



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 22, 2023

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

RE: CCN: 245275
Cycle Start Date: January 26, 2023

Dear Administrator:

On February 2, 2023, we notified you a remedy was imposed. On February 17, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 14, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 17, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 2, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 17, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 14, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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February 22, 2023

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

Re: Reinspection Results
Event ID: 6JHD12

Dear Administrator:

On February 17, 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 January 26, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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Administrator
Edenbrook Of Edina
6200 Xerxes Avenue South
Minneapolis, MN 55423

RE: CCN: 245275
Cycle Start Date: January 26, 2023

Dear Administrator:

On January 26, 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 actual harm that was not immediate jeopardy (Level G), 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 17, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 17, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 17, 2023.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by February 17, 2023, 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 February 17, 2023. 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 July 26, 2023 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized flourish at the end.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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February 2, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 6JHD11

Dear Administrator:

The above facility was surveyed on January 25, 2023 through January 26, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 01/26/2023
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 On 1/25/23 - 1/26/23 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, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52757781C (MN90389/MN90469/MN90442) with a deficiency cited at F686 The following complaints were found to be UNSUBSTANTIATED H52757536C (MN90062) & H52757818C (MN88631) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		2/14/23	

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

Electronically Signed

TITLE

(X6) DATE

02/08/2023

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 686	Continued From page 1 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to effectively monitor and report skin condition changes for 1 of 3 residents (R3) reviewed for pressure ulcers. R1 developed an avoidable stage 2 pressure ulcer (defined as skin breaking open, wears away, or forms an ulcer) and deep tendon injury (defined as purple or maroon localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear). Findings include: R3's undated face sheet identified current diagnoses as acute or chronic congestive heart failure, chronic kidney disease (stage 4), anemia, shortness of breath, weakness, spinal stenosis, acute pericarditis, pleural effusion, chronic embolism and thrombosis of unspecified vein, thrombocytopenia, prosthetic heart valve, and diverticulosis of the large intestine. R3's admission documentation dated 1/14/23 indicated R3 was incontinent of bowel and bladder, had no current skin integrity or history of skin issues. R3 was at risk for skin breakdown with interventions that included apply moisturizer to my skin as needed - do not massage over my bony prominences, keep skin clean and dry, and use a pressure relieving cushion for the	F 686	F686 Plan of Correction: R3 discharged from the facility on 1/21/2023. All residents have a potential of being affected. Residents have had a skin assessment completed In-house wounds assessed and staged appropriately and documented. Licensed nurses educated on the following by 2/13/2023. Licenses staff who have not completed education prior to 2/13/202 will complete education prior to working their next shift. Importance of properly assessing staging/categorization of wounds, and importance of monitoring wounds every 7 days via weekly wound rounds by wound team. Appropriate management of treatments and monitoring effectiveness of treatments as recommended by the physician. Notification of DON, primary care physician, and resident or responsible party of all declines in wound status Weekly skin assessments are to be completed routinely on shower day and skin impairments to be listed on the weekly skin assessment.		

