DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 5, 2023

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

RE: CCN: 245560
Cycle Start Date: October 20, 2022

Dear Administrator:

On December 20, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 9, 2022

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

RE: CCN: 245560
Cycle Start Date: October 20, 2022

Dear Administrator:

On October 20, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 January 20, 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 April 20, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
November 9, 2022

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

Re: State Nursing Home Licensing Orders
Event ID: SFJX11

Dear Administrator:

The above facility was surveyed on October 17, 2022 through October 20, 2022 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	C 10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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
E 000	Initial Comments On 10/17/22 through 10/20/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/17/22 through 10/20/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5560041C (MN81781), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 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 substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/2022

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R32 and R39) observed to have medications left at their dining tables were assessed and approved to be able to safely self-administer medications. Findings include: R32's quarterly Minimum Data Set (MDS) dated 9/6/22, indicated R32 had mild cognitive deficits and required extensive assistance of one staff for dressing, personal hygiene, and toileting and was independent for eating. R32 had diagnoses that included dementia, renal failure, gastro-esophageal reflux (GERD), and hypothyroidism (low functioning thyroid). R32's care plan dated 6/23/22, indicated R32 had impaired cognitive function related to short term memory loss. Interventions included monitoring and documenting any changes in cognition, decision making ability, memory, recall and general awareness. R32 also had altered cardiovascular status and high blood pressure. R32 also had an activities of daily living (ADL) deficit related to dementia and episodes of confusion. R32's care plan lacked indication R32	F 554	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. Assessment for self-administration was completed to ensure R32 and R39 are safe to self-administer medication. 2. All residents at the center who self-administer medication have the potential to be affected. Corrective action was taken and assessments have been reviewed and are appropriate. 3. To ensure systemic changes are made all licensed nurses and TMAs will be educated on the medication	12/16/22

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F 554	Continued From page 2 had been assessed and approved to self-administer medications. R32's physician orders dated 10/20/22, indicated R32's morning medications included: -Amlodipine 10 milligrams (mg) for high blood pressure -Tylenol extra strength 1000 mg for pain -Pantoprazole 20 mg for GERD -Lisinopril 20 mg for high blood pressure -Oxybutynin 2.5 mg for bladder hyperactivity -Levothyroxine 50 micrograms (mcg) for hypothyroidism -Furosemide 20 mg (a diuretic for water retention) R32's physician orders lacked an order for self-administration for any medications. R32's medical record lacked a Self-Administration of Medication assessment. During an observation on 10/18/22, at 8:52 a.m. a medication cup with multiple medications was observed on the dining table in front of R32. It was not known how long the medications had been there and no nursing staff was in the dining room. After an unidentified tablemate got a cup of water from the dining kitchenette for R32, R32 began taking her medications with no nursing staff present in the dining room to ensure they were taken safely and completely. During an interview on 10/19/22, at 8:01 a.m. R32 stated the nurse would always leave her morning medications at her table for R32 to take when she wanted. During an interview on 10/20/22, at 3:05 p.m. registered nurse (RN)-B stated some residents	F 554	administration policy and procedure for administering self-medications to those who are Care Planned for self-administering medication on 11/28/22. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for (R32 and R39) and (2) other random residents regarding self-administer medication administration. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure medication is being properly given and self-administer medication assessments are completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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F 554	Continued From page 3 liked to take their medications themselves and the staff would walk around and make sure they were taking them. RN-B stated the residents should probably have a self-administration of medication form filled out if she was going to leave the medications on the resident's table to take later and verified R32 did not have one completed. RN-B stated they have had residents pocket their medications in the past. RN-B further stated she liked to watch the residents take their medications but some "just take a while". During an interview on 10/20/22, at 2:17 p.m. the director of nursing (DON) stated unless a resident had an evaluation and physician order to self-administer medications, staff should observe residents take their medications and not leave them on a table unattended. The facility Medication: Administration Including Scheduling and Medication Aides policy dated 8/24/22, indicated a resident had the right to self-administer medication if the interdisciplinary team (IDT) determined it was safe for the resident and it was documented in the resident's care plan, and a physician's order was required. The policy also indicated not to leave medications at a table unless there was a specific physician order to do so and the resident had been evaluated for self-administration. If the resident had not been evaluated for safe self-administration of medication and there was not a physician order to do so, the staff must stay with the resident until the medication is taken and they have observed the resident swallow. The facility Resident Self-Administration of Medication policy dated 10/15/21, indicated staff must complete a Self-Administration of	F 554		

