



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 6, 2023

Administrator
Edenbrook Of St Cloud
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: September 22, 2023

Dear Administrator:

On November 1, 2023, we notified you a remedy was imposed. On November 30, 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 November 22, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 22, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 1, 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 December 22, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 22, 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 Therefore, the NATCEP prohibition is rescinded.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 cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 6, 2023

Administrator
Edenbrook Of St Cloud
1717 University Drive Southeast
Saint Cloud, MN 56304

Re: Reinspection Results
Event ID: RFZ812

Dear Administrator:

On November 16, 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 September 22, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2023

Administrator
Edenbrook Of St Cloud
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: September 22, 2023

Dear Administrator:

On September 22, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 December 22, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 22, 2024 (six months after the

Edenbrook Of St Cloud

October 17, 2023

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identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

https://mdhprovidercontent.web.health.state.mn.us/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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 11/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/22/2023
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 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
F 000	INITIAL COMMENTS On 9/19/23 through 9/22/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54385540C (MN00096555) H54385440C (MN00096742) H54385539C (MN00096382) H54385602C (MN00096945, MN00096954, and MN00096984) with a deficiency issued at F580. H54385541C (MN00096539) with a deficiency issued at F572, F940, F656, and F838. H54385662C (MN00096378) with a deficiency issued at F550. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550			11/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/2023

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

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F 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure dignity was maintained by answering call lights in a timely manner.			F 550	How corrective action will be accomplished for those residents found to have been affected by the deficient.		

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F 550	Continued From page 2 Findings include: On 9/20/23, at 11:40 a.m., RN-C stated, "Call light times are ridiculous." On 9/20/23, at 12:18 p.m., R2 stated she had her call light on and waited over four and a half hours for her wet brief to be changed on 9/17/23. On 9/21/23, at 1:28 p.m., R7 stated, "Sometimes I wait for hours. Sometimes they don't come at all, especially on the weekends." R7 stated, "I'm suffering. I just cry and cry." R7 stated she continued to be frustrated. On 9/21/23, at 2:06 p.m., the director of maintenance (DOM) stated extended call wait times were not due to mechanical issues. On 9/21/23, at 3:27 p.m., nursing assistant (NA)-E stated call light wait times were extended 9/17/23 evening shift due to short-staffing and two resident falls. On 9/22/23, at 9:37 a.m., the administrator stated there was not a system in place to routinely monitor call light response times. On 9/22/23, at 11:09 a.m., R8 stated, the weekends were the worst waiting for help to go to the bathroom. "The bell just goes and goes." On 9/22/23, at 11:55 a.m., family member (FM)-C stated one day he observed R5's call light on and R5 screaming for help for over three hours. Facility call light records reviewed for the last week 9/14/23 to 9/21/23, identified excessive call	F 550	No lasting affect noted related to call light wait times for R2, R7, R8, R5. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Staff re-educated on call light response policy. Staffing levels have been adjusted to include an additional staff each day and agency staff approved to help the facility fill those additional positions. Nursing schedule will be reviewed/audited daily in IDT to identify, and problem solve any concerns noted. Full house call light audit for location and proper functioning was completed on 10/05/23 and noted concerns were corrected. New call light system was ordered prior to this survey visit and is to be implemented as soon as possible. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Call light times, function, and availability will be audited 3x per week x 1 month. 2 x per week x 2 month, and weekly x 1 month. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits.		

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F 550	Continued From page 3 light wait times, with the longest response time of 413 min and 49 seconds. The review identified the following: 95 call light times that exceeded 30 minutes. 84 call light times that exceeded 60 minutes. 14 call light times that exceeded 90 minutes. 4 call light times that exceeded 120 minutes. 3 call light times that exceeded 180 minutes. 3 call light times that exceeded 210 minutes. 1 call light times that exceeded 410 minutes, over 6 hours. A facility document Call Light Use and Response dated 7/18/23, directed Purpose: To respond promptly to resident's call for assistance. Procedure: All facility personnel must be aware of call lights at all times. Answer call lights promptly whether or not the staff personal is assigned to the resident or not. Answer call lights in a prompt, calm, and courteous manner, turn off the call light as you enter the room and attend to the resident needs.	F 550	Date of compliance: 11/03/23 Person responsible: Administrator		
F 572 SS=D	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident	F 572			11/10/23

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F 572	Continued From page 4 understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-English speaking residents (R1, R3, R6) and/or their families were provided an interpreter, allowing them to be fully informed about their health status in a language they understood. Findings include: R1's care plan indicated he had a communication deficit due to a language barrier. The care plan directed R1 preferred to communicate in Spanish. R3's care plan indicated R3 had a communication deficit related to language barrier. The care plan directed to provide translator as necessary to communicate with the resident. Translator: Somali. R6's care plan indicated R6 had a cognitive/communication deficit due to stroke and language barrier, no longer able to speak English, speaks Somali and Arabic. The care plan directed R6 was able to communicate by: calling translator line, translating with wife or Somali speaking staff member, or communication board. On 9/19/23 at 9:03 a.m., registered nurse (RN)-F	F 572	F572 Notice of rights and rules (Interpreter services) How corrective action will be accomplished for those residents found to have been affected by the deficient. R1 discharged from the facility. R3 and her family were offered interpreter services on 10/19/2023 and would only like one at care conferences . R6 (Yusef Abdi) and his family were offered interpreter services on 10/04/2023 and declined. How the facility will identify other residents having the potential to be affected by the same deficient practice. All non-English speaking residents have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All non-English speaking residents will have interpreter services offered per the facility policy and procedure. If interpreter services via telephone or other technology are not effective, resident and/or family		