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F 686	Continued From page 2 wheelchair. R3's Braden Scale for Predicting Pressure Sore Risk dated 1/14/23 indicated a score of 21 identifying R3 did not have a risk for developing a pressure ulcer. R3's Task List report dated 1/14/23, indicated certified nursing assistance (CNA) or personal care attendant (PCA) was to monitor R3's skin every shift. R3's Point of Care Response History (Facilities CNA/PCA documentation system) dated 1/14/23, indicated R3's skin was monitored 1/14/23 at 8:40 p.m. no new alterations, 1/17/23 at 9:47 p.m. no new alterations, 1/18 11:47 a.m. and 9:59 p.m. no new alterations, 1/20/23 1:59 p.m. and 9:59 p.m. no new alterations. All other shifts skin monitoring during R3's stay at the facility from 1/14/23 through 1/21/23 were left blank. R3's daily skilled charting dated 1/16/23 and 1/19/23 under objective data indicated R3 had no skin alterations, no skin concerns. A physician progress note dated 1/17/23 to establish patient care indicated R3 discharged from the hospital on 1/14/23 after a diagnosis of congestive heart failure. R3 reported diarrhea since arriving to the facility with a history of constipation. The physician placed an order for an abdominal x-ray. R3's admission care plan dated 1/14/23, indicated on 1/19/23 the facility identified R3 was at risk for skin alterations and skin integrity related to incontinence. R3's goal was to remain free from skin breakdown. The interventions	F 686	Skin and wound care plans reviewed and updated as needed. DON or designee will perform audit starting 2/14/2023 weekly x 4, bi-weekly x 2, and monthly x 1. Audit will include reviewing completion and accuracy of admission skin assessments, weekly skin assessments, and weekly wound rounds. Audit results to be reviewed through the QAPI process to evaluate the results of the audits and the need for audit continuation and the completion of the above listed audit timeframe. In addition, an Ad hoc QAPI will be completed with the Interdisciplinary Team by the compliance date. Director of Nursing or designee responsible for ensuring compliance.		

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F 686	Continued From page 3 were 1. Apply moisture to skin as needed and do not massage bony prominences. 2. Keep skin clean and dry. 3. Manage R3's clinical conditions and contributing factors to decrease the risk of skin breakdown. 4. Use a pressure relieving cushion for the wheelchair. On 1/19/23 the facility identified R3 had limited physical mobility related to weakness requiring the transfer assistance of one staff, and two staff with a stand-up lift. On 1/19/23 the facility identified R3 was unable to perform activities of daily living requiring the assistance of one staff for bathing and/or showering, and dressing. On 1/19/23 the facility identified a potential for alteration in elimination related to incontinence and staff were to apply barrier cream to peri area after each incontinent episode, check and change R3's incontinent brief, provide urinal at bedside. On 1/18/23 the facility identified R3 had bowel incontinence with interventions to provide a bedpan/bedside commode and loose fitting easy to remove clothing. R3's admission Minimum Data Set (MDS) assessment dated 1/20/23, indicated R3 required extensive assistance of one staff member for dressing, toilet use, transferring and personal hygiene. R3 was frequently incontinent of urine and bowel. R3 was determined to be at risk for a pressure ulcer or injury. R3 did not have pressure ulcers, wounds, or dermatitis. A photo dated 1/21/23 of R3's buttock wounds was reviewed. R3 was laying in his bed at the facility on his right side. His bed sheet was being changed and he was laying directly on the mattress. The facility room could be identified on the photo. R3's right side showed five areas, (unmeasurable due to photo) of maroon	F 686			

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F 686	Continued From page 4 discoloration the length of his buttock fold, over a bony prominence and two maroon marks lateral to his buttock fold. His left side showed a large maroon area the entire length of the buttock fold and one more maroon marking posterior of his fold. In addition, an open circular area midline to his buttock fold was identified. The open area was light red color appearing moist on the photo. R3's Care Area Assessment (CAA) dated 1/24/23, indicated pressure ulcer/injury was triggered for potential pressure ulcer due to the need for extensive assistance with bed mobility. Complicated by incontinence and immobility. R3 did not have any skin issues at the time of the assessment but remained at risk. Upon interview on 1/25/23 at 10:28 a.m. licensed practical nurse (LPN)-A stated on 1/21/23, the day R3 was transferred to the hospital was the first day she had worked with him. She stated R3's wife and two other people were present in his room and R3 was complaining of stomach pain. His vital signs were taken and they were "low." R3 was sent to the emergency department. She stated that prior to be to R3's transfer to the emergency department, she was to administer a suppository to R3 and it was at that point LPN-A found the pressure ulcer "it was a stage II, with patches of open areas and both buttocks covered with maroon discoloration." Upon interview on 1/25/23 11:09 a.m. nursing assistant (NA)-A stated she first worked with R3 on 1/21/23. She stated that he was incontinent of stool following a suppository. NA-A stated R3 had two small open areas inside the folds of his buttocks and the surrounding skin had multiple large deep red areas. She stated she did not	F 686			