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F 554	Continued From page 4 Medications UDA to determine if the resident could safely administer medications. The IDT would determine if the resident required education or accommodation in-order to self-administer medications, where the medication would be stored, where the medication would be administered, and who would document the administration. The IDT would document their determination of self-administration on the UDA and a physician's order must be obtained. The resident's care plan must indicate the resident is safe to self-administer medication and their ability to do so would be re-evaluated quarterly or with any significant change assessment.	F 554		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services	F 582		12/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 582	Continued From page 5 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) in a timely manner to 2 of 3 residents (R15 and R101), whose Medicare A coverage had ended.	F 582	1. Proper notice was issued for residents R15 and R101. 2. All residents at the center with Medicare part A coverage have the potential to be affected. Corrective action was taken and additional training/education was provided to all	

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F 582	Continued From page 6 Findings include: Review of R15's medical record identified he received skilled Medicare covered services form 8/12/22 through 10/5/22. The form identified services had been discontinued by the facility prior to benefit days being exhausted and a Notice of Medicare non-coverage (NOMNC) had been issued. The record did not contain a date of when the notice had been issued and failed to identify the notice had been provided within the two calendar days prior to discharge from Medicare covered services. Review of R101's medical record identified she received skilled Medicare covered services from 5/20/22 through 6/30/22. The form identified services had been discontinued by the facility prior to benefit days being exhausted and a NOMNC had been issued. The record did not contain a date of when the notice had been issued and failed to identify the notice had been provided within the two calendar days prior to discharge from Medicare covered services. Interview on 10/19/22 at 11:01 a.m., with registered nurse (RN)-C identified she was responsible for providing the Medicare denial letters to residents and/or responsible parties and the requirement was to issue them at least two days prior to the last covered day of service. RN -C reported R15's last covered day of service was 10/5/22, and the documents were dated and signed 10/4/22, which did not provide the required 2-day notice. She identified the notice should have been dated and signed on 10/3/22, or documentation in the record of verbal notification provided to the resident and/or responsible party prior to the date of 10/4/22. RN-C reported	F 582	MDS nurses and designees. 3. To ensure systemic changes are made all MDS Nurses or designee will be educated on the Notice of Medicare Non-Coverage expectation for timely Skilled Nursing Facility Advanced Beneficiary Notice on 11/28/22. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee on two random residents for timely Skilled Nursing Facility Advanced Beneficiary Notice. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure notice is being properly given. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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 582	Continued From page 7 R101's last covered day of service was 6/30/22, and the Medicare denial letter was also signed and dated on 6/30/22. She reported the denial letter should have been provided by 6/28/22, and if not able to be dated and signed on/or before that date, there should have been documentation of verbal issuance in the medical record and there was nothing to indicate it had taken place. Interview on 10/20/22 at 9:49 a.m., with the administrator and director of nursing (DON) reported they were aware of the requirement to give 2-day notice for discontinuation of Medicare services, and there was no documentation for 2 of the 3 records reviewed that appropriate notification had been provided prior to the discontinuation of Medicare Skilled services. Review of the 10/1/19 Notice of Medicare Non-Coverage identified any beneficiary who received Medicare Part A or B services must be notified that their coverage was ending. Medicare providers are responsible for delivery of the notice and requirement for the notice to be signed and dated to confirm receipt of the notice and the option to dispute the decision that services would no longer be covered under Medicare. The notice was to be delivered to the beneficiary at least two calendar days before Medicare covered services ended or the second to last day of service if the service was not provided daily.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		12/16/22

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	245560	A. BUILDING _____ B. WING _____	C 10/20/2022

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F 584	Continued From page 8 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the resident environment	F 584	1. All affected vents were cleaned on 10/24/22.	

