



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 8, 2026

Administrator
EDENBROOK OF ST CLOUD
1717 UNIVERSITY DRIVE SOUTHEAST
SAINT CLOUD, MN 56304

RE: CCN: 245438
Cycle Start Date: July 22, 2026

Dear Administrator:

On September 2, 2026, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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September 8, 2026

Administrator
EDENBROOK OF ST CLOUD
1717 UNIVERSITY DRIVE SOUTHEAST
SAINT CLOUD, MN 56304

Re: Reinspection Results
Event ID: 2AA7B2-H2

Dear Administrator:

On September 2, 2026, 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 July 22, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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August 5, 2026

Administrator
EDENBROOK OF ST CLOUD
1717 UNIVERSITY DRIVE SOUTHEAST
SAINT CLOUD, MN 56304

RE: CCN:245438

Cycle Start Date: July 22, 2026

Dear Administrator:

On July 22, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
 Health Regulation Division
 Minnesota Department of Health
 Rochester District Office
 3425 40th Avenue NW, Suite 115
 Rochester, MN 55901
 Email: Lisa.Krebs@state.mn.us
 Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by **October 22, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **January 22, 2027** (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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August 5, 2026

Administrator
EDENBROOK OF ST CLOUD
1717 UNIVERSITY DRIVE SOUTHEAST
SAINT CLOUD, MN 56304

Re: State Nursing Home Licensing Orders

Event ID: 2AA7B2-H1

Dear Administrator:

The above facility survey was completed on July 22, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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.