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F 686	Continued From page 5 report the skin condition findings to the nurse because R3 was sent to the emergency department within the hour after discovery due to shortness of breath and stomach pain with a low blood pressure reading. Upon interview on 1/25/23 at 3:12 p.m. a hospital social worker read the hospital wound notes dated 1/22/23 which indicated R3 had a community acquired wound. He had a scattered deep maroon boggy area covering his buttocks described as a deep tissue injury. R3 was receiving treatment every other day by cleansing the wound, covering with a Mepilex dressing and turning him every two hours. In addition, R3 had a heel ulcer being treated with betadine and covered with a 4x4 dressing. Upon interview on 1/25/23 at 4:35 p.m. family member (FM)-A stated she was visiting R3 on 1/21/23 and R3 was complaining of stomach pain, he had been having diarrhea and underwent an x-ray prior in the week which showed constipation. Upon request, LPN-A came in the room to give R3 a suppository. FA-A noticed at that time his skin, had some bleeding with broken down skin with his entire buttock region a deep red color. FM-A stated she took a picture of the wounds. Upon interview on 1/26/23 at 10:25 a.m. NA-B stated she worked with R3 the day shift on 1/18/23. She stated she did not change R3's incontinent brief, toilet him or clean him and therefore did not observe R3's buttock. She stated his brief was not soiled because he was using a urinal, therefore was not changed. At the end of her shift, she assisted him to a seated position on the toilet with an EZ-stand. She	F 686			

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F 686	Continued From page 6 stated she did not observe R3's buttock. She did not assist him with getting off the toilet as her shift had ended and the evening shift assisted him then. Upon interview on 1/26/23 at 10:43 a.m. a hospital registered nurse (RN) stated R3 was admitted on 1/21/23 to the Intensive Care Unit (ICU) and has remained there. His admitting diagnosis was a gastrointestinal bleed, sepsis, syncope with hypotension and a low hemoglobin level of 7.4, deep tissue injury of the sacral area and pressure ulcer. The RN stated the sacral wound was closed. Staff is watching closing and it is covered with Mepilex dressing. For the deep tissue injury, the staff was focused on offloading at all times by turning from left turn right every 1-2 hours. The area remained the dark maroon color and no sloughing. The wound care team was following him. Upon interview on 1/26/23 at 11:00 a.m. the facility wound care physician observed the photo of R3's wounds and stated she had not seen him for a wound evaluation. She identified the wound as a deep tissue injury, which can come upon quickly within 24-48 hours, stating the staff should have noticed it. The deep tissue was likely caused by moisture and pressure. The circular area observed in the photo was a Stage II pressure ulcer. Upon interview on 1/26/23 at 12:18 p.m. NA-C stated she worked with R3 on his admission day 1/14/23, and the evening prior to his transfer to the hospital 1/21/23. On 1/14/23, R3 had a bowel movement and his skin showed no signs of discoloration or breakdown. On 1/20/23, NA-C	F 686			

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F 686	Continued From page 7 did not observe his skin under his incontinent brief. She stated she transferred him from his wheelchair to his bed. She denied doing any peri-care or clothing change. She stated "My understanding is that if I am doing cares, I observe the skin I am seeing and report to the nurse, I have never been told that I do a total skin check on my shift." Upon interview on 1/26/23 at 1:26 p.m. registered nurse (RN)-A stated all NA's should notify the nurse of any concerns with skin as they are performing their activities of daily living (ADL's). She stated she was not familiar with the NA's daily routines or what education they received from the facility on ADL specifics, and the exact reporting measures. RN-A stated in the Point Click Care (PCC), the facilities software system, there is a trigger response for documenting and was uncertain what triggers the nurse's attention, if missed and what NA documentation triggers it or not. In addition, she was not certain who is responsible for monitoring the NA documentation. Upon interview on 1/26/23 at 1:59 p.m. the assistant director of nursing (ADON) stated her expectation of NA's was to follow the care plan and that each resident has clean clothing and provided assistance with any other assessed ADL needs. She stated that a resident who is incontinent and receives extensive assistance with ADL's would have their full skin observed by an NA at least during morning and evening cares. Upon interview on 1/26/23 at 3:02 p.m. the director of nursing (DON) stated her expectation of staff is to complete all tasks on the care plan and report to nursing as appropriate. She stated the documentation for the nursing assistance	F 686			