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F 584	Continued From page 9 including 15 of 17 resident's bathroom vents (R13, R45, R48, R42, R14, R34, R19, R32, R41, R17, R40, R24 and R26, R8 and R35, R38, and R7) were maintained in a clean manner. Findings include: During an environmental tour on 10/17/22 the following observations were made of thick, gray covering of dust, dirt, and debris was discovered at: (1) 7:09 p.m., in the bathroom vent in R24 and R26's room. (2) 7:10 p.m., in the bathroom vent in R8 and R35's room and also had loose debris hanging from the vent slits. (3) 7:12 p.m., the bathroom vent in R38's room. (4) 7:13 p.m., the bathroom vent in R7's room. In addition, a vent located next to the toilet on the wall had multiple areas of paint chipped off with rust-like deterioration of the metal present. During facility tour on 10/18/22, at 2:01 p.m. the following residents' room vents were found to be covered in heavy thick, gray covering of dust, dirt and debris: R13, R45, R48, R42, R14, R34, R19, R32, R41, R17, and R40. During a tour with the administrator and maintenance (M-A) on 10/20/22, at 10:20 a.m., the administrator and maintenance director confirmed the above-mentioned vents were in need of cleaning. They would make sure all residents in the facility would have their vents cleaned. The M-A also verified there was paint chipped off and rust was present on the vent in R7's room. A policy and procedure on cleaning of vents was	F 584	2. All residents at the center have the potential to be affected by the deficiency practice. Corrective action was taken, and vents were cleaned along with a cleaning schedule created. 3. To ensure systemic changes are made all maintenance and housekeeping staff will be educated on standard of light cleaning policy and procedure for maintaining and cleaning the vents according to the manufactures direction on 11/28/2022 by the DNS or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee 10 random residents regarding if their vent is properly cleaned. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure vent cleaning is being properly completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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F 584	Continued From page 10 requested but none was received.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 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	F 656		12/16/22

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F 656	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive care plan for 1 of 1 residents (R15) on a Continuous Positive Airway Pressure (CPAP) machine (used during sleep hours to assist with breathing to prevent apnea, (periods of not breathing)). Findings include: R15's admission Minimum Data Set (MDS) dated 8/9/22, indicated R15 had intact cognition with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease), pneumonia, COVID-19, occlusion and stenosis (hardening) of the carotid artery, insomnia, obesity, atrial fibrillation (irregular heartbeat causing an increased risk to form blood clots) and chronic rhinitis (inflammation of the nasal passages). R15 required extensive assistance of one staff for dressing, toileting, and personal hygiene. R15's care area assessment (CAA) dated 7/26/22, lacked any indication that R15 had respiratory concerns and required respiratory equipment including oxygen or a CPAP used during sleep hours to assist with breathing machine at night. R15's care plan dated 8/12/22, indicated R15 had	F 656	1. Based on provider order and R15 s request the CPAP has been discontinued. 2. All residents with a CPAP machine have the potential to be affected. Corrective action was taken and licensed nurses were educated. 3. To ensure systemic changes are made all licensed nurses will be educated on comprehensive care plan and care conferences policy and procedure for proper documentation regarding a CPAP machines within the care plan on 11/28/22 by the DNS or designee. 4. No resident has a CPAP currently for Observation. Any new resident with a CPAP, weekly random audits will be initiated for 2 months to ensure accurate assessment and care planning is completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022	

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F 656	Continued From page 12 limited physical mobility related to pneumonia as evidenced by weakness and shortness of breath with exertion. R15 was also at risk for sleep disturbance related to insomnia. Interventions included adjusting the room temperature and ventilation to promote sleep, use of amber lighting and pen lights, and decreasing sounds that disrupt sleep. R15's care plan lacked any indication or interventions for the use of R15's CPAP machine. The care plan also lacked instructions for the proper operation of R15's CPAP machine including the use of distilled water. During an interview on 10/20/22 at 12:39 p.m., registered nurse (RN)-C stated she did not know what care areas would trigger on a CAA and she had not reviewed R15's care plan recently. RN-C also stated R15's use of a CPAP with appropriate interventions should have been listed on his care plan to ensure staff were aware of it's proper use. During an interview on 10/20/22 at 2:06 p.m., the director of nursing (DON) stated she was unaware R15's care plan lacked an intervention the proper use of R15's CPAP and should have. The DON also stated the management team, including herself and RN- Sarah, would review and update resident care plans. A facility policy for care plans was not received.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		12/16/22