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F 572	Continued From page 5 stated they have some Spanish-speaking staff and have utilized an interpreter on a few occasions. Hospice nurse stated R1 was reported to have unclear speech, according to the interpreter. The hospice nurse stated the interpreter services were helpful in communicating with FM-A. On 9/19/23 at 9:44 a.m., licensed practical nurse (LPN)-A stated he has tried using a translation application (Google Translate) to determine what R1 was saying, but it had not been effective. LPN-A stated R1's family translated for him. LPN-A stated R3 and R6 were both able to use hand gestures to communicate what they wanted or needed. LPN-A stated R3 and R6's families interpreted for them when necessary. On 9/19/23 at 9:52 a.m., nursing assistant (NA)-A stated a paper with photos was used to determine R1's needs. NA-A stated it was not effective, requiring staff to anticipate his needs. On 9/19/23 at 10:04 a.m., NA-B stated she was not able to understand R1's wants and needs. She stated yes and no were the only clear words he spoke. NA-B stated R3 could point to things and was cognitively intact. On 9/19/23 at 11:39 a.m., registered nurse (RN)-A stated R1 did not speak any English. She said she tried using the application to translate what the resident was saying, but it was ineffective. On 9/19/23 at 1:27 p.m., FM-A stated the facility had not offered interpreter services since R1's admission to the facility on 6/29/23. FM-A stated hospice had offered interpreter services on a	F 572	will be offered alternative interpreter services. All staff will be educated on the interpreter services policy and the process. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits will be conducted weekly x 1 month and monthly x 1 month, to ensure residents interpreter needs are met. Date of compliance:11/10/2023 Person responsible: Administrator and/or DON		

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F 572	Continued From page 6 couple of occasions, but the facility had not offered the service for her or R1. FM-A stated her son often interpreted for her and her father. FM-A stated sometimes there were words the son cannot interpret for her. FM-A stated she understood some English. FM-A stated on the first day at the facility, she told the administrator (who is no longer employed at the facility) she needed an interpreter. FM-A stated the previous administrator said the owner's spouse could interpret and they didn't have interpreters at the facility. FM-A stated she did not ever receive interpreter services from the owner's spouse. On 9/19/23 at 3:31 p.m., the director of nursing (DON) stated it was not sufficient to expect family to assume the role as the interpreter for the resident or with their family, due to a potential conflict of interest. The DON stated a communication board had been initiated for R1, but was not effective. On 9/19/23 at 4:02 p.m., FM-B stated she told the facility R3 needed an interpreter. FM-B stated R3 could communicate with yes or no only. FM-B stated she has requested an interpreter several times. FM-B stated therapy provided verbal discharge instructions for R3 in English, so R3 did not understand them. FM-B stated the facility has asked her to interpret for R3. On 9/19/23 at 4:30 p.m., LPN-B stated she did not speak Spanish. She stated she was instructed to use the translation application, but it had not been effective with R1. On 9/19/23 at 4:38 p.m., RN-B stated R1 did not speak English. RN-B stated family often interpreted for him. RN-B stated she was not sure	F 572			

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F 572	Continued From page 7 how interpreters worked at the facility. RN-B stated interpreter services were not covered in orientation. RN-B stated it was not acceptable to expect family to interpret for the resident or other family members as they could misinterpret or change what was said. RN-B stated she believed she could typically understand what R3 and R6 needed. RN-B stated both R3 and R6's families often interpreted for them. On 9/20/23, at 11:00 a.m., R3 stated interpreter services had never been offered to her by the facility. R3 stated she felt comfortable with her family interpreting for her, but the facility had never asked her that question. On 9/20/23 at 11:40 a.m., RN-C stated staff were instructed the options for translation were to use the application on their phone for residents and family members. RN-C stated it was not effective with R1. RN-C stated gestures were sometimes effective with R1. RN-C stated she felt she could usually understand when R3 and R6 were trying to communicate. On 9/20/23 at 12:37 p.m., social worker (SW)-A stated an interpreter service should have been used for communication with residents and families who were not primarily English-speaking. SW-A stated R3 understood very little English. SW-A stated she recently utilized a phone interpreter service to complete social security paperwork. SW-A stated she was not sure if there was an interpreter service that would provide in-person interpreter services for R1. On 9/20/23 at 2:31 p.m., R6 stated he had never been offered an interpreter service. R6 stated he was comfortable with his children interpreting for	F 572			

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F 572	Continued From page 8 him. R6 stated he typically communicated with staff by use of gestures and action. On 9/20/23 at 2:44 p.m., RN-C stated she spoke the same language as R3 and R6 so she was able to communicate effectively with both of them and their families. RN-C stated residents who speak languages other than English or Somali, she depended on gestures and body language. RN-C stated she was unsure if there was an interpreter service available. On 9/21/23 at 11:50 a.m., county worker (CW)-A stated she was at a care conference for R1 where it was apparent the facility was not trying to arrange for interpreter services for R1 or FM-A. On 9/21/23 at 12:34 p.m., case manager (CM)-B stated she could understand what R3 needed. CM-B stated she attended all care conferences for R3. CM-B stated she was unsure if R3 was invited to attend her own care conferences. CM-B stated she was aware of an instance where the interpreter service was used to assist R3 with her county worker. CM-B stated it was not sufficient to ask family to interpret for residents. CM-B stated there was a service, communication boards or the translation application. On 9/22/23 at 9:37 a.m., the administrator stated the facility lacked a policy on the use of interpreter services. The administrator stated there was a language line instruction sheet available to staff. Administrator stated training on interpreter had not been offered to staff. The facility document Eden Senior Care Language Hotline Form undated, provided instructions to utilize phone interpreter services. It	F 572			