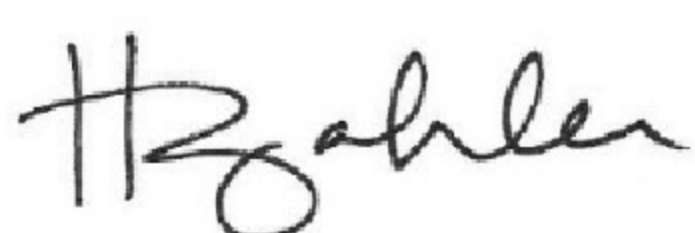
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST , SAINT CLOUD, Minnesota, 56304			
(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
F0000	INITIAL COMMENTS On 7/21/26 through 7/22/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54383439C (3105175) with citations issued at F580 and F686. 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.			F0000			08/07/2026
F0580 SS = D	Notify of Changes (Injury/Delirium/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident			F0580	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident identified (R2) during the survey was immediately assessed by the licensed nurse. The attending provider was notified of the wound and the resident's current condition. The resident's responsible party was notified of the change in condition, and the notification was documented in the medical record. A comprehensive wound assessment was completed, appropriate treatment orders were obtained and implemented, and documentation was updated to accurately reflect the assessment findings, notifications, interventions, and plan of care. The interdisciplinary team reviewed the resident's care plan and revised it as needed to address the wound and ongoing monitoring Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing (DON), designee, or Unit Manager will conduct an audit of residents identified with new wounds or significant skin changes within		08/30/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST , SAINT CLOUD, Minnesota, 56304			
(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
F0580 SS = D	Continued from page 1 from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide timely notification for change in skin condition to the physician for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2's hospital discharge summary note dated 6/9/26 identified R2's diagnoses included catheter associated urinary tract infection (UTI), acute toxic metabolic encephalopathy, proximal muscle weakness and sepsis due to UTI. R2's admission Minimum Data Set (MDS) dated 6//22/26 indicated R2 was at risk of developing pressure ulcers and had moderate cognitive impairment. The MDS also indicated R2 required			F0580	Continued from page 1 the previous 30 days to verify that provider notification, responsible party notification (when applicable), complete nursing documentation, physician orders, and care plan updates were completed in accordance with facility policy. Any identified concerns will be addressed immediately through assessment, notification, documentation correction, and staff education as appropriate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility has re-educated all licensed nursing staff on the policy and procedure for identifying and responding to changes in condition, including newly identified wounds. Education includes requirements for timely assessment, complete and accurate documentation of wound findings, prompt notification of the attending provider and resident representative when appropriate, obtaining and implementing orders, and updating the resident's care plan. The facility will reinforce the use of standardized wound assessment documentation and communication processes to ensure all required notifications and interventions are completed and documented consistently. Newly hired licensed nurses will receive education on these requirements during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON or designee will complete weekly audits of five residents with new wounds or changes in skin condition for four weeks, then monthly audits of five residents for two additional months. Audits will verify timely provider notification, responsible party notification when indicated, comprehensive documentation, implementation of treatment orders, and care plan updates. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process. Identified trends or concerns will result in additional education, coaching, and corrective action as necessary. Monitoring will continue until sustained compliance is achieved. Completion Date: 08/30/2026		08/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST , SAINT CLOUD, Minnesota, 56304			
(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
F0580 SS = D	Continued from page 2 extensive total assistance with activities of daily living (ADL). During an observation on 7/22/26 at 3:45 p.m., a licensed practical nurse (LPN)-B identified a new stage 2 pressure ulcer (PU) (partial-thickness skin loss with exposed dermis) on R2's left gluteus measuring 2.19 cm x 1.24 cm. LPN-B described the wound as having light serosanguinous drainage, excoriation of the surrounding tissue and no odor. Additionally, LPN-B also identified a new stage 1 PU on R2's right gluteus measuring 0.68 cm x 0.62 cm. The wound bed was pink and fragile, and the surrounding tissue was intact. During an interview on 7/22/26 at 3:14 p.m., LPN-B stated when a new skin impairment was identified, nursing staff were expected to complete a skin assessment, initiate a risk management report, document the wound description and measurements, record the finding in the progress note, notify the nurse manager and the provider, initiate treatment according to the provider's orders, and inform the resident's family. LPN-B stated nursing staff did not document measurements or a description of R2's PU in the coccyx area and did not notify the provider of the wound. During an interview on 7/22/26 at 4:16 p.m., the DON stated she expected nursing staff to follow the facility's wound care policy. The DON stated when a new skin impairment was identified, nursing staff were required to notify the wound care team and the primary provider, document the wound measurements and description as well as initiating appropriate interventions. The DON confirmed nursing staff did not notify the provider regarding R2's newly identified wound. The DON stated the facility would provide house-wide education to nursing staff regarding wound care practices and timely physician notification. During an interview on 7/22/26 at 4:47 p.m., a nurse practitioner (NP)-A stated she expected nursing staff to follow the facility's change in condition and wound care policies. NP-A stated when a new skin impairment was identified, nursing staff were required to notify the provider and the dietitian. NP-A confirmed she was not notified of R2's PU in the coccyx area. The facility Change in Condition policy dated 8/1/15 and revised 11/13/24 instructed nurses to promptly notify the physician of changes in the resident's condition. Specific information that require prompt			F0580	Continued from page 2 Responsible Party: Director of Nursing / Wound Care Nurse/ nurse designee.		08/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
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F0580 SS = D	Continued from page 3 notification include, but is not limited to: Onset of pressure ulcer and a need to alter the resident's medical treatment significantly.			F0580			08/30/2026
