signs of infection daily, observe for bleeding. Additionally, the policy indicated the care plan would include: Identify potential risks and complications of dialysis Measurable goal for potential risks and complications Monitor for complications Frequency of monitoring vital signs, respiratory distress, chest pain, headache, seizure, etc. Monitoring of shunt or access site for signs of infection Potential for bleeding Care of the access site Potential for infection Nutritional/fluid management Alternation in skin integrity Medications with appropriate scheduling as related to dialysis Changes and/or decline related to dialysis Compatible goals and interventions between SNF and dialysis providers	F 698			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure intravenous (IV) medication was administered as ordered for 1 of 1 resident (R3), reviewed.	F 760	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited		4/30/23

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F 760	Continued From page 13 Findings include: R3's admission Minimum Data Set (MDS) dated 4/10/23, indicated R3 was moderately cognitively impaired, and required IV therapy. R3's orders dated 4/4/23 at 2:35 p.m., indicated piperacillin-tazobactam (Zosyn) (a medication used to treat infections caused by bacteria) in dextrose IV solution 4.5 gram IV every 6 hours for 7 days. R3's care plan dated 4/11/23, lacked a focus area for IV medication administration and interventions for the IV site care. R3's April medication administration record (MAR) indicated R3 missed three consecutive doses of Zosyn IV antibiotics on 4/4/23 at 6:00 p.m., 4/5/23 at 12:00 a.m., and 4/5/23 at 6:00 a.m. R3's progress notes lacked indication the provider was notified of the missed medication doses. When interviewed on 4/10/23 at 2:39 p.m., trained medication aide (TMA)-A stated if residents were admitted with IV medication orders, the nurses process the orders, some medications come within two hours depending upon which pharmacy is utilized, and each contracted pharmacy had a daily scheduled delivery. TMA-A stated only nurses could administer IV medications and tube feedings, and sometimes there is not a nurse assigned to each floor, and treatments get missed. When interviewed on 4/10/23 at 2:45 p.m.,	F 760	in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R3's physician was updated on the missed dose, orders received to extend 3 doses, all of which were administered. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving IV medications have the potential to be affected. All residents receiving IV therapy will have a focus area on the care plan for IV medication administration and interventions for the IV site care. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Medication administration and IV therapy education to be completed for nursing staff to include importance of timely administration along with a review of the Intermittent Infusion Policy and Administrating Medications Policy. Nurse management educated and admission audit (admissions and re-admissions) reviewed to ensure focus		

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F 760	Continued From page 14 registered nurse (RN)-A stated IV meds normally arrive the morning after they were ordered from the pharmacy, and nursing staff was required to notify the providers if the medication was not available for scheduled doses. RN-A acknowledged R3 did not get the first dose of Zosyn (IV antibiotic) on 4/4/23, but stated upon review of the medication treatment record (MAR), had received all subsequent doses. RN-A stated the provider was notified about the missing first dose after the fact, but acknowledged the medical record lacked documentation of that notification. During interview on 4/11/23 at 11:44 a.m., the consulting pharmacist stated R3 was admitted 4/4/23, and nine doses of Zosyn were sent to the facility on 4/4/23, at 7:00 p.m., and an unidentified staff signed for the medication at approximately 9:00 p.m. The pharmacist stated, "I am assuming it was not a mild infection if IV antibiotics were prescribed, " and further stated R3 could have regressed in his treatment and could have required a hospital readmission. During interview on 4/11/23 at 12:52 p.m., registered nurse (RN)-B stated if the IV for R3 was missed on 4/4/23, it may not have been delivered on time, but did not know why two doses were missed after they were delivered, but acknowledged R3 missed the first three doses of IV antibiotic upon admission. RN-B stated the facility is short of nurses, especially on the morning shift. RN-B stated missed doses of IV medications could cause an infection to get worse, and acknowledged the provider was not notified of the missed doses.	F 760	area is on the care plan for IV medication administration and interventions for the IV site care. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator or designee will audit IV care plans for all residents receiving IV medications to ensure care plans are accurate x2 weekly x 4 weeks then 1x weekly x8 weeks. Administrator or designee will audit IV medication administration 2x weekly x4 weeks then 1x weekly x8 weeks. Results of audits will be reported to Quarterly Quality Assurance and Improvement committee X1 for further problem resolution if needed. DON is responsible for compliance.		