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F 572	Continued From page 9 indicated an acceptable alternative is to utilize free apps like Google Translate that can be accessed from any smart phone. This app can allow a speaker to speak into the phone in their native language and the phone will translate into any other desired language. This can allow the staff members and the residents to interact. The facility who elects this option should ensure that this app is accessible in the event they have such a need, either via a dedicated device, an employee's phone on duty, or iPad. To obtain an Interpreter please ask the receptionist or contact the Facility Administrator. The Facility will make every effort to provide Interpreter services when needed. If you feel that your Interpreter needs have not been met, you can contact the Minnesota Department of Public Health at the following number: 1-651-201-5897. The Facility Assessment dated 1/10/23, indicated to overcome language barriers, communication books are created for residents who have limited use of English. Reading materials and videos in the resident's primary language are obtained through the public library as appropriate. Interpreters are brought in for assessments and individual needs. A policy on the use of interpreters was requested but not received.	F 572			
F 580 SS=D	Notify of Changes (Injury/Denial/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-	F 580			11/4/23

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F 580	Continued From page 10 (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 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	F 580			

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F 580	Continued From page 11 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 notify a family member of a fall which occurred for 1 of 2 residents (R1) reviewed. Findings include: R1's Medical Diagnoses List indicated R1's diagnoses included cerebral infarction (stroke), heart failure, and chronic pain. R1's Face Sheet indicated his emergency contact was his family member (FM)-A. R1's admission Minimum Data Set (MDS) dated 7/6/23 indicated R1 had severely impaired cognition, memory problems, and disorganized thinking. The MDS indicated R1 was unsteady on his feet. R1's care plan indicated he was at high risk for falls related to hemiparesis (partial paralysis on one side of the body), impaired cognition, and communication. R1's progress notes lacked an entry, at the time of the incident, for a fall which occurred on 9/13/23. On 9/14/23 a facility document Risk Management (incident report) indicated on 9/14/23 FM-A reported to a floor nurse R1 fell on 9/13/23 at 10:56 p.m. FM-A reported she had a video of the fall, and a lift was not used when the resident was			F 580	How corrective action will be accomplished for those residents found to have been affected by the deficient. R1's family was notified of the fall on 9/14/23 and she also observed the fall on the cameras in residents' room. How the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident who has a fall could be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Licensed nurses were educated to call resident responsible party for healthcare of all falls at the time of the incident (after resident assessed and safe) regardless of time of day or whether there is or is not an injury noted. Facility post fall policy and notification of change policy was reviewed and updated to include notifying the resident representative at the time of a fall unless they have requested to delay communication such as during the night if there is no injury. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.		

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F 580	Continued From page 12 moved back to the bed. On 9/15/23, at 8:42 a.m., a progress note indicated the interdisciplinary team (IDT) met to discuss R1's fall that occurred on 9/13/23. On 9/15/23, at 10:47 a.m. a progress note indicated a meeting was held with the director of nursing (DON) and hospice regarding the fall that occurred on 9/13/23, and right arm x-ray ordered. On 9/19/23, at 11:39 a.m., registered nurse (RN)-A stated nursing assistant (NA)-C informed her R1 fell around 10:30 p.m. on 9/13/23. RN-A stated when she arrived to R1's room, he was kneeling at the edge of the bed with his head on the bed. She stated R1 was lifted into bed along with NA-C. RN-A stated she did not call R1's daughter as it was the middle of the night. She said she did not inform the provider, as there were no injuries upon assessment. RN-A stated she did not complete an incident report or create a progress note detailing the incident. On 9/19/23, at 1:27 p.m., FM-A stated she informed the facility about R1's fall, which occurred on 9/13/23 in the evening, on 9/14/23. FM-A stated hospice was not made aware. FM-A stated the facility did not contact her at the time of the fall. FM-A stated she had a video recording of the incident. On 9/19/23, at 3:08 p.m., NA-C stated it was her first time working on the unit for R1 on 9/13/23. NA-C stated RN-A called her into the room for assistance with the resident. She stated R1 was found on the floor, next to his bed, on the mat. On 9/20/23, at 3:10 p.m., the administrator stated	F 580	Facility will conduct audits, to ensure nurses understand and complete notification requirements, weekly x 4 weeks, every other week x 1 month, and monthly x 1 month. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. Date of compliance:11/03/2023 Person responsible: Administrator and/or DON		

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F 580	Continued From page 13 he learned of R1's fall that occurred on 9/13/23 on 9/14/23 in the evening. Administrator stated FM-A sent him a video of the incident. Administrator stated the facility policy was to report falls to the physician and family. On 9/20/23, at 3:47 p.m., the director of nursing (DON) stated she first became aware of R1's fall which occurred on 9/13/23 on 9/14/23 in the evening. The DON stated FM-A came into facility asking about his fall and why hospice was not notified. The DON reported she had viewed the video recording. The facility Fall Reduction Policy revised 5/18/22 directed: Purpose: To identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries. To promote a systematic approach and monitoring process for the care of residents who have fallen and/or those who are determined to be at risk: If injury is known or suspected: provide emergency first aid treatment as applicable, notify the physician of incident, assessment, and possible signs of injury, notify the responsible party. If no injury is present from fall: notify the physician, notify the resident's responsible party, document in the clinical record a summary of the fall including, but not limited to, assessment, intervention, and resident response.	F 580			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656			11/3/23

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F 656	Continued From page 14 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656			

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F 656	Continued From page 15 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan which included cultural plans/interventions for 2 of 3 residents reviewed (R1, R3). Findings include: R1's Medical Diagnoses List indicated R1 had diagnoses of cerebral infarction (stroke), neoplasm of prostate (prostate cancer), secondary malignant neoplasm of bone (bone cancer), heart failure, and chronic pain. R1's admission Minimum Data Set (MDS) dated 7/6/23, indicated R1's preferences were not assessed. R1's care plan dated 7/5/23, indicated he had a communication deficit related to language barrier and stroke. The care plan indicated R1's primary language was Spanish. R1's care plan indicated he had impaired cognitive function/dementia or impaired thought process related to stroke. R1's care plan lacked the development or implementation of culturally competent care plan interventions, including food and meals, activities, and interests. R1's nutrition assessment dated 7/2/23, failed to address dietary cultural preferences. R3's Face Sheet indicated her primary language was Somali. R3's medical diagnoses indicated R3 had	F 656	How corrective action will be accomplished for those residents found to have been affected by the deficient. R1 has discharged from the facility. R3 was interviewed for food and meals, activities and interests and her care plan was updated with indicated preferences. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All residents/representatives will be interviewed specific to their cultural preferences and care plans will be updated based on the results. All interdisciplinary team members (IDT) will be educated on the importance of assessing cultural preferences, including results in care plans, and providing interventions to meet resident needs. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits will be conducted weekly x 1 month and monthly x 1 month, to ensure residents' cultural preferences are care planned and met.		