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F 684	Continued From page 13 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary medical supplies to 1 of 1 resident (R15) who had a Continuous Positive Airway Pressure machine (CPAP- used during sleep hours to assist with breathing) that required distilled water. In addition, the facility failed to ensure eye drops were administered according to professional standards of practice and manufacturer's guidelines for 1 of 1 (R14) residents observed for eye drop administration. Findings include: R15's admission Minimum Data Set (MDS) dated 8/9/22, indicated R15 had intact cognition with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease), pneumonia, COVID-19, occlusion and stenosis (hardening) of the carotid artery, insomnia, obesity, atrial fibrillation (irregular heartbeat causing an increased risk of blood clots) and chronic rhinitis (inflammation of the nasal passages). R15 required extensive assistance of one staff for dressing, toileting, and personal hygiene. R15's care area assessment (CAA) dated 7/26/22, lacked any indication that R15 had respiratory concerns or required respiratory equipment including oxygen or a CPAP machine at night.	F 684	1. Based on provider order and R15s request the CPAP has been discontinued. 2. All residents at the center using a CPAP have the potential to be affected. Corrective action was taken and nursing staff were educated. 3. To ensure systemic changes are made all licensed nurses, TMAs, CNAs will be educated on the correct procedure for utilizing proper medical supplies for CPAP machines according to the manufactures direction through a review of the non-invasive respiratory policy and procedure on 11/28/22 by the DNS or designee. 4. No resident has a CPAP currently for Observation. Any new resident with a CPAP, weekly random audits will be initiated for 2 months to ensure correct procedure for utilizing proper medical supplies for CPAP machines is used. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022. 1. A competency will be completed to ensure R14 eye drops are administered in accordance to medication administration policy.	

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F 684	Continued From page 14 R15's care plan dated 8/12/22, indicated R15 had limited physical mobility related to pneumonia as evidenced by weakness and shortness of breath with exertion. R15 was also at risk for sleep disturbance related to insomnia. Interventions included adjusting the room temperature and ventilation to promote sleep, use of amber lighting and pen lights, and decreasing sounds that disrupt sleep. R15's care plan lacked any indication or interventions for the use of R15's CPAP machine. The care plan also lacked instructions for the proper operation of R15's CPAP machine including the use of distilled water in the machine. R15's physician orders dated 9/7/22, indicated R15 was on oxygen 4 liters per minute at bedtime and as needed for COPD. The orders lacked indication that R15 was on CPAP. R15's Treatment Record (TAR) dated August, September 2022 indicated R15 used CPAP every night from 8/15/22, to 9/30/22. R15's TAR dated October 2022 indicated staff documented R15 use of his CPAP as follows: -10/1/22, to 10/4/22, "applied" -10/5/22, "see progress notes" (below) -10/6/22, "applied" -10/7/22, to 10/9/22, "see progress notes" (below) -10/10/22, to 10/19/22, "applied" R15's progress notes indicated the following: -10/5/22, "No distilled water available, will contact [family]" in AM. -10/7/22, "No distilled water, [family] contacted". -10/8/22, "No distilled water received from (family)". -10/9/22, "Nasal cannula O2 on instead of CPAP	F 684	2. All residents in the center receiving eye drops have the potential to be affected. Corrective action was taken and all licensed nurses and TMA s were educated. 3. To ensure systemic changes are made all licensed nurses and TMAs will be educated on the proper procedure for storing and administering eye drops according to the manufactures direction through a review of the Medication administration policy on 11/28/22 by the DNS or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for (R14) and (2) other random residents regarding eye drop administration. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure eye drops are being properly given. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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F 684	Continued From page 15 per no distilled H20". -10/10/22 to 10/17/22, staff failed to document any progress notes regarding R15's CPAP use. -10/18/22, "CPAP on at bedtime". During an observation and interview on 10/17/22, at 1:25 p.m. an unlabeled, clear jug with an orange lid was observed on a bookshelf in R15's room. R15 stated the facility did not have distilled water, therefore; family member (FM)-A had been bringing it in for the staff to use in R15's CPAP machine since his admission to the facility a few months ago. During an interview on 10/19/22, at 9:44 a.m. FM-A stated R15's personal CPAP machine was brought to the facility from R15's home in August 2022. FM-A stated R15 was initially expected to be a short-term resident and therefore the family thought it was their responsibility to provide the water. FM-A stated R15's girlfriend also used a CPAP machine and would get water from the store, then pour half of the water into the recycled jug for R15 to use in his machine at the facility. FM-A further stated he did not recall the facility notifying him that R15 had ever run out of water. During an interview on 10/18/22, at 3:06 p.m. registered nurse (RN)-B verified, although R15's CPAP required distilled water the water being used was in a recycled jug, that was unlabeled, and RN-B assumed it to be distilled. RN-B stated FM-A had been "taking care" of R15's CPAP machine water since R15 was admitted to the facility and because R15 had intact cognition, R15 knew what was going on and therefore, RN-B was not concerned about the unlabeled jug of water being used.	F 684		

