



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 13, 2022

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

RE: CCN: 245275
Cycle Start Date: December 30, 2021

Dear Administrator:

On December 30, 2021, 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 delivered CMS-2567, whereby significant 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 Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 30, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 30, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 30, 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.

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 \$11,160; 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 March 30, 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 March 30, 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 June 30, 2022 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

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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/lrc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



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

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

PRINTED: 01/31/2022
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 12/30/2021
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 On 12/29/21, through 12/30/21, a standard abbreviated survey was conducted at your facility. 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 complaint was found to be SUBSTANTIATED: H5275177C (MN79543), with deficiencies cited at F684 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 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 interview and document review, the	F 684	R1 orders for daily weights and vitals for		1/28/22

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

TITLE

(X6) DATE

Electronically Signed

01/21/2022

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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F 684	Continued From page 1 facility failed to ensure daily weights and vital signs were obtained as ordered by the physician for 1 of 3 resident's R1 reviewed for dialysis. Findings include: R1's admission Minimum Data Set dated 11/19/21, indicated R1 had a moderate cognitive impairment and was totally dependent upon staff for transferring. R1's diagnoses included heart failure, peripheral vascular disease, bilateral lower leg amputations, and kidney failure with dialysis. DAILY WEIGHTS: R1's care plan dated 11/14/21, directed staff to monitor R1's weights, per policy, and notify the medical doctor (MD) and/or registered dietician (RD) of any significant changes. R1's Order Summary Report dated 12/30/21, included an order for daily weights which started on 11/11/21. R1's Weights and Vitals Summary dated 1/3/22, indicated R1 had weights documented for 10 of 29 possible days during the month of December 2021. During an interview on 12/29/21, at 12:48 p.m. licensed practical nurse (LPN)-A stated R1's weight was taken weekly when he received a bath. During an interview on 12/29/21, at 1:08 p.m. trained medication assistant (TMA)-A stated the nurse determined which residents needed weights and vital signs taken based upon	F 684	dialysis have been reviewed and implemented. Residents with orders for daily weights and vitals for dialysis have the potential to be affected by this. All residents on dialysis have had their orders reviewed to determine the frequency of weights and vitals ordered for each to ensure orders are being followed and documentation is in place. Licensed nurses will be educated on the need to ensure orders for daily weights and vitals for dialysis are being followed and documented on in the medical record. Weekly audits will be completed of residents with daily weight and vitals orders for dialysis to ensure documentation is completed x 4 weeks. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. DON/Designee is responsible for ensuring compliance.		

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F 684	Continued From page 2 reminders in the electronic health record (EHR). TMA-A stated R1 required daily weights and the resident had never refused a weight for her. Upon review of R1's EHR, TMA-A confirmed some of R1's weights were not documented. During an interview on 12/29/21, at 1:15 p.m. LPN-A stated scheduled weights appeared on the medication administration record (MAR). Upon review of R1's EHR, LPN-A stated R1 had an order for daily weights and the medical provider was to be called if there was a weight gain of two pounds or more in a day or five pounds or more in a week. LPN-A stated R1's last weight was documented on 12/23/21, and confirmed R1's weight was not documented daily. LPN-A stated R1 had kidney disease and heart failure. If staff did not take R1's weight daily they would not realize he may be retaining fluid. LPN-A stated to her knowledge, R1 did not refuse to have his weight taken. During an interview on 12/30/21, at 11:44 a.m. registered nurse (RN)-A stated weights should be done weekly before meals. If a resident refused, it should be documented in the medical record. Upon review of R1's medical record, RN-A confirmed R1 had an order for daily weights and identified R1's weight documentation was, "few and far between." RN-A stated it appeared R1 had not had a weight taken during the past week. If a resident had heart failure, such as R1, there could be a potential exacerbation and subsequent hospitalization if weights were not monitored. VITALS BEFORE DIALYSIS: R1's Order Summary Report dated 12/30/21, included an order for vital signs prior to dialysis	F 684			

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F 684	Continued From page 3 every Tuesday, Thursday, and Saturday started on 11/12/21, until 12/22/21. An additional order was entered for vital signs prior to dialysis starting on 12/24/21, for every Monday, Wednesday, and Friday. R1's Post Treatment Dialysis documentation indicated he went to dialysis on the following dates without having his vital signs taken beforehand: - 11/11/21 - 11/16/21 - 11/20/21 - 11/26/21 - 12/11/21 - 12/15/21 - 12/17/21 During an interview on 12/29/21, at 12:48 p.m. LPN-A stated vital signs appeared on the treatment administration record (TAR) when needing to be recorded. Vital sign results were recorded in the EHR. LPN-A stated R1 needed to have vital signs recorded before going to dialysis as staff needed to know the results. During an interview on 12/30/21, at 11:30 a.m. medical doctor (MD)-A stated R1 came to the facility with an order for daily weights related to congestion in the past which led to heart failure. R1 also required blood pressure checks before dialysis as he had significant drops in blood pressure. He stated if R1 went to dialysis with low blood pressure, they would have to stop. Daily weights and vital signs were expected to be done as ordered. During an interview on 12/30/21, at 11:44 a.m. RN-A reviewed R1's EHR and confirmed there	F 684			