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F 656	Continued From page 16 diagnoses of cerebrovascular disease (condition that affects blood flow and the blood vessels in the brain), and vascular dementia (brain damage caused by multiple strokes, causing memory loss). R3's significant change MDS dated 6/22/23 indicated R3 had severe cognitive impairment. On 9/18/23 a Brief Interview of Mental Status (BIMS) assessment indicated moderate cognitive impairment. R3's care plan dated 5/8/23, indicated R3 had a communication deficit related to language barrier. Interventions included using alternative communication tools as needed and to provide a translator as necessary to communicate. R3's care plan indicated R3 had impaired cognitive function. Interventions included to use yes and no questions to determine her needs. R3's care plan indicated she disliked pork. R3's care plan lacked the development or implementation of culturally competent care plan interventions, including food and meals, activities, and interests. On 9/19/23 at 1:27 p.m., R1's family member (FM)-A confirmed she and R1's primary language was Spanish, as they immigrated to the United States from El Salvador. FM-A stated she could speak and understand some English, but R1 could not. FM-A stated she had never been asked about cultural preferences for R1. FM-A stated there were several ethnic foods R1 would prefer over the general meals offered at the facility. FM-A stated she would bring R1 ethnic foods whenever she could for his comfort. On 9/19/23 at 3:31 p.m., the administrator stated the activities department was expected to	F 656	Date of compliance: 11/03/2023 Person responsible: Administrator or designee		

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F 656	Continued From page 17 complete the assessment for activities, preferences, and interests. On 9/19/23 at 4:02 p.m., R3's FM-B stated R3 did not want to be served pork for religious reasons. FM-B stated R3 had been served pork on several occasions. FM-B stated that R3 was not offered ethnic food and would likely prefer more starch-based options. FM-B stated she would occasionally bring R3 ethnic food. FM-B stated, "It would be great if they could offer food of her preference." FM-B stated the facility did not feel like home for R3. On 9/19/23 at 4:30 p.m., licensed practical nurse (LPN)-B stated she knew R1 liked mashed potatoes and warm fluids. She stated R1's daughter frequently brought him ethnic food from home. On 9/19/23 at 4:38 p.m., registered nurse (RN)-B stated no cultural/ethnic food were provided by the facility. RN-B stated she had observed families bring in preferred foods from home at times. RN-B stated R3 was able to make needs known, but she could not communicate effectively with R1. On 9/20/23 at 11:00 a.m., R3 stated the facility has never asked her about her preferences. R3 stated she was not invited to attend her own care conferences. She stated she would like to be involved so she could share her preferences with them. R3 stated she has been served pork several times. On 9/20/23 at 11:40 a.m., RN-C stated she did not receive cultural competence training from the facility, but was aware of some Somali	F 656			

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F 656	Continued From page 18 preferences, such as no male caregivers for the females and no pork. On 9/20/23 at 12:37 p.m., the social worker (SW)-A stated the activities director was expected to conduct an assessment upon admission to determine cultural preferences, activities, and interests. SW-A stated the director of dietary was expected to address dietary preferences. On 9/20/23 at 1:35 p.m., the director of dining (DOD) stated food likes and dislikes and special instructions were addressed in care conferences. The DOD stated residents could have an alternate meal choice if they did not like what was on the menu. The DOD stated the families of R1 and R3 have said the food was fine but had not been offered ethnic foods. The DOD stated it would be hard to create a custom menu for each resident at the facility. The DOD stated he was not provided cultural competence training. On 9/20/23 at 2:44 p.m., RN-D stated if R3 did not like what was being served for a meal, she usually opted for rice. She stated R3's family frequently brought in ethnic foods. On 9/21/23 at 10:46 a.m., clinical manager (CM)-A stated there were no cultural activities offered for R1 such as music, reading material, or television programs in Spanish. On 9/22/23 at 9:37 a.m., the administrator stated they have not provided any training in cultural competency. The administrator stated residents were asked what they liked and disliked, but were not asked if they have preferred ethnic food or activities.	F 656			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/22/2023
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F 656	Continued From page 19	F 656			
F 838 SS=C	A policy on cultural care plans was requested but not provided. Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.	F 838			10/25/23

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F 838	Continued From page 20 §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Facility Assessment was complete to help determine staffing needs based on resident acuity. This had the potential to affect all 64 residents. Findings include: The Facility Assessment (used to determine staffing needs based upon resident acuity as well as daily admission and discharge information) dated 1/10/23, failed to include current details for	F 838	How corrective action will be accomplished for those residents found to have been affected by the deficient. No residents identified in this deficiency. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place, or		

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F 838	Continued From page 21 the resident population. A section of the form titled Special Treatments and Conditions had not been updated since 6/1/21. The section Assistance with Activities of Daily Living lacked detail to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies lacking detail regarding the number of residents who required assistance with dressing, bathing, transfers, eating, toileting, mobility, and other care. On 9/22/23, at 9:37 a.m., the administrator stated he was unsure who was responsible to complete the Facility Assessment, how often it was to be reviewed, and what it currently directed.	F 838	systemic changes made, to ensure that the deficient practice will not recur. The facility assessment was updated and completed on 10/18/2023 and will be reviewed in QAPI on 10/25/23. Facility assessment updated to include current details for the resident population, necessary resources to care for residents competently during day-to-day operations and emergencies, and the details of the number of residents who require assistance with dressing, bathing, transfers, eating, toileting, mobility and other care. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audit will be completed 1 x per month x 2 months to ensure accuracy. Date of compliance: 10/25/2023 Person responsible: Administrator		
F 940 SS=F	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to-	F 940			11/4/23