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F 684	Continued From page 16 Review of the Sysco Invoice dated 10/7/22, indicated 6 1-gallon jugs of Ice Mountain distilled water were ordered by the facility. There was no indication the facility had provided the distilled water upon admission. During an interview on 10/19/22, at 1:04 p.m. RN-D stated she was an agency nurse and did not know who ordered the supplies for the facility. RN-D stated when R15 was admitted to the facility in June 2022, she asked staff where to find the distilled water for R15's CPAP but was told the family needed to supply it, therefore: RN-D had been using the water supplied by the family in the unlabeled jug since R15 admitted to the facility. RN-D assumed the water to be distilled. During an interview on 10/18/22, at 3:12 p.m. the food and nutrition director (DD) stated she ordered distilled water for residents when nursing staff reported it was needed, and that residents, or their family should not have to provide it. The DD stated although she knew R15 had a CPAP machine she did not order distilled water for him until an unknown nurse reported R15 was out of water. The DM then ordered 6 1-gallon jugs of distilled water on 10/7/22, which were delivered the following day, however; the DM did not know where the distilled water was being stored or if nursing staff was aware it was available. The DD further stated she was unaware the family had been supplying it. The DD was not concerned about the unlabeled jug of water being used for R15's CPAP, stating the family was "very involved" and knew what they were doing. During an interview on 10/19/22, at 10:33 a.m. the DD stated she spoke to R15's girlfriend the previous day and was told the water for R15's	F 684		

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F 684	Continued From page 17 CPAP was dispensed from a machine at the grocery store and could not verify it was distilled. The DM stated there would be a concern for increased bacteria leading to infection if distilled water was not being used in R15's CPAP machine. R14's quarterly minimum data set dated 8/9/22, indicated R14 had no cognitive deficits, required extensive assistance of one staff for personal hygiene and was independent for eating. R14 had diagnoses that included weakness, arthritis, and carpal tunnel (narrowing of the structures of the wrist causing pain and decreased movement). R14's physician orders dated 6/15/20, indicated R14 received Carboxymethylcellulose-Glycerin (Optive) ophthalmic solution for dry eyes two times a day. During an observation on 10/19/22, at 7:52 a.m. R14 was in the dining room eating breakfast when registered nurse (RN)-B applied one eye drop in each of R14's eyes. R14 was unable to tilt her head back and RN-B placed the eye dropper into the inside, bottom corner of each eye, allowing the eye dropper to touch the tissue of the eyes. During an interview on 10/20/22, at 3:05 p.m. RN-B stated she preferred to administer eye drops to residents in their room while they were lying in bed if possible, however; the residents were often already in the dining room so RN-B would often administer medications including eye drops during meals. RN-B stated R14's eye drops should have been administered by placing one drop in the bottom eye lid mucosa without touching the eye tissue to ensure it covers the eye surface evenly and to avoid contamination of	F 684		