F0686 SS = D	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 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 observation, interview, and document review, the facility failed to identify, assess, monitor, and respond to changes in skin integrity, including notification of the provider and implementation of appropriate interventions, for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2's hospital discharge summary note dated 6/9/26 identified R2's diagnoses included catheter associated urinary tract infection (UTI), acute toxic metabolic encephalopathy, proximal muscle weakness and sepsis due to UTI. R2's hospital wound care instructions dated 6/9/26 included the following: Apply layer of Zinc oxide paste to buttocks and perianal skin and surrounding tissue twice a day and as needed for incontinence. Remove all barrier cream with skin assessment. Then only remove soiled barrier cream and re-apply more with each incontinence episode. R2's admission Minimum Data Set (MDS) dated 6//22/26 indicated R2 was at risk of developing			F0686	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident (R2) identified during the survey was immediately reassessed by the licensed nurse, including a comprehensive wound assessment with measurements, wound characteristics, drainage, and surrounding skin condition. The attending provider and POA were notified of the current wound status, and treatment orders were reviewed and updated as appropriate. The resident's wound treatment was implemented as ordered, the care plan was revised to reflect current interventions, and the resident's responsible party was notified as appropriate. Documentation was completed to accurately reflect assessment, interventions, notifications, and ongoing monitoring). Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing (DON), Wound Nurse, or designee will conduct an audit of all residents with pressure ulcers, skin tears, surgical wounds, or other identified wounds to verify that: · Comprehensive wound assessments are completed and documented. · Wound measurements and characteristics are documented according to facility policy. · Treatment orders are current and implemented as ordered. · Provider notification has occurred when there is a change in wound status. · Care plans accurately reflect current wound care interventions. · Weekly wound documentation is complete and consistent with facility policy. Any identified concerns will be corrected immediately, including provider notification, updated orders, documentation, and staff follow-up.		08/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
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F0686 SS = D	Continued from page 4 pressure ulcers and had moderate cognitive impairment. The MDS also indicated R2 required extensive total assistance with activities of daily living (ADL). R2's care plan dated 6/18/26, indicated R2 was at risk for alteration in skin integrity related to incontinence, impaired mobility, weakness, and deconditioning with staff interventions to position R2's body with pillows/support devices, and protect bony prominence, routinely turn and reposition as tolerated by R2, apply barrier cream to affected sites as ordered, assess/monitor the alteration in R'2 skin integrity and document status weekly. R2's skin evaluation document, dated 7/15/26 at 2:33 p.m. indicated R2 had no new skin alterations identified. The evaluation did not address R2's pressure ulcers (PU) at her coccyx area. R2's Point of Care (POC) monitor task records dated from 7/9/26 through 7/21/26 indicated skin checks were documented as completed during cares with "no new skin alteration noted" recorded for each assessment. Review of R2's medical record including skin assessments and progress notes lacked documentation of PU assessment for the coccyx area prior to the survey entrance conference on 7/21/26. The medical record lacked documentation of wound measurements, staging, or description of the coccyx PU. During this time period, facility nursing staff were responsible for monitoring, assessing, documenting, and maintaining R2's skin integrity. During an observation on 7/22/26 at 9:05 a.m., a licensed practical nurse (LPN)-A stated R2 had a stage 1 PU on the coccyx area with blanchable tissue surrounding the wound. LPN-A stated the PU was an existing wound and the provider was aware of the wound condition. During an interview on 7/22/26 at 10:24 a.m., LPN-A explained during weekly skin assessments, nursing staff were expected to assess existing wounds, compare current findings with previous assessments, and document the wounds' progress. LPN-A stated any newly identified skin impairment should be reported to the nurse manager and the provider for further evaluation and treatment instructions. During an observation on 7/22/26 at 10:10 a.m., R2 remained lying flat on her back in bed.			F0686	Continued from page 4 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All licensed nursing staff will receive education regarding the facility's wound care and skin integrity policies, including: · Timely identification and assessment of skin alterations. · Completion of comprehensive wound assessments with required measurements and documentation. · Prompt implementation of physician or practitioner orders. · Timely notification of the provider for changes in wound condition. · Documentation of wound treatments and resident response. · Updating the interdisciplinary care plan to reflect current wound care interventions. The facility will reinforce the use of standardized wound assessment documentation tools and review wound documentation during routine clinical meetings. Newly hired licensed nurses will receive education on wound assessment and documentation during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON, Wound Nurse, or designee will audit skin checks completed five times weekly for three weeks, three times weekly for three weeks, and two times weekly for three weeks. Audits will verify: · Timely wound assessments. · Complete wound measurements and documentation. · Treatments completed as ordered. · Provider notification when clinically indicated. · Accurate care plan updates. · Ongoing monitoring of wound progression or		08/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST , SAINT CLOUD, Minnesota, 56304			
(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
F0686 SS = D	Continued from page 5 During an interview on 7/22/26 at 10:49 a.m., a nursing assistant (NA)-A stated she was assigned to care for R2 during the day shift. NA-A stated R2 was to be repositioned every two hours using pillows for pressure relief. NA-A was unable to recall when R2 had last been repositioned and confirmed she had not repositioned R2 during her shift as of the time of the interview. During an observation on 7/22/26 at 3:45 p.m., LPN-B identified a new stage 2 PU (partial-thickness skin loss with exposed dermis) on R2's left gluteus measuring 2.19 cm x 1.24 cm. LPN-B described the wound as having light serosanguinous drainage, excoriation of the surrounding tissue and no odor. Additionally, LPN-B also identified a new stage 1 PU on R2's right gluteus measuring 0.68 cm x 0.62 cm. The wound bed was pink and fragile, and the surrounding tissue was intact. LPN-B confirmed R2 had been lying on her back and had not been repositioned before the assessment. During an interview on 7/22/26 at 3:14 p.m., LPN-B stated when a new skin impairment was identified, nursing staff were expected to complete a skin assessment, initiate a risk management report, document the wound description and measurements, record the finding in the progress note, notify the nurse manager and the provider, initiate treatment according to the provider's orders, and inform the resident's family. RN-A stated nursing staff did not document measurements or a description of R2's PU in the coccyx area and did not notify the provider of the wound. LPN-B explained R2 was at risk for developing PU and should have been repositioned every two hours, with any refusal documented in the medical record. LPN-B confirmed R2 had not been repositioned at that time. During an interview on 7/22/26 at 4:16 p.m., the DON stated she expected nursing staff to follow the facility's wound care policy. The DON stated when a new skin impairment was identified, nursing staff were required to notify the wound care team and the primary provider, document the wound measurements and description as well as initiating appropriate interventions. Additionally, The DON stated residents at risk for pressure ulcers were to be repositioned every two to three hours, as directed by the care plan. The DON confirmed nursing staff did not notify the provider regarding R2's newly identified wound. The DON stated the facility would provide house-wide education to nursing staff regarding wound care practices and timely physician notification.			F0686	Continued from page 5 healing. Audit results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program. Any identified trends or deficiencies will result in additional education, observation, and corrective action. Monitoring will continue until sustained compliance is demonstrated. Completion Date: Education completed by 08/30/2026 Responsible Party: Director of Nursing / Wound Care Nurse/ or nurse designee.		08/30/2026