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F 940	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide all staff education on cultural competence. Findings include: On 9/19/23 at 9:52 a.m., nursing assistant (NA)-A stated she had not received training in cultural competence. On 9/19/23 at 12:07 p.m., licensed practical nurse (LPN)-A stated he had not received cultural competence training. On 9/19/23 at 1:27 p.m., family member (FM)-A stated nobody had inquired about her R1's cultural preferences or practices since he had been at the facility. R1 moved into the facility on 6/29/23. On 9/19/23 at 4:02 p.m., FM-B stated R3 was served pork on several occasions. R3's culture directed R3 not to have any pork. On 9/19/23 at 4:38 p.m., registered nurse (RN)-B stated she had not received cultural competence training from the facility. On 9/20/23 at 11:00 a.m., R3 stated she was never asked about her cultural preferences. R3 stated that her culture prohibits pork, and she had been served pork on several occasions. On 9/20/23 at 1:35 p.m., the director of dining (DOD) stated he had not received training in cultural competence.			F 940	How corrective action will be accomplished for those residents found to have been affected by the deficient. No residents identified to have been affected by the deficiency. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Culturally competent education has been assigned to all staff through the online education system. Any staff not trained by compliance date will complete training prior to next shift. and is now required upon hire and annually. Cultural Competency policy created and will be brought to QAPI for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Relias online education is monitored by HR for compliance. Audits will be conducted after every orientation x 2 months to ensure Cultural competence training is completed. Date of compliance: 11/10/2023 Person responsible: Admin/ Human Resources Designee		

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F 940	Continued From page 23 On 9/22/23 at 9:37 a.m., the administrator stated cultural competency training had not been provided to any of the staff.	F 940			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2023

Administrator
Edenbrook Of St Cloud
1717 University Drive Southeast
Saint Cloud, MN 56304

Re: State Nursing Home Licensing Orders
Event ID: RFZ811

Dear Administrator:

The above facility was surveyed on September 19, 2023 through September 22, 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2023
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/19/23 through 9/22/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/23

Minnesota Department of Health

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H54385540C (MN00096555) H54385440C (MN00096742) H54385539C (MN00096382) H54385602C (MN00096945, MN00096954, and MN00096984) with a licensing order issued at 4658.0085. H54385541C (MN00096539) with licensing orders issued at 144.651, Subd 4; 4658.0405, Subp 3; and 4658.0065, Subp 3. H54385662C (MN00096378) with licensing orders issued at 144.651, Subp 5. 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	2 000			

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2 000	Continued From page 2 is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 240	MN Rule 4658.0065 Subp. 3 Resident Safety and Disaster Planning Subp. 3. Written disaster plan. A nursing home must have a written disaster plan specific to the nursing home with procedures for the protection and evacuation of all persons in the case of fire or explosion or in the event of floods, tornadoes, or other emergencies. The plan must include information and procedures about the location of alarm signals and fire extinguishers, frequency of drills, assignments of specific tasks and responsibilities of the personnel on each shift, persons and local emergency departments to be notified, precautions and safety measures during tornado alerts, procedures for evacuation of all persons during fire or floods, planned evacuation routes from the various floor areas to safe areas within the building, or from the building when necessary, and arrangements for temporary emergency housing in the community in the event of total evacuation.	2 240			11/10/23

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2 240	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Facility Assessment was complete to help determine staffing needs based on resident acuity. This had the potential to affect all 64 residents. Findings include: The Facility Assessment (used to determine staffing needs based upon resident acuity as well as daily admission and discharge information) dated 1/10/23, failed to include current details for the resident population. A section of the form titled Special Treatments and Conditions had not been updated since 6/1/21. The section Assistance with Activities of Daily Living lacked detail to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies lacking detail regarding the number of residents who required assistance with dressing, bathing, transfers, eating, toileting, mobility, and other care. On 9/22/23, at 9:37 a.m., the administrator stated he was unsure who was responsible to complete the Facility Assessment, how often it was to be reviewed, and what it currently directed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could conduct a current facility assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The administrator or designee could periodically review the facility assessment	2 240	Corrected		

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2 240	Continued From page 4 to ensure its ongoing accuracy. The administrator or designee could review the facility assessment with the interdisciplinary care team (IDT). TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 240			
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status 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	2 265			11/10/23

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2 265	Continued From page 5 resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify a family member of a fall which occurred for 1 of 2 residents (R1) reviewed. Findings include: R1's Medical Diagnoses List indicated R1's diagnoses included cerebral infarction (stroke), heart failure, and chronic pain. R1's Face Sheet indicated his emergency contact was his family member (FM)-A. R1's admission Minimum Data Set (MDS) dated 7/6/23 indicated R1 had severely impaired cognition, memory problems, and disorganized thinking. The MDS indicated R1 was unsteady on his feet. R1's care plan indicated he was at high risk for falls related to hemiparesis (partial paralysis on one side of the body), impaired cognition, and communication. R1's progress notes lacked an entry, at the time of the incident, for a fall which occurred on 9/13/23. On 9/14/23 a facility document Risk Management (incident report) indicated on 9/14/23 FM-A reported to a floor nurse R1 fell on 9/13/23 at 10:56 p.m. FM-A reported she had a video of the fall, and a lift was not used when the resident was	2 265	Corrected		