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F 684	Continued From page 18 the eye dropper. During an interview on 10/20/22, at 10:46 a.m. RN-C stated eye droppers should not touch a resident's eye or the surrounding tissue during administration to avoid contaminating the eye dropper or infecting the eye. During an interview on 10/20/22, at 2:06 p.m. the director of nursing (DON) stated staff should follow the manufacturer's recommendations for R15's CPAP machine and use distilled water. The DON was unaware R15's family had been supplying the water and was concerned for potential bacterial growth if distilled water was not being used. The DON further stated the facility should have been supplying R15's distilled water. The DON also stated eye droppers should not touch the eye or surrounding tissue to avoid contamination of the eye dropper and possible infection. The facility Non-invasive Respiratory Support policy dated 5/3/22, indicated to provide the most effective treatment for reducing CO2 in hypercapnic (chronically high levels of carbon dioxide) COPD residents. The policy defined CPAP as continuous positive airway pressure that is titrated to blow air at a constant pressure to keep air passages open. CPAP is the most common treatment for sleep apnea (brief periods during sleep when a resident will stop breathing). The policy lacked instructions on the use of humidified oxygen or distilled water when using the CPAP machine. The facility Oxygen Administration, Safety, Mask Types policy dated 6/29/22, indicated equipment required for administering various levels of	F 684		

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EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

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F 684	Continued From page 19 oxygen concentration and/or humidity in a safe manner, included: humidifier with distilled water. The policy further instructed to fill the humidifier bottle, if ordered, with distilled water and keep filled adequately at all times. The facility Medication: Administration Including Scheduling and Medication Aides policy dated 8/24/22, indicated medication was to be administered correctly and effectively.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure safe, and appropriate water temperatures were maintained below 120 degrees Fahrenheit to prevent potential burns to residents residing in 15 of 36 rooms observed in the facility. Findings include: During a tour of the facility on 10/17/2,2 at 7:10 p.m., the water temperatures were obtained in degree of Fahrenheit (F). The following rooms were as follows: (1) R24's room water temperature was 124.0 F (2) R8 and R35's room water temperature was	F 689	1. Additional outside company was called to inspect the hot water tank to ensure it has proper temperatures. 2. All residents in the center have the potential to be affected. Corrective action was taken and outside company was called to ensure proper hot water temperatures. 3. To ensure systemic changes are made all maintenance staff will be educated on the correct procedure for monitoring hot water temperatures according to the manufactures direction through a review of the GSS policy titled Water Temperatures on 11/28/22 by the DNS or	12/16/22

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F 689	Continued From page 20 123.8 F (3) R20 and R36's room water temperature was 124.2 F During tour of the facility on 10/18/22, at 2:00 p.m., the water temperatures were obtained in degree of Fahrenheit (F) in the following rooms: (1) R13's room water temperature was 129.2 F (2) R45's room water temperature was 127.9 F (3) R48's room water temperature was 130.6 F (4) R42's room water temperature was 125.0 F (5) R14's room water temperature was 127.5 F (6) R41's room water temperature was 123.6 F Review of the 3/20/12, Consumer Product Safety Commission at https://www.cpsc.gov/s3fs-public/5098-Tap-Water-Scalds.pdf identified water temperatures should be maintained at less than 120 degrees to prevent burns. During interview and observation on 10/19/22, at 10:05 a.m. with administrator and maintenance (M)-A and M-B, rooms belonging to R24, R8 and R35, R2, R20 and R7 identified water temperatures at that time ranged from 98 to 104 degrees F. The administrator indicated the facility recently purchased a new water heater and was currently having difficulty maintaining safe and/or comfortable parameters of temperature. The administrator indicated maintenance had been monitoring temperatures and working with the company to resolve the issue. M-A indicated he had turned down the water heater on 10/18/22 due to temperatures being "too high". There was no indication the administrator had a plan in place or had educated staff on what to do when water reached high temperatures 120 degrees or higher to prevent potential burns for all 48 residents.	F 689	designee. If water temperatures are not within appropriate range all nursing and maintenance staff will be notified immediately. Maintenance will adjust water heater and a recheck of the temperatures will be completed until the water temperatures are within range. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for 10 random residents regarding hot water temperature. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure hot water temperatures are within range. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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F 689	Continued From page 21 During observation and recheck of water temperatures on 10/20/22, at 8:20 a.m. the following room water temperatures were as follows: (1) R48's room water temperature was 132.0 F (2) R28's room water temperature was 130.0 F (4) R41's room water temperature was 127.2 F (5) R1's room water temperature was 130.0 F (6) R8 and R35's room water temperature was 132.2 F (7) R2's room water temperature was 128.0 F During record review on 10/20/22, at 8:42 a.m., a copy of the facility monitoring included on: 1) 9/21/22 at 10:00 a.m., rooms belonging to R6 and R16, and R45 had water temperature to be 120 F. 2) 10/5/22 at 11:00 p.m. rooms belonging to R28 and R14 had water temperatures noted to be 120 F. 3) 10/12/22 at 2:00 p.m. rooms belonging to R27 and R22, and R43 had water temperatures note to be 120 F. Each time staff noted the high temperature and adjusted the water heater. There was no indication nursing staff were alerted to the potential for increased risk of resident burns. During interview on 10/20/22, at 8:32 a.m., nursing assistant (NA)-A indicated water was either "too hot or too cold"over the past few weeks. NA-A indicated to her knowledge there have been no injuries related to the water temperatures and was not educated on what to do if water temperatures were too high and had the potential to burn residents. During interview on 10/20/22, at 8:34 a.m., NA-B	F 689		