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F 760	Continued From page 15 During interview on 4/11/23 at 2:32 p.m., the director of nursing (DON) stated the expectation was for IV therapy to be administered as ordered, and providers would be notified if they were not. The Administration of an Intermittent Infusion policy dated 6/1/21, lacked direction for nurses to report missing doses. The Administering Medications policy dated 8/1/22, indicated if a medication is not given as ordered the appropriate code shall be entered into the medical record to indicate why it was not given. The policy further indicated if a medication was withheld or refused three consecutive doses, the physician would be notified.	F 760			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 20, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: E7M311

Dear Administrator:

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

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

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

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

Edenbrook Of Edina

April 20, 2023

Page 2

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:

Pete Cole, RN Unit Supervisor
Metro Team C 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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00740	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2023
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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: From 4/10/23, through 4/11/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

04/24/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00740	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2023
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF EDINA			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH MINNEAPOLIS, MN 55423		
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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued: H52751128C (MN92544), H52751130C (MN91540), H52751133C (MN88828), H52751180C (MN86865), H52751129C (MN86172), H52751132C (MN85502), H52751162C (MN84379), H52752868C (MN84484), H52751240C (MN92605 and MN92607), and The following complaints were reviewed: H52751141C (MN92549) with a licensing order issued at 0840 and 1545, H52751124C (MN92526) with a licensing order issued at 0840 and 0940 H52751131C (MN89330) with a licensing order issued at 0840. 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	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is 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			
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 840			4/30/23

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2 840	Continued From page 3 B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840			

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2 840	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure baths were provided for 3 of 3 residents (R3, R4, R6) reviewed for ADLs. Findings Include: R3's admission Minimum Data Set (MDS) dated 4/10/23, indicated R3 was moderately cognitively impaired, and required on person physical assistance for bathing and personal hygiene needs. Further, the MDS indicated R3 was always incontinent of bowel and bladder. R3's care plan dated 4/6/23, indicated R3 required one staff to assist with bathing. The posted bath schedule on the 2nd floor nurses' station cupboard indicated R3, was scheduled for baths Thursday evenings. R3's electronic health record (EHR) tasks documentation for baths lacked a preference for bath day, and had one documented bath on 4/10/23, in the last thirty days. During interview and observation on 4/10/23 at 12:19 p.m., family member (FM)-C stated often when family visits R3 had food on the face, body, and clothes, and was not getting baths. FM-C stated the family washed R3 and cleaned R3's dentures when they visit because the baths and denture care were not provided. FM-C stated she looked for evidence of toothpaste, toothbrush, and a denture cup, and there was none in the room. When observed, none of the denture supplies were present in the room. FM-C further stated family is frequently present, and had not	2 840	Acknowledged		

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2 840	Continued From page 5 seen R3 refuse baths. R4's quarterly MDS dated 2/28/23, indicated severely impaired cogitation, bathing had not occurred in the previous seven days, and R4 required extensive assistance of two staff for personal hygiene needs. Further, the MDS indicated R4 was always incontinent of bowel and bladder. R4's orders dated 9/29/21, indicated heel boots when in bed. R4's orders dated 6/2/22, indicated have R4 in bed by 4:00 p.m., per family request; another order dated 3/18/23, indicated have R4 in bed by 3:00 p.m., per family request. R4's care plan dated 8/30/22, indicated R4 required staff assistance for bathing and was incontinent of bowel and bladder. The posted bath schedule in the 2nd floor nurses' station indicated R4, was scheduled for baths on Friday evening shift. R4's electronic health record (EHR) bath task documentation indicated a preference for Friday evening baths and as needed, but R4 received no baths on Friday evenings. The task documentation indicated R4 had a bath 3/19/23, and then not again until 4/6/23. During interview and observation on 4/10/23 at 9:53 a.m., nursing assistant (NA)-B stated there was not enough NA help to complete work some days. NA-B stated sometimes R4 sits in her chair for long periods of time, up to six or seven hours, and does not get checked for incontinence and/or have the incontinence brief changed often enough. NA-B stated many residents required two staff for cares, and the aides had to run	2 840			