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2 265	Continued From page 6 moved back to the bed. On 9/15/23, at 8:42 a.m., a progress note indicated the interdisciplinary team (IDT) met to discuss R1's fall that occurred on 9/13/23. On 9/15/23, at 10:47 a.m. a progress note indicated a meeting was held with the director of nursing (DON) and hospice regarding the fall that occurred on 9/13/23, and right arm x-ray ordered. On 9/19/23, at 11:39 a.m., registered nurse (RN)-A stated nursing assistant (NA)-C informed her R1 fell around 10:30 p.m. on 9/13/23. RN-A stated when she arrived to R1's room, he was kneeling at the edge of the bed with his head on the bed. She stated R1 was lifted into bed along with NA-C. RN-A stated she did not call R1's daughter as it was the middle of the night. She said she did not inform the provider, as there were no injuries upon assessment. RN-A stated she did not complete an incident report or create a progress note detailing the incident. On 9/19/23, at 1:27 p.m., FM-A stated she informed the facility about R1's fall, which occurred on 9/13/23 in the evening, on 9/14/23. FM-A stated hospice was not made aware. FM-A stated the facility did not contact her at the time of the fall. FM-A stated she had a video recording of the incident. On 9/19/23, at 3:08 p.m., NA-C stated it was her first time working on the unit for R1 on 9/13/23. NA-C stated RN-A called her into the room for assistance with the resident. She stated R1 was found on the floor, next to his bed, on the mat. On 9/20/23, at 3:10 p.m., the administrator stated he learned of R1's fall that occurred on 9/13/23	2 265			

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2 265	Continued From page 7 on 9/14/23 in the evening. Administrator stated FM-A sent him a video of the incident. Administrator stated the facility policy was to report falls to the physician and family. On 9/20/23, at 3:47 p.m., the director of nursing (DON) stated she first became aware of R1's fall which occurred on 9/13/23 on 9/14/23 in the evening. The DON stated FM-A came into facility asking about his fall and why hospice was not notified. The DON reported she had viewed the video recording. The facility Fall Reduction Policy revised 5/18/22 directed: Purpose: To identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries. To promote a systematic approach and monitoring process for the care of residents who have fallen and/or those who are determined to be at risk: If injury is known or suspected: provide emergency first aid treatment as applicable, notify the physician of incident, assessment, and possible signs of injury, notify the responsible party. If no injury is present from fall: notify the physician, notify the resident's responsible party, document in the clinical record a summary of the fall including, but not limited to, assessment, intervention, and resident response. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement education to ensure timely notification to resident representatives. The DON or designee could conduct periodic audits to ensure the notifications are occurring timely. The facility could perform measurable audits and report the findings to the Quality Assessment and Performance Improvement	2 265			

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2 265	Continued From page 8 (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265	Corrected		11/10/23
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan which included cultural plans/interventions for 2 of 3 residents reviewed (R1, R3). Findings include: R1's Medical Diagnoses List indicated R1 had diagnoses of cerebral infarction (stroke), neoplasm of prostate (prostate cancer), secondary malignant neoplasm of bone (bone cancer), heart failure, and chronic pain. R1's admission Minimum Data Set (MDS) dated 7/6/23, indicated R1's preferences were not assessed. R1's care plan dated 7/5/23, indicated he had a communication deficit related to language barrier and stroke. The care plan indicated R1's primary language was Spanish. R1's care plan indicated	2 565			

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2 565	Continued From page 9 he had impaired cognitive function/dementia or impaired thought process related to stroke. R1's care plan lacked the development or implementation of culturally competent care plan interventions, including food and meals, activities, and interests. R1's nutrition assessment dated 7/2/23, failed to address dietary cultural preferences. R3's Face Sheet indicated her primary language was Somali. R3's medical diagnoses indicated R3 had diagnoses of cerebrovascular disease (condition that affects blood flow and the blood vessels in the brain), and vascular dementia (brain damage caused by multiple strokes, causing memory loss). R3's significant change MDS dated 6/22/23 indicated R3 had severe cognitive impairment. On 9/18/23 a Brief Interview of Mental Status (BIMS) assessment indicated moderate cognitive impairment. R3's care plan dated 5/8/23, indicated R3 had a communication deficit related to language barrier. Interventions included using alternative communication tools as needed and to provide a translator as necessary to communicate. R3's care plan indicated R3 had impaired cognitive function. Interventions included to use yes and no questions to determine her needs. R3's care plan indicated she disliked pork. R3's care plan lacked the development or implementation of culturally competent care plan interventions, including food and meals, activities, and interests. On 9/19/23 at 1:27 p.m., R1's family member	2 565			

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2 565	Continued From page 10 (FM)-A confirmed she and R1's primary language was Spanish, as they immigrated to the United States from El Salvador. FM-A stated she could speak and understand some English, but R1 could not. FM-A stated she had never been asked about cultural preferences for R1. FM-A stated there were several ethnic foods R1 would prefer over the general meals offered at the facility. FM-A stated she would bring R1 ethnic foods whenever she could for his comfort. On 9/19/23 at 3:31 p.m., the administrator stated the activities department was expected to complete the assessment for activities, preferences, and interests. On 9/19/23 at 4:02 p.m., R3's FM-B stated R3 did not want to be served pork for religious reasons. FM-B stated R3 had been served pork on several occasions. FM-B stated that R3 was not offered ethnic food and would likely prefer more starch-based options. FM-B stated she would occasionally bring R3 ethnic food. FM-B stated, "It would be great if they could offer food of her preference." FM-B stated the facility did not feel like home for R3. On 9/19/23 at 4:30 p.m., licensed practical nurse (LPN)-B stated she knew R1 liked mashed potatoes and warm fluids. She stated R1's daughter frequently brought him ethnic food from home. On 9/19/23 at 4:38 p.m., registered nurse (RN)-B stated no cultural/ethnic food were provided by the facility. RN-B stated she had observed families bring in preferred foods from home at times. RN-B stated R3 was able to make needs known, but she could not communicate effectively with R1.	2 565			