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F 689	Continued From page 22 indicated the water temperatures have fluctuated over the past month being either "too hot or too cold". To her knowledge, no resident had injuries related to hot water temperatures. Staff "just know to check it" before residents would potentially wash their hands or before putting residents into the bathtub. During interview and document review on 10/20/22, at 9:51 a.m., administrator and M-A indicated they were performing routine monitoring of temperatures daily, but it is on a separate sheet than the normal weekly monitoring. M-A indicated he did check the water temperature at 7:00 a.m. that morning which was too high, so the water heater was turned down. M-A indicated he did not notify nursing staff of the hot water issue. The administrator had an invoice dated 9/1/22 for the new water heater, but the administrator stated it was not installed until "after that date" and was unaware when it was reportedly to have been installed. Review of water temperature monitoring provided by maintenance included dates 9/1/22 through 10/19/22 completed daily with water temperatures ranging from 110 to 115 degrees F. Three temperatures on 9/21/22, 10/5/22 and 10/12/22 were noted to be at 120 degrees F. On 9/21/22 and 10/5/22, the water temperatures was note to be adjusted. The temperature monitoring sheet did not include time or location the water temperature was checked. During subsequent interview on 10/20/22, at 11:30 a.m., the administrator confirmed more frequent water temperature monitoring and also communication with staff was imperative to ensure the safety of all residents. A policy and procedure titled "Water	F 689		

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F 689	Continued From page 23 Temperatures" dated 2/2/2022 identified residents typically had thinner skin so the risk of burns even with brief exposure to unsafe high water temperatures was "substantial". Additionally residents may have medical conditions that limited their ability to communicate or even recognize that the water they are exposed to had the potential to burn them. The exposure time required to produce a third degree burn was 120 degrees F for five minutes. At 127 degrees, it took 1 minute to cause burns. Monitoring water temperaures was to be done on a weekly basis or more frequently if conditions were identified to ensure a comfortable and safe environment for residents. Monitoring was to include rooms closest to and furthest away from the water source at least weekly per wing or water loop. The recommended temperature range for hot water at the point of use, was between 100 and 115 degrees F. Documenting water temperatures should include the following information: - Name or initials of the person taking the temperature - Specific location of the monitoring (for example: room number) - Date and time of the monitoring - Temperature of the water.	F 689		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 698		12/16/22