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F 686	Continued From page 8 compliance is scattered at this point in time and the facility is putting together an action plan for the missed charting. Upon observation of the photo of R3's wound, the DON stated her expectation was that staff would have noticed that significant of a skin condition and reported. A facility policy titled Pressure Injury Prevention and Wound Care Management dated 4/27/21, indicated the facility will ensure residents who are admitted without a pressure injury do not develop a pressure injury, unless clinically avoidable. Resident's skin will be monitored daily during cares by nursing assistant and skin check will be weekly by licensed nurse.	F 686			

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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 1/25/23 - 1/26/23 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 when they will be completed.	2 000		

Minnesota Department of Health		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/23

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52757781C (MN90389/MN90469/MN90442), with a licensing order issued at ST0900 The following complaints were found to be UNSUBSTANTIATED: H52757536C (MN90062) & H52757818C (MN88631) 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	2 000			

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2 000	Continued From page 2 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		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to effectively monitor and report skin condition changes for 1 of 3 residents (R3) reviewed for pressure ulcers. R1 developed an avoidable stage 2 pressure ulcer (defined as skin	2 900	Corrected	2/14/23

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2 900	Continued From page 3 breaking open, wears away, or forms an ulcer) and deep tendon injury (defined as purple or maroon localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear). Findings include: R3's undated face sheet identified current diagnoses as acute or chronic congestive heart failure, chronic kidney disease (stage 4), anemia, shortness of breath, weakness, spinal stenosis, acute pericarditis, pleural effusion, chronic embolism and thrombosis of unspecified vein, thrombocytopenia, prosthetic heart valve, and diverticulosis of the large intestine. R3's admission documentation dated 1/14/23 indicated R3 was incontinent of bowel and bladder, had no current skin integrity or history of skin issues. R3 was at risk for skin breakdown with interventions that included apply moisturizer to my skin as needed - do not massage over my bony prominences, keep skin clean and dry, and use a pressure relieving cushion for the wheelchair. R3's Braden Scale for Predicting Pressure Sore Risk dated 1/14/23 indicated a score of 21 identifying R3 did not have a risk for developing a pressure ulcer. R3's Task List report dated 1/14/23, indicated certified nursing assistance (CNA) or personal care attendant (PCA) was to monitor R3's skin every shift. R3's Point of Care Response History (Facilities CNA/PCA documentation system) dated 1/14/23, indicated R3's skin was monitored 1/14/23 at 8:40	2 900		

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2 900	Continued From page 4 p.m. no new alterations, 1/17/23 at 9:47 p.m. no new alterations, 1/18 11:47 a.m. and 9:59 p.m. no new alterations, 1/20/23 1:59 p.m. and 9:59 p.m. no new alterations. All other shifts skin monitoring during R3's stay at the facility from 1/14/23 through 1/21/23 were left blank. R3's daily skilled charting dated 1/16/23 and 1/19/23 under objective data indicated R3 had no skin alterations, no skin concerns. A physician progress note dated 1/17/23 to establish patient care indicated R3 discharged from the hospital on 1/14/23 after a diagnosis of congestive heart failure. R3 reported diarrhea since arriving to the facility with a history of constipation. The physician placed an order for an abdominal x-ray. R3's admission care plan dated 1/14/23, indicated on 1/19/23 the facility identified R3 was at risk for skin alterations and skin integrity related to incontinence. R3's goal was to remain free from skin breakdown. The interventions were 1. Apply moisture to skin as needed and do not massage bony prominences. 2. Keep skin clean and dry. 3. Manage R3's clinical conditions and contributing factors to decrease the risk of skin breakdown. 4. Use a pressure relieving cushion for the wheelchair. On 1/19/23 the facility identified R3 had limited physical mobility related to weakness requiring the transfer assistance of one staff, and two staff with a stand-up lift. On 1/19/23 the facility identified R3 was unable to perform activities of daily living requiring the assistance of one staff for bathing and/or showering, and dressing. On 1/19/23 the facility identified a potential for alteration in elimination related to incontinence and staff were to apply barrier cream to peri area after each	2 900		