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2 840	Continued From page 6 between floors to help each other or ask nurses for help. NA-B stated residents miss showers, and NAs did not have enough time to do rounds to check on residents more than once a shift. Further, NA-B stated some residents required range of motion exercises, and were not getting those either and said, "We have to pick our battles." NA-B stated if baths for residents were not done, it was becuase staff did not have time to do them. When interviewed on 4/10/23 at 10:11 a.m. NA-C stated she was required to work between two floors twice in the previous week. NA-C stated most days there was only one NA per floor, and there was not enough time or staff to provide evening cares, baths, and put residents to bed. During interview and observation on 4/11/23 at 10:21 a.m., in R4's room, NA-A stated two staff called in for morning shift, and she did not did not know what care each resident required and did not have time to review resident care sheets on the Kardex in the EHR. Further, NA-A stated when the facility is short-staffed, residents did not get up on time, and did not get incontinence briefs checked and/or changed timely, or baths as scheduled. During observation on 4/11/23 at 10:25 a.m., NA-A walked down the hall and told staff sitting at the desk, "I'm tired. [expletive]," and then NA-A walked down the stairs off the unit. R6's significant change MDS dated 4/8/23, indicated R6 was cognitively intact, required dialysis, and bathing had not occurred in the previous seven days, and required extensive assistance of two staff for personal hygiene needs. Further, the MDS indicated R6 was	2 840			

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2 840	Continued From page 7 occasionally incontinent of bladder, and frequently incontinent of bowel. R6's orders dated 3/1/23, indicated R4 was scheduled for dialysis on Mondays, Wednesday, and Friday mornings. R6's care plan revised 3/30/23, indicated R6 required extensive assistance of one person for bathing. The posted bath schedule in the 2nd floor nurses' station indicated R4 was scheduled for baths on Tuesday evening shift. R6's electronic health record (EHR) tasks documentation for baths indicated a preference for Friday morning shift baths. The task documentation indicated R6 was not available for a bath on 3/17/23 at 11:47 a.m., and 3/31/23 at 1:59 p.m., which were dates/times R6 was scheduled to be out of the building for dialysis. R6 received a bath on 4/1/23, and had none since 4/1/23. During interview and observation on 4/10/23 at 1:46 p.m., R6's hair appeared greasy, uncombed, and she wore pants soaked with liquid on the front. R6 recalled one bath in the past two months, and reportedly would never refuse a bath. R6 stated her pants were wet from washing her face because after dialysis she got sweaty, and because she does not get a bath, at least wanted a clean face. R6 inquired if she had a body odor. During interview on 4/11/23 at 12:52 p.m., registered nurse (RN)-B stated the facility did not have enough NAs and as a result weights and baths were not getting done as ordered. RN-B	2 840			

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2 840	Continued From page 8 acknowledged R6's baths were scheduled when she was out of the facility for dialysis. During interview on 4/11/23 2:32 p.m., the director of nursing (DON) stated she expected residents would have baths as scheduled, and that baths were scheduled when residents were available. The Activities of Daily Living policy dated 3/15/21, indicated the facility must provide the necessary care and services including oral hygiene and bathing. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents who require assistance with bathing receive baths; educate staff as appropriate; then develop monitoring systems or audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 840			
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure tube feedings were administered for 1 of 2 residents (R4)	2 940	Acknowledged		4/30/23

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2 940	Continued From page 9 reviewed for tube feeding administration. Findings include: R4's quarterly MDS dated 2/28/23, indicated severely impaired cognition, and R4 required tube feeding. R4's orders dated 5/6/20, indicated nothing by mouth for food. Orders dated 2/22/23, indicated enteral (tube) feed three times a day via gravity, and an order dated 12/20/22, indicated Jevity three times a day. R4's care plan dated 8/30/22, indicated R4 required tube feeding per provider orders. R4's treatment administration record (TAR) indicated feedings were missed 4/5/23 at 8:00 a.m., 4/5/23 at 1:00 p.m., and 4/10/23, at 1:00 p.m. R4's progress notes lacked indication the provider was notified of the missed tube feedings. During interview on 4/11/23 at 12:52 p.m., registered nurse (RN)-B stated R4's tube feedings were missed because there was only a TMA working on 2nd floor the shifts the feedings were missed and not nurse. RN-B stated TMAs could not administer tube feedings. Also, RN-B stated if the IV for R3 was missed on 4/4/23, it may not have been delivered on time, but did not know why two doses were missed after they were delivered, but acknowledged R3 missed the first three doses of IV antibiotic upon admission. RN-B stated the facility is short of nurses, especially on the morning shift. RN-B stated missed doses of IV medications could cause an infection to get worse, and acknowledged the	2 940			