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2 565	Continued From page 11 On 9/20/23 at 11:00 a.m., R3 stated the facility has never asked her about her preferences. R3 stated she was not invited to attend her own care conferences. She stated she would like to be involved so she could share her preferences with them. R3 stated she has been served pork several times. On 9/20/23 at 11:40 a.m., RN-C stated she did not receive cultural competence training from the facility, but was aware of some Somali preferences, such as no male caregivers for the females and no pork. On 9/20/23 at 12:37 p.m., the social worker (SW)-A stated the activities director was expected to conduct an assessment upon admission to determine cultural preferences, activities, and interests. SW-A stated the director of dietary was expected to address dietary preferences. On 9/20/23 at 1:35 p.m., the director of dining (DOD) stated food likes and dislikes and special instructions were addressed in care conferences. The DOD stated residents could have an alternate meal choice if they did not like what was on the menu. The DOD stated the families of R1 and R3 have said the food was fine but had not been offered ethnic foods. The DOD stated it would be hard to create a custom menu for each resident at the facility. The DOD stated he was not provided cultural competence training. On 9/20/23 at 2:44 p.m., RN-D stated if R3 did not like what was being served for a meal, she usually opted for rice. She stated R3's family frequently brought in ethnic foods. On 9/21/23 at 10:46 a.m., clinical manager	2 565			

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2 565	Continued From page 12 (CM)-A stated there were no cultural activities offered for R1 such as music, reading material, or television programs in Spanish. On 9/22/23 at 9:37 a.m., the administrator stated they have not provided any training in cultural competency. The administrator stated residents were asked what they liked and disliked, but were not asked if they have preferred ethnic food or activities. A policy on cultural care plans was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement education to ensure care plans included cultural interventions. The DON or designee could conduct periodic audits to ensure the care plans addressed cultural interventions. The DON or designee could perform measurable audits and report the findings to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565			
21800	MN St. Statute 144.651 Subd. 4 Patients & Residents of HC Fac. Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and	21800			11/10/23

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21800	Continued From page 13 responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-English speaking residents (R1, R3, R6) and/or their families were provided an interpreter, allowing them to be fully informed about their health status in a language they understood. Findings include: R1's care plan indicated he had a communication deficit due to a language barrier. The care plan directed R1 preferred to communicate in Spanish.	21800	Corrected		

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21800	Continued From page 14 R3's care plan indicated R3 had a communication deficit related to language barrier. The care plan directed to provide translator as necessary to communicate with the resident. Translator: Somali. R6's care plan indicated R6 had a cognitive/communication deficit due to stroke and language barrier, no longer able to speak English, speaks Somali and Arabic. The care plan directed R6 was able to communicate by: calling translator line, translating with wife or Somali speaking staff member, or communication board. On 9/19/23 at 9:03 a.m., registered nurse (RN)-F stated they have some Spanish-speaking staff and have utilized an interpreter on a few occasions. Hospice nurse stated R1 was reported to have unclear speech, according to the interpreter. The hospice nurse stated the interpreter services were helpful in communicating with FM-A. On 9/19/23 at 9:44 a.m., licensed practical nurse (LPN)-A stated he has tried using a translation application (Google Translate) to determine what R1 was saying, but it had not been effective. LPN-A stated R1's family translated for him. LPN-A stated R3 and R6 were both able to use hand gestures to communicate what they wanted or needed. LPN-A stated R3 and R6's families interpreted for them when necessary. On 9/19/23 at 9:52 a.m., nursing assistant (NA)-A stated a paper with photos was used to determine R1's needs. NA-A stated it was not effective, requiring staff to anticipate his needs. On 9/19/23 at 10:04 a.m., NA-B stated she was not able to understand R1's wants and needs.	21800			

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21800	Continued From page 15 She stated yes and no were the only clear words he spoke. NA-B stated R3 could point to things and was cognitively intact. On 9/19/23 at 11:39 a.m., registered nurse (RN)-A stated R1 did not speak any English. She said she tried using the application to translate what the resident was saying, but it was ineffective. On 9/19/23 at 1:27 p.m., FM-A stated the facility had not offered interpreter services since R1's admission to the facility on 6/29/23. FM-A stated hospice had offered interpreter services on a couple of occasions, but the facility had not offered the service for her or R1. FM-A stated her son often interpreted for her and her father. FM-A stated sometimes there were words the son cannot interpret for her. FM-A stated she understood some English. FM-A stated on the first day at the facility, she told the administrator (who is no longer employed at the facility) she needed an interpreter. FM-A stated the previous administrator said the owner's spouse could interpret and they didn't have interpreters at the facility. FM-A stated she did not ever receive interpreter services from the owner's spouse. On 9/19/23 at 3:31 p.m., the director of nursing (DON) stated it was not sufficient to expect family to assume the role as the interpreter for the resident or with their family, due to a potential conflict of interest. The DON stated a communication board had been initiated for R1, but was not effective. On 9/19/23 at 4:02 p.m., FM-B stated she told the facility R3 needed an interpreter. FM-B stated R3 could communicate with yes or no only. FM-B stated she has requested an interpreter several	21800			

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21800	Continued From page 16 times. FM-B stated therapy provided verbal discharge instructions for R3 in English, so R3 did not understand them. FM-B stated the facility has asked her to interpret for R3. On 9/19/23 at 4:30 p.m., LPN-B stated she did not speak Spanish. She stated she was instructed to use the translation application, but it had not been effective with R1. On 9/19/23 at 4:38 p.m., RN-B stated R1 did not speak English. RN-B stated family often interpreted for him. RN-B stated she was not sure how interpreters worked at the facility. RN-B stated interpreter services were not covered in orientation. RN-B stated it was not acceptable to expect family to interpret for the resident or other family members as they could misinterpret or change what was said. RN-B stated she believed she could typically understand what R3 and R6 needed. RN-B stated both R3 and R6's families often interpreted for them. On 9/20/23, at 11:00 a.m., R3 stated interpreter services had never been offered to her by the facility. R3 stated she felt comfortable with her family interpreting for her, but the facility had never asked her that question. On 9/20/23 at 11:40 a.m., RN-C stated staff were instructed the options for translation were to use the application on their phone for residents and family members. RN-C stated it was not effective with R1. RN-C stated gestures were sometimes effective with R1. RN-C stated she felt she could usually understand when R3 and R6 were trying to communicate. On 9/20/23 at 12:37 p.m., social worker (SW)-A stated an interpreter service should have been	21800			