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F0686 SS = D	Continued from page 6 During an interview on 7/22/26 at 4:47 p.m., a nurse practitioner (NP)-A stated she expected nursing staff to follow the facility's change in condition and wound care policies. NP-A stated when a new skin impairment was identified, nursing staff were required to notify the provider and the dietitian. NP-A confirmed she was not notified of R2's PU in the coccyx area. The facility Change in Condition policy dated 8/1/15 and revised 11/13/24 instructed nurses to notify the physician of changes in the resident's condition. Nurse will complete assessment and document findings in resident record including but not limited to vital signs, pain, respiratory status as applicable etc. The care plan will be updated as necessary.			F0686			08/30/2026

Minnesota Department of Health

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20000	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 7/21/26 through 7/22/26, 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. The following complaint was reviewed: H54383439C (3105175) with licensing orders issued at 20265 and 20900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and			20000			08/07/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
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20000	Continued from page 1 therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			08/07/2026
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide timely notification for change in skin condition to the physician for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include:			20265	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident identified (R2) during the survey was immediately assessed by the licensed nurse. The attending provider was notified of the wound and the resident's current condition. The resident's responsible party was notified of the change in condition, and the notification was documented in the medical record. A comprehensive wound assessment was completed, appropriate treatment orders were obtained and implemented, and documentation was updated to accurately reflect the assessment findings, notifications, interventions, and plan of care. The interdisciplinary team reviewed the resident's care plan and revised it as needed to address the wound and ongoing monitoring Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing (DON), designee, or Unit Manager will conduct an audit of residents identified with new wounds or significant skin changes within the previous 30 days to verify that provider notification, responsible party notification (when applicable), complete nursing documentation, physician orders, and care plan updates were completed in accordance with facility policy. Any identified concerns will be addressed immediately through assessment, notification, documentation correction, and staff education as appropriate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility has re-educated all licensed nursing staff on the policy and procedure for identifying and responding to changes in condition, including newly identified wounds. Education includes requirements for timely assessment, complete and accurate documentation of wound findings, prompt notification of the attending provider and resident representative when appropriate, obtaining and implementing orders, and updating the resident's		08/30/2026