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2 900	Continued From page 5 incontinent episode, check and change R3's incontinent brief, provide urinal at bedside. On 1/18/23 the facility identified R3 had bowel incontinence with interventions to provide a bedpan/bedside commode and loose fitting easy to remove clothing. R3's admission Minimum Data Set (MDS) assessment dated 1/20/23, indicated R3 required extensive assistance of one staff member for dressing, toilet use, transferring and personal hygiene. R3 was frequently incontinent of urine and bowel. R3 was determined to be at risk for a pressure ulcer or injury. R3 did not have pressure ulcers, wounds, or dermatitis. A photo dated 1/21/23 of R3's buttock wounds was reviewed. R3 was laying in his bed at the facility on his right side. His bed sheet was being changed and he was laying directly on the mattress. The facility room could be identified on the photo. R3's right side showed five areas, (unmeasurable due to photo) of maroon discoloration the length of his buttock fold, over a bony prominence and two maroon marks lateral to his buttock fold. His left side showed a large maroon area the entire length of the buttock fold and one more maroon marking posterior of his fold. In addition, an open circular area midline to his buttock fold was identified. The open area was light red color appearing moist on the photo. R3's Care Area Assessment (CAA) dated 1/24/23, indicated pressure ulcer/injury was triggered for potential pressure ulcer due to the need for extensive assistance with bed mobility. Complicated by incontinence and immobility. R3 did not have any skin issues at the time of the assessment but remained at risk.	2 900			

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2 900	Continued From page 6 Upon interview on 1/25/23 at 10:28 a.m. licensed practical nurse (LPN)-A stated on 1/21/23, the day R3 was transferred to the hospital was the first day she had worked with him. She stated R3's wife and two other people were present in his room and R3 was complaining of stomach pain. His vital signs were taken and they were "low." R3 was sent to the emergency department. She stated that prior to be to R3's transfer to the emergency department, she was to administer a suppository to R3 and it was at that point LPN-A found the pressure ulcer "it was a stage II, with patches of open areas and both buttocks covered with maroon discoloration." Upon interview on 1/25/23 11:09 a.m. nursing assistant (NA)-A stated she first worked with R3 on 1/21/23. She stated that he was incontinent of stool following a suppository. NA-A stated R3 had two small open areas inside the folds of his buttocks and the surrounding skin had multiple large deep red areas. She stated she did not report the skin condition findings to the nurse because R3 was sent to the emergency department within the hour after discovery due to shortness of breath and stomach pain with a low blood pressure reading. Upon interview on 1/25/23 at 3:12 p.m. a hospital social worker read the hospital wound notes dated 1/22/23 which indicated R3 had a community acquired wound. He had a scattered deep maroon boggy area covering his buttocks described as a deep tissue injury. R3 was receiving treatment every other day by cleansing the wound, covering with a Mepilex dressing and turning him every two hours. In addition, R3 had a heel ulcer being treated with betadine and covered with a 4x4 dressing.	2 900			