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21800	Continued From page 17 used for communication with residents and families who were not primarily English-speaking. SW-A stated R3 understood very little English. SW-A stated she recently utilized a phone interpreter service to complete social security paperwork. SW-A stated she was not sure if there was an interpreter service that would provide in-person interpreter services for R1. On 9/20/23 at 2:31 p.m., R6 stated he had never been offered an interpreter service. R6 stated he was comfortable with his children interpreting for him. R6 stated he typically communicated with staff by use of gestures and action. On 9/20/23 at 2:44 p.m., RN-C stated she spoke the same language as R3 and R6 so she was able to communicate effectively with both of them and their families. RN-C stated residents who speak languages other than English or Somali, she depended on gestures and body language. RN-C stated she was unsure if there was an interpreter service available. On 9/21/23 at 11:50 a.m., county worker (CW)-A stated she was at a care conference for R1 where it was apparent the facility was not trying to arrange for interpreter services for R1 or FM-A. On 9/21/23 at 12:34 p.m., case manager (CM)-B stated she could understand what R3 needed. CM-B stated she attended all care conferences for R3. CM-B stated she was unsure if R3 was invited to attend her own care conferences. CM-B stated she was aware of an instance where the interpreter service was used to assist R3 with her county worker. CM-B stated it was not sufficient to ask family to interpret for residents. CM-B stated there was a service, communication boards or the translation application.	21800			

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21800	Continued From page 18 On 9/22/23 at 9:37 a.m., the administrator stated the facility lacked a policy on the use of interpreter services. The administrator stated there was a language line instruction sheet available to staff. Administrator stated training on interpreter had not been offered to staff. The facility document Eden Senior Care Language Hotline Form undated, provided instructions to utilize phone interpreter services. It indicated an acceptable alternative is to utilize free apps like Google Translate that can be accessed from any smart phone. This app can allow a speaker to speak into the phone in their native language and the phone will translate into any other desired language. This can allow the staff members and the residents to interact. The facility who elects this option should ensure that this app is accessible in the event they have such a need, either via a dedicated device, an employee's phone on duty, or iPad. To obtain an Interpreter please ask the receptionist or contact the Facility Administrator. The Facility will make every effort to provide Interpreter services when needed. If you feel that your Interpreter needs have not been met, you can contact the Minnesota Department of Public Health at the following number: 1-651-201-5897. The Facility Assessment dated 1/10/23, indicated to overcome language barriers, communication books are created for residents who have limited use of English. Reading materials and videos in the resident's primary language are obtained through the public library as appropriate. Interpreters are brought in for assessments and individual needs. A policy on the use of interpreters was requested	21800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/22/2023
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304			
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21800	Continued From page 19 but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement cultural competence education, including the use of interpreters to all staff. The administrator, DON, or designee could audit periodically to ensure the needs of resident(s) who do not speak English as their primary language are maintained. The facility could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800			
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure dignity was maintained by answering call lights in a timely manner. Findings include: On 9/20/23, at 11:40 a.m., RN-C stated, "Call light times are ridiculous."	21805	Corrected		11/10/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2023
NAME OF PROVIDER OR SUPPLIER EDENBROOK OF ST CLOUD		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304			
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21805	Continued From page 20 On 9/20/23, at 12:18 p.m., R2 stated she had her call light on and waited over four and a half hours for her wet brief to be changed on 9/17/23. On 9/21/23, at 1:28 p.m., R7 stated, "Sometimes I wait for hours. Sometimes they don't come at all, especially on the weekends." R7 stated, "I'm suffering. I just cry and cry." R7 stated she continued to be frustrated. On 9/21/23, at 2:06 p.m., the director of maintenance (DOM) stated extended call wait times were not due to mechanical issues. On 9/21/23, at 3:27 p.m., nursing assistant (NA)-E stated call light wait times were extended 9/17/23 evening shift due to short-staffing and two resident falls. On 9/22/23, at 9:37 a.m., the administrator stated there was not a system in place to routinely monitor call light response times. On 9/22/23, at 11:09 a.m., R8 stated, the weekends were the worst waiting for help to go to the bathroom. "The bell just goes and goes." On 9/22/23, at 11:55 a.m., family member (FM)-C stated one day he observed R5's call light on and R5 screaming for help for over three hours. Facility call light records reviewed for the last week 9/14/23 to 9/21/23, identified excessive call light wait times, with the longest response time of 413 min and 49 seconds. The review identified the following: 95 call light times that exceeded 30 minutes. 84 call light times that exceeded 60 minutes.	21805			

Minnesota Department of Health

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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, MN 56304			
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21805	Continued From page 21 14 call light times that exceeded 90 minutes. 4 call light times that exceeded 120 minutes. 3 call light times that exceeded 180 minutes. 3 call light times that exceeded 210 minutes. 1 call light times that exceeded 410 minutes, over 6 hours. A facility document Call Light Use and Response dated 7/18/23, directed Purpose: To respond promptly to resident's call for assistance. Procedure: All facility personnel must be aware of call lights at all times. Answer call lights promptly whether or not the staff personal is assigned to the resident or not. Answer call lights in a prompt, calm, and courteous manner, turn off the call light as you enter the room and attend to the resident needs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could assess the acuity of the residents to determine and provide the level of staffing required to answer call lights. The DON or designee could monitor call light response times on a weekly basis. The The DON or designee could share measurable date with the Quality Assessment and Performance Improvement (QAPI) committee for further review and monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21805			