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20265	Continued from page 2 R2's hospital discharge summary note dated 6/9/26 identified R2's diagnoses included catheter associated urinary tract infection (UTI), acute toxic metabolic encephalopathy, proximal muscle weakness and sepsis due to UTI. R2's admission Minimum Data Set (MDS) dated 6//22/26 indicated R2 was at risk of developing pressure ulcers and had moderate cognitive impairment. The MDS also indicated R2 required extensive total assistance with activities of daily living (ADL). During an observation on 7/22/26 at 3:45 p.m., a licensed practical nurse (LPN)-B identified a new stage 2 pressure ulcer (PU) (partial-thickness skin loss with exposed dermis) on R2's left gluteus measuring 2.19 cm x 1.24 cm. LPN-B described the wound as having light serosanguinous drainage, excoriation of the surrounding tissue and no odor. Additionally, LPN-B also identified a new stage 1 PU on R2's right gluteus measuring 0.68 cm x 0.62 cm. The wound bed was pink and fragile, and the surrounding tissue was intact. During an interview on 7/22/26 at 3:14 p.m., LPN-B stated when a new skin impairment was identified, nursing staff were expected to complete a skin assessment, initiate a risk management report, document the wound description and measurements, record the finding in the progress note, notify the nurse manager and the provider, initiate treatment according to the provider's orders, and inform the resident's family. LPN-B stated nursing staff did not document measurements or a description of R2's PU in the coccyx area and did not notify the provider of the wound. During an interview on 7/22/26 at 4:16 p.m., the DON stated she expected nursing staff to follow the facility's wound care policy. The DON stated when a new skin impairment was identified, nursing staff were required to notify the wound care team and the primary provider, document the wound measurements and description as well as initiating appropriate interventions. The DON confirmed nursing staff did not notify the provider regarding R2's newly identified wound. The DON stated the facility would provide house-wide education to nursing staff regarding wound care practices and timely physician notification. During an interview on 7/22/26 at 4:47 p.m., a nurse practitioner (NP)-A stated she expected nursing staff to follow the facility's change in condition and			20265	Continued from page 2 care plan. The facility will reinforce the use of standardized wound assessment documentation and communication processes to ensure all required notifications and interventions are completed and documented consistently. Newly hired licensed nurses will receive education on these requirements during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON or designee will complete weekly audits of five residents with new wounds or changes in skin condition for four weeks, then monthly audits of five residents for two additional months. Audits will verify timely provider notification, responsible party notification when indicated, comprehensive documentation, implementation of treatment orders, and care plan updates. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process. Identified trends or concerns will result in additional education, coaching, and corrective action as necessary. Monitoring will continue until sustained compliance is achieved. Completion Date: 08/30/2026 Responsible Party: Director of Nursing / Wound Care Nurse/ nurse designee.		08/30/2026

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20265	Continued from page 3 wound care policies. NP-A stated when a new skin impairment was identified, nursing staff were required to notify the provider and the dietitian. NP-A confirmed she was not notified of R2's PU in the coccyx area. The facility Change in Condition policy dated 8/1/15 and revised 11/13/24 instructed nurses to promptly notify the physician of changes in the resident's condition. Specific information that require prompt notification include, but is not limited to: Onset of pressure ulcer and a need to alter the resident's medical treatment significantly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review notification of changes policies and procedures to make appropriate and timely notification to the physician and resident's representative. Staff could be educated on the need to make appropriate and timely notification to the physician and resident's representative with supporting assessments. The DON or designee could review all current resident orders to ensure timely notification to the physician/resident's representative of any changes in condition and audit periodically per recommendation from the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time. Those results could be taken back to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20265			08/30/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 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			20900	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident (R2) identified during the survey was immediately reassessed by the licensed nurse, including a comprehensive wound assessment with measurements, wound characteristics, drainage, and surrounding skin condition. The attending provider and POA were notified of the current wound status, and treatment orders were reviewed and updated as appropriate. The resident's wound treatment was implemented as ordered, the care plan was revised to reflect current interventions, and the resident's responsible party was notified as appropriate. Documentation was completed to accurately reflect assessment, interventions, notifications, and ongoing monitoring).		08/30/2026