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F 684	Continued From page 4 was missing vital signs documentation prior to each dialysis appointment. RN-A stated he was unable to tell if vital signs were completed, but needed to be completed due to R1's low blood pressure concerns. It should had also been documented if vital signs had been refused.	F 684			
F 880 SS=D	Facility policy titled Resident Heights and Weights undated, directed, "All residents will be weighed upon admission and subsequently as the policy directs to provide a baseline and ongoing record for monitoring stability of weight as an indicator of nutritional status and medical condition over a period of time." Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880			1/28/22

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F 880	Continued From page 5 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880			

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F 880	Continued From page 6 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement Centers for Disease Control (CDC) guidance to assess residents for signs and symptoms of COVID-19 daily for 1 of 3 residents (R1) who was at risk for COVID-19 infection. Findings include: CDC guidance titled Infection Control for Nursing Homes dated 9/10/21, directed, "Actively monitor all residents upon admission and at least daily for fever (temperature =100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions described in Section: Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection." R1's admission Minimum Data Set dated 11/19/21, indicated R1 had a moderate cognitive impairment and required the assistance of two staff with bed mobility, dressing, and toilet use. R1's diagnoses included heart failure, peripheral vascular disease, kidney failure with dialysis, and bilateral lower leg amputations. R1's progress notes dated 12/1/21, indicated full-house COVID-19 outbreak testing was conducted due to a employee testing positive.	F 880	- Resident R1 monitoring orders were corrected to include supplementary documentation to allow nurses to take credit for the vital signs on 1/3/2022. - House wide review of all resident COVID monitoring orders completed on 1/3/2022. Identified three additional residents whose orders were missing the supplementary documentation to allow nurses to take credit for the vitals signs. All orders corrected. - RCA completed on 1/17/2022. - Policy for monitoring residents was reviewed. Residents are to be monitored at least daily for temperature (>100.0F or subjective) and signs and symptoms including new or worsening cough or sore throat, diarrhea, change of taste/smell, and any additional COVID symptoms as defined by CDC. - Implemented an infection sign and symptom tracking tool to monitor all residents for communicable, respiratory infection. - Nursing staff educated on the facility's policy and procedures for screening residents for COVID-19, including but not limited to: - At least daily monitoring of temperature and potential COVID symptoms including new or worsening cough or sore throat, diarrhea, change of taste/smell, and any additional CVODI		

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F 880	Continued From page 7 R1's Order Summary Report dated 1/3/22, included an order for Respiratory Active Screening - monitor for shortness of breath, fever (100.4 degrees Fahrenheit or greater, per CDC) new or worsening cough or sore throat, diarrhea, change if taste/smell, and any additional COVID-19 symptoms as defined by the CDC. Evidence of respiratory symptoms were to be documented in R1's progress notes. The order was dated 12/6/21, and was scheduled every shift. Review of R1's Weights and Vitals Summary dated 1/3/22, revealed R1's temperature was documented on 10 of 29 days in December 2021. During an interview on 12/29/21, at 1:08 p.m. trained medication aide (TMA)-A stated all resident were to have vital signs taken every shift due to a COVID-19 outbreak. During an interview on 12/29/21, at 3:02 p.m. licensed practical nurse (LPN)-A stated staff were to monitor resident temperatures and oxygen levels every shift for all residents. LPN-A stated residents were asked about symptoms, but there was not a place to document this in the medical record. During an interview on 12/30/21, at 11:30 a.m. medical doctor (MD)-A stated there was a facility nursing order to monitor residents for COVID-19 each shift. During an interview on 12/30/21, at 11:44 a.m. registered nurse (RN)-A stated since the facility was in outbreak status they switched from daily COVID-19 screenings to every shift. He defined active screening to include cough, weakness,	F 880	symptoms as defined by CDC. - o If a resident has new or worsening symptoms, a progress note is to be written to document the symptoms. Provider is also to be updated with new or worsening respiratory symptoms. - o If a resident has any new or worsening symptoms, they will be logged on the Infection Sign and Symptom Tracking Tool. • The DON or designee shall audit completion of daily screening for all residents daily x 7 days, then a sample of residents daily x 7 days, then daily until 100% compliance is met. • The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.		

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

PRINTED: 01/31/2022
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 12/30/2021
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 880	Continued From page 8 bowel issues, headache, and low oxygen saturation levels. Staff were monitoring daily for symptoms, but only checking vital signs weekly. RN-A stated vital signs were documented in the medical record and a progress note was to be written if anything was out of the ordinary. RN-A stated he had not addressed the need for daily vital signs (including temperature) and was unsure of the COVID-19 outbreak protocol. RN-A stated he should have solidified the process with the previous director of nursing (DON) prior to leaving the facility. RN-A reinitiated vital signs were only done weekly unless a resident was unstable. RN-A reviewed R1's temperature and oxygen saturation documentation and confirmed R1's temperature was only monitored one to twice weekly. RN-A stated due to the lack of monitoring they could be behind in detecting COVID-19 cases. The facility infection preventionist was unavailable for interview. Facility policy titled COVID-19 dated 9/13/21, indicated the facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of COVID-19. Due to the constantly changing and fluid nature of the virus; the facilities will monitor, follow, and implement recommendations and guidelines in accordance with the CDC, the World Health Organization (WHO), Centers for Medicare and Medicaid Services (CMS), and the State Department of Health to include identification and isolation of any suspected cases. Respiratory active screening will be completed daily for all residents. Respiratory active screening includes monitor for shortness of breath, fever (100.0 degrees Fahrenheit or	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 01/31/2022
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F 880	Continued From page 9 greater, per CDC), pulse, respirations, oxygen saturations, new or worsening cough or sore throat.	F 880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 13, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 1OWO11