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2 940	Continued From page 10 provider was not notified of the missed doses. During interview on 4/11/23 at 2:21 p.m., family member (FM)-E stated there are cameras in R4's room and on 4/10/23, R4 was fed at 8:00 a.m., 8:00 p.m. and the 1:00 p.m. feeding was missed. RM-E stated they called the facility around 6:00 p.m. to remind staff about the tube feeding and was told the next feeding could be administered at 8:00 p.m. when staff had time to do it. During interview on 4/11/23 at 2:32 p.m., the director of nursing (DON) stated the expectation was for tube feedings to be administered as ordered, and providers would be notified if they were not. The Tube Feeding Policy dated 10/20/21, indicated tube feeding is to provide nourishment to the resident who is unable to obtain nourishment orally. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise policies and procedures for monitoring tube feeding schedules and fluid intake, and provide additional training to staff. A designated staff could monitor the system for compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 940			
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of	21545			4/30/23

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21545	Continued From page 11 the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.	21545			

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21545	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure intravenous (IV) medication was administered as ordered for 1 of 1 resident (R3), reviewed. Findings include: R3's admission Minimum Data Set (MDS) dated 4/10/23, indicated R3 was moderately cognitively impaired, and required IV therapy. R3's orders dated 4/4/23 at 2:35 p.m., indicated piperacillin-tazobactam (Zosyn) (a medication used to treat infections caused by bacteria) in dextrose IV solution 4.5 gram IV every 6 hours for 7 days. R3's care plan dated 4/11/23, lacked a focus area for IV medication administration and interventions for the IV site care. R3's April medication administration record (MAR) indicated R3 missed three consecutive doses of Zosyn IV antibiotics on 4/4/23 at 6:00 p.m., 4/5/23 at 12:00 a.m., and 4/5/23 at 6:00 a.m. R3's progress notes lacked indication the provider was notified of the missed medication doses. When interviewed on 4/10/23 at 2:39 p.m., trained medication aide (TMA)-A stated if residents were admitted with IV medication orders, the nurses process the orders, some medications come within two hours depending upon which pharmacy is utilized, and each	21545	Acknowledged		

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21545	Continued From page 13 contracted pharmacy had a daily scheduled delivery. TMA-A stated only nurses could administer IV medications and tube feedings, and sometimes there is not a nurse assigned to each floor, and treatments get missed. When interviewed on 4/10/23 at 2:45 p.m., registered nurse (RN)-A stated IV meds normally arrive the morning after they were ordered from the pharmacy, and nursing staff was required to notify the providers if the medication was not available for scheduled doses. RN-A acknowledged R3 did not get the first dose of Zosyn (IV antibiotic) on 4/4/23, but stated upon review of the medication treatment record (MAR), had received all subsequent doses. RN-A stated the provider was notified about the missing first dose after the fact, but acknowledged the medical record lacked documentation of that notification. During interview on 4/11/23 at 11:44 a.m., the consulting pharmacist stated R3 was admitted 4/4/23, and nine doses of Zosyn were sent to the facility on 4/4/23, at 7:00 p.m., and an unidentified staff signed for the medication at approximately 9:00 p.m. The pharmacist stated, "I am assuming it was not a mild infection if IV antibiotics were prescribed, " and further stated R3 could have regressed in his treatment and could have required a hospital readmission. During interview on 4/11/23 at 12:52 p.m., registered nurse (RN)-B stated if the IV for R3 was missed on 4/4/23, it may not have been delivered on time, but did not know why two doses were missed after they were delivered, but acknowledged R3 missed the first three doses of IV antibiotic upon admission. RN-B stated the facility is short of nurses, especially on the	21545			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00740	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2023
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF EDINA			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21545	Continued From page 14 morning shift. RN-B stated missed doses of IV medications could cause an infection to get worse, and acknowledged the provider was not notified of the missed doses. During interview on 4/11/23 at 2:32 p.m., the director of nursing (DON) stated the expectation was for IV therapy to be administered as ordered, and providers would be notified if they were not. The Administration of an Intermittent Infusion policy dated 6/1/21, lacked direction for nurses to report missing doses. The Administering Medications policy dated 8/1/22, indicated if a medication is not given as ordered the appropriate code shall be entered into the medical record to indicate why it was not given. The policy further indicated if a medication was withheld or refused three consecutive doses, the physician would be notified. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545			