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20900	Continued from page 4 from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to identify, assess, monitor, and respond to changes in skin integrity, including notification of the provider and implementation of appropriate interventions, for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2’s hospital discharge summary note dated 6/9/26 identified R2’s diagnoses included catheter associated urinary tract infection (UTI), acute toxic metabolic encephalopathy, proximal muscle weakness and sepsis due to UTI. R2’s hospital wound care instructions dated 6/9/26 included the following: Apply layer of Zinc oxide paste to buttocks and perianal skin and surrounding tissue twice a day and as needed for incontinence. Remove all barrier cream with skin assessment. Then only remove soiled barrier cream and re-apply more with each incontinence episode. R2’s admission Minimum Data Set (MDS) dated 6/22/26 indicated R2 was at risk of developing pressure ulcers and had moderate cognitive impairment. The MDS also indicated R2 required extensive total assistance with activities of daily living (ADL). R2's care plan dated 6/18/26, indicated R2 was at risk for alteration in skin integrity related to incontinence, impaired mobility, weakness, and deconditioning with staff interventions to position R2’s body with pillows/support devices, and protect bony prominence, routinely turn and reposition as tolerated by R2, apply barrier cream to affected sites as ordered, assess/monitor the alteration in R’2 skin integrity and document status weekly. R2’s skin evaluation document, dated 7/15/26 at 2:33 p.m. indicated R2 had no new skin alterations identified. The evaluation did not address R2’s pressure ulcers (PU) at her coccyx area. R2’s Point of Care (POC) monitor task records dated from 7/9/26 through 7/21/26 indicated skin checks were documented as completed during cares with “no new skin alteration noted” recorded for each			20900	Continued from page 4 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing (DON), Wound Nurse, or designee will conduct an audit of all residents with pressure ulcers, skin tears, surgical wounds, or other identified wounds to verify that: · Comprehensive wound assessments are completed and documented. · Wound measurements and characteristics are documented according to facility policy. · Treatment orders are current and implemented as ordered. · Provider notification has occurred when there is a change in wound status. · Care plans accurately reflect current wound care interventions. · Weekly wound documentation is complete and consistent with facility policy. Any identified concerns will be corrected immediately, including provider notification, updated orders, documentation, and staff follow-up. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All licensed nursing staff will receive education regarding the facility's wound care and skin integrity policies, including: · Timely identification and assessment of skin alterations. · Completion of comprehensive wound assessments with required measurements and documentation. · Prompt implementation of physician or practitioner orders. · Timely notification of the provider for changes in wound condition. · Documentation of wound treatments and resident response. · Updating the interdisciplinary care plan to reflect		08/30/2026