Dear Administrator:

The above facility was surveyed on December 29, 2021 through December 30, 2021 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

Edenbrook Of Edina

January 13, 2022

Page 2

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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Edenbrook Of Edina

January 13, 2022

Page 3

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@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 12/30/2021
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	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 12/29/21, through 12/30/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

01/21/22

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 12/30/2021
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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H5275177C (MN79543) with a licensing orders issued at 1375. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor 's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 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		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement Centers for Disease Control (CDC) guidance to assess residents for signs and symptoms of COVID-19 daily for 1 of 3 residents (R1) who was at risk for COVID-19 infection. Findings include: CDC guidance titled Infection Control for Nursing Homes dated 9/10/21, directed, "Actively monitor all residents upon admission and at least daily for fever (temperature =100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions described in Section: Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection."	21375	Corrected.	1/28/22

Minnesota Department of Health

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21375	Continued From page 3 R1's admission Minimum Data Set dated 11/19/21, indicated R1 had a moderate cognitive impairment and required the assistance of two staff with bed mobility, dressing, and toilet use. R1's diagnoses included heart failure, peripheral vascular disease, kidney failure with dialysis, and bilateral lower leg amputations. R1's progress notes dated 12/1/21, indicated full-house COVID-19 outbreak testing was conducted due to a employee testing positive. R1's Order Summary Report dated 1/3/22, included an order for Respiratory Active Screening - monitor for shortness of breath, fever (100.4 degrees Fahrenheit or greater, per CDC) new or worsening cough or sore throat, diarrhea, change if taste/smell, and any additional COVID-19 symptoms as defined by the CDC. Evidence of respiratory symptoms were to be documented in R1's progress notes. The order was dated 12/6/21, and was scheduled every shift. Review of R1's Weights and Vitals Summary dated 1/3/22, revealed R1's temperature was documented on 10 of 29 days in December 2021. During an interview on 12/29/21, at 1:08 p.m. trained medication aide (TMA)-A stated all resident were to have vital signs taken every shift due to a COVID-19 outbreak. During an interview on 12/29/21, at 3:02 p.m. licensed practical nurse (LPN)-A stated staff were to monitor resident temperatures and oxygen levels every shift for all residents. LPN-A stated residents were asked about symptoms, but there was not a place to document this in the medical	21375		

Minnesota Department of Health

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21375	Continued From page 4 record. During an interview on 12/30/21, at 11:30 a.m. medical doctor (MD)-A stated there was a facility nursing order to monitor residents for COVID-19 each shift. During an interview on 12/30/21, at 11:44 a.m. registered nurse (RN)-A stated since the facility was in outbreak status they switched from daily COVID-19 screenings to every shift. He defined active screening to include cough, weakness, bowel issues, headache, and low oxygen saturation levels. Staff were monitoring daily for symptoms, but only checking vital signs weekly. RN-A stated vital signs were documented in the medical record and a progress note was to be written if anything was out of the ordinary. RN-A stated he had not addressed the need for daily vital signs (including temperature) and was unsure of the COVID-19 outbreak protocol. RN-A stated he should have solidified the process with the previous director of nursing (DON) prior to leaving the facility. RN-A reinitiated vital signs were only done weekly unless a resident was unstable. RN-A reviewed R1's temperature and oxygen saturation documentation and confirmed R1's temperature was only monitored one to twice weekly. RN-A stated due to the lack of monitoring they could be behind in detecting COVID-19 cases. The facility infection preventionist was unavailable for interview. Facility policy titled COVID-19 dated 9/13/21, indicated the facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of COVID-19. Due to the constantly changing and	21375			

Minnesota Department of Health

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21375	Continued From page 5 fluid nature of the virus; the facilities will monitor, follow, and implement recommendations and guidelines in accordance with the CDC, the World Health Organization (WHO), Centers for Medicare and Medicaid Services (CMS), and the State Department of Health to include identification and isolation of any suspected cases. Respiratory active screening will be completed daily for all residents. Respiratory active screening includes monitor for shortness of breath, fever (100.0 degrees Fahrenheit or greater, per CDC), pulse, respirations, oxygen saturations, new or worsening cough or sore throat. SUGGESTED METHOD OF CORRECTION: The infection preventionist, director of nursing, or designee, could review and/or revise policies related to COVID-19 monitoring; educate staff on the policies and procedures; and, conduct ongoing audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375			