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2 900	Continued From page 7 Upon interview on 1/25/23 at 4:35 p.m. family member (FM)-A stated she was visiting R3 on 1/21/23 and R3 was complaining of stomach pain, he had been having diarrhea and underwent an x-ray prior in the week which showed constipation. Upon request, LPN-A came in the room to give R3 a suppository. FA-A noticed at that time his skin, had some bleeding with broken down skin with his entire buttock region a deep red color. FM-A stated she took a picture of the wounds. Upon interview on 1/26/23 at 10:25 a.m. NA-B stated she worked with R3 the day shift on 1/18/23. She stated she did not change R3's incontinent brief, toilet him or clean him and therefore did not observe R3's buttock. She stated his brief was not soiled because he was using a urinal, therefore was not changed. At the end of her shift, she assisted him to a seated position on the toilet with an EZ-stand. She stated she did not observe R3's buttock. She did not assist him with getting off the toilet as her shift had ended and the evening shift assisted him then. Upon interview on 1/26/23 at 10:43 a.m. a hospital registered nurse (RN) stated R3 was admitted on 1/21/23 to the Intensive Care Unit (ICU) and has remained there. His admitting diagnosis was a gastrointestinal bleed, sepsis, syncope with hypotension and a low hemoglobin level of 7.4, deep tissue injury of the sacral area and pressure ulcer. The RN stated the sacral wound was closed. Staff is watching closing and it is covered with Mepilex dressing. For the deep tissue injury, the staff was focused on offloading at all times by turning from left turn right every 1-2 hours. The area remained the dark maroon color and no sloughing. The wound care team was	2 900			

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2 900	Continued From page 8 following him. Upon interview on 1/26/23 at 11:00 a.m. the facility wound care physician observed the photo of R3's wounds and stated she had not seen him for a wound evaluation. She identified the wound as a deep tissue injury, which can come upon quickly within 24-48 hours, stating the staff should have noticed it. The deep tissue was likely caused by moisture and pressure. The circular area observed in the photo was a Stage II pressure ulcer. Upon interview on 1/26/23 at 12:18 p.m. NA-C stated she worked with R3 on his admission day 1/14/23, and the evening prior to his transfer to the hospital 1/21/23. On 1/14/23, R3 had a bowel movement and his skin showed no signs of discoloration or breakdown. On 1/20/23, NA-C did not observe his skin under his incontinent brief. She stated she transferred him from his wheelchair to his bed. She denied doing any peri-care or clothing change. She stated "My understanding is that if I am doing cares, I observe the skin I am seeing and report to the nurse, I have never been told that I do a total skin check on my shift." Upon interview on 1/26/23 at 1:26 p.m. registered nurse (RN)-A stated all NA's should notify the nurse of any concerns with skin as they are performing their activities of daily living (ADL's). She stated she was not familiar with the NA's daily routines or what education they received from the facility on ADL specifics, and the exact reporting measures. RN-A stated in the Point Click Care (PCC), the facilities software system, there is a trigger response for documenting and was uncertain what triggers the nurse's attention,	2 900			

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 01/26/2023
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
2 900	Continued From page 9 if missed and what NA documentation triggers it or not. In addition, she was not certain who is responsible for monitoring the NA documentation. Upon interview on 1/26/23 at 1:59 p.m. the assistant director of nursing (ADON) stated her expectation of NA's was to follow the care plan and that each resident has clean clothing and provided assistance with any other assessed ADL needs. She stated that a resident who is incontinent and receives extensive assistance with ADL's would have their full skin observed by an NA at least during morning and evening cares. Upon interview on 1/26/23 at 3:02 p.m. the director of nursing (DON) stated her expectation of staff is to complete all tasks on the care plan and report to nursing as appropriate. She stated the documentation for the nursing assistance compliance is scattered at this point in time and the facility is putting together an action plan for the missed charting. Upon observation of the photo of R3's wound, the DON stated her expectation was that staff would have noticed that significant of a skin condition and reported. A facility policy titled Pressure Injury Prevention and Wound Care Management dated 4/27/21, indicated the facility will ensure residents who are admitted without a pressure injury do not develop a pressure injury, unless clinically avoidable. Resident's skin will be monitored daily during cares by nursing assistant and skin check will be weekly by licensed nurse. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to	2 900			

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2 900	Continued From page 10 ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 900			