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20900	Continued from page 5 assessment. During an observation on 7/22/26 at 9:05 a.m., a licensed practical nurse (LPN)-A stated R2 had a stage 1 PU on the coccyx area with blanchable tissue surrounding the wound. LPN-A stated the PU was an existing wound and the provider was aware of the wound condition. Review of R2's medical record including skin assessments and progress notes lacked documentation of PU assessment for the coccyx area prior to the survey entrance conference on 7/21/26. The medical record lacked documentation of wound measurements, staging, or description of the coccyx PU. During this time period, facility nursing staff were responsible for monitoring, assessing, documenting, and maintaining R2's skin integrity. During an interview on 7/22/26 at 10:24 a.m., LPN-A explained during weekly skin assessments, nursing staff were expected to assess existing wounds, compare current findings with previous assessments, and document the wounds' progress. LPN-A stated any newly identified skin impairment should be reported to the nurse manager and the provider for further evaluation and treatment instructions. During an observation on 7/22/26 at 10:10 a.m., R2 remained lying flat on her back in bed. During an interview on 7/22/26 at 10:49 a.m., a nursing assistant (NA)-A stated she was assigned to care for R2 during the day shift. NA-A stated R2 was to be repositioned every two hours using pillows for pressure relief. NA-A was unable to recall when R2 had last been repositioned and confirmed she had not repositioned R2 during her shift as of the time of the interview. During an observation on 7/22/26 at 3:45 p.m., LPN-B identified a new stage 2 PU (partial-thickness skin loss with exposed dermis) on R2's left gluteus measuring 2.19 cm x 1.24 cm. LPN-B described the wound as having light serosanguinous drainage, excoriation of the surrounding tissue and no odor. Additionally, LPN-B also identified a new stage 1 PU on R2's right gluteus measuring 0.68 cm x 0.62 cm. The wound bed was pink and fragile, and the surrounding tissue was intact. LPN-B confirmed R2 had been lying on her back and had not been repositioned before the assessment. During an interview on 7/22/26 at 3:14 p.m., LPN-B			20900	Continued from page 5 current wound care interventions. The facility will reinforce the use of standardized wound assessment documentation tools and review wound documentation during routine clinical meetings. Newly hired licensed nurses will receive education on wound assessment and documentation during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON, Wound Nurse, or designee will audit skin checks completed five times weekly for three weeks, three times weekly for three weeks, and two times weekly for three weeks. Audits will verify: · Timely wound assessments. · Complete wound measurements and documentation. · Treatments completed as ordered. · Provider notification when clinically indicated. · Accurate care plan updates. · Ongoing monitoring of wound progression or healing. Audit results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program. Any identified trends or deficiencies will result in additional education, observation, and corrective action. Monitoring will continue until sustained compliance is demonstrated. Completion Date: Education completed by 08/30/2026 Responsible Party: Director of Nursing / Wound Care Nurse/ or nurse designee.		08/30/2026

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NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST , SAINT CLOUD, Minnesota, 56304			
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20900	Continued from page 6 stated when a new skin impairment was identified, nursing staff were expected to complete a skin assessment, initiate a risk management report, document the wound description and measurements, record the finding in the progress note, notify the nurse manager and the provider, initiate treatment according to the provider's orders, and inform the resident's family. RN-A stated nursing staff did not document measurements or a description of R2's PU in the coccyx area and did not notify the provider of the wound. LPN-B explained R2 was at risk for developing PU and should have been repositioned every two hours, with any refusal documented in the medical record. LPN-B confirmed R2 had not been repositioned at that time. During an interview on 7/22/26 at 4:16 p.m., the DON stated she expected nursing staff to follow the facility's wound care policy. The DON stated when a new skin impairment was identified, nursing staff were required to notify the wound care team and the primary provider, document the wound measurements and description as well as initiating appropriate interventions. Additionally, The DON stated residents at risk for pressure ulcers were to be repositioned every two to three hours, as directed by the care plan. The DON confirmed nursing staff did not notify the provider regarding R2's newly identified wound. The DON stated the facility would provide house-wide education to nursing staff regarding wound care practices and timely physician notification. During an interview on 7/22/26 at 4:47 p.m., a nurse practitioner (NP)-A stated she expected nursing staff to follow the facility's change in condition and wound care policies. NP-A stated when a new skin impairment was identified, nursing staff were required to notify the provider and the dietitian. NP-A confirmed she was not notified of R2's PU in the coccyx area. The facility Change in Condition policy dated 8/1/15 and revised 11/13/24 instructed nurses to notify the physician of changes in the resident's condition. Nurse will complete assessment and document findings in resident record including but not limited to vital signs, pain, respiratory status as applicable etc. The care plan will be updated as necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies and procedures, educate staff, and implement measures to ensure residents are receiving the necessary services to prevent pressure ulcers or improve areas from occurring. The director of			20900			08/30/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
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20900	Continued from page 7 nursing or designee, could conduct random audits of the delivery of care, to ensure appropriate care and services are implemented to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20900			08/30/2026