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F 698	Continued From page 24 Based on interview, observation and document review, the facility failed to monitor 1 of 1 resident (R38) for potential complications post-dialysis and have a method of communication with the dialysis facility to ensure consistent continuity of care. Finding include: R38's face sheet 10/29/22, included a diagnosis of chronic kidney disease and diabetes. R38's quarterly Minimum Data Set (MDS) dated 9/13/22, included R38 was cognitively intact, independent with activities of daily living and on dialysis. R38's plan of care dated 5/2/22, included R38 needed hemodialysis related to end stage kidney disease with a goal to have no signs and symptoms of complications related to dialysis. Staff were to monitor and document for peripheral edema, hypovolemia (increased pulse, increased respirations, decreased systolic blood pressure, sweating, and anxiousness) or hypervolemia (increased blood pressure, lung crackles, headache, and/or shortness of breath). R38 attended dialysis Mondays, Wednesday and Fridays with Thursdays at the dialysis health care provider discretion. If bleeding was noted to R38's fistula site, staff were to apply immediate pressure and call for nurse. During observation and interview on 10/17/22, at 5:32 p.m., R38 returned to the facility from dialysis and wheeled himself straight to the dining room. An unidentified staff brought him his medications in a cup. No vital signs were completed and the fistula was not visualized or assessed after returning from dialysis..	F 698	1. A post dialysis assessment was completed to ensure R38 is monitored. 2. All residents in the facility receiving dialysis have the potential to be affected. Corrective action was taken and all licensed nurses were educated. 3. To ensure systemic changes are in place, all licensed nurses will be educated on the correct GSS policy and procedure titled dialysis for monitoring post-dialysis care and procedure for proper communication to the dialysis facility on 11/28/22 by the DNS or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for (R38) regarding post-dialysis monitoring and communication. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure post-dialysis monitoring is properly done and proper communication is being given. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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F 698	Continued From page 25 During observation and interview on 10/17/22, at 6:18 p.m., R38 indicated he has been receiving dialysis for 3 years ever since he moved into this facility. R38 showed his port, which was located in the left upper arm and had two 2x2' gauze pads held on by tape on his fistula which were dry and intact. R38 indicated the staff do not monitor or assess the dialysis site. He usually just removes the dressing himself. R38 indicated he generally takes it off the following day or dialysis staff will take it off other following day when he goes for his next treatment. During an observation and interview 10/18/22, at 3:25 p.m., R38 indicated he removed his bandage this morning around 7:00 a.m., when the nursing assistant (NA) took him to get his bath. R38 indicated nursing staff do not look at his dialysis port or complete any assessment when he returns. During interview on 10/19/22, 7:20 a.m., registered nurse (RN)-A indicated they fax 2 forms which includes a pre-dialysis assessment to the dialysis unit on the morning R38 goes for his dialysis treatment. RN-A indicated when R38 returns he will check in with the nursing staff. RN-A indicated R38 was to notify staff if he is having any bleeding at the site or if there was any trouble after dialysis. RN-A added R38 "likes to manage the fistula site himself". There was no indication the facility had a process to ensure an assessment was performed, or communication was maintained between facility staff and dialysis staff vs. rely on R38 to assess himself. During interview on 10/19/22, at 9:14 a.m., RN-A indicated they receive post-dialysis reports via fax	F 698		

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F 698	Continued From page 26 from the dialysis center but was unsure when they actually arrived or were noted. RN-A added if there are any new orders, she felt they would come from R38's medical doctor and not the dialysis facility. During interview on 10/19/22, at 10:13 a.m., dietary personnel (DP)-A indicated dialysis used to send a renal report card for R38 that included most recent lab work, weights before and after dialysis and if they ran extra fluid offload. DP-A reported the registered dietician (RD) had contacted the dialysis facility requesting information but had not received a return call, after multiple attempts. DP-A indicated there was not adequate communication being received from the dialysis company. During interview 10/19/22, at 12:33 p.m., patient care technician (PCT)-A from dialysis company indicated she worked with R38 frequently when he received dialysis. R38 frequently arrives with extra fluid onboard and they will do an extra run for dialysis to just pull extra fluid off after his 4 hour dialysis run. PCT-A indicated they used to send his post-dialysis sheet with R38 to give to the facility, but they frequently found it remained in his bag when he returned for his next dialysis visit. PCT-A indicated they now fax the information to the facility since they weren't removing it from his bag. The post-dialysis report included pertinent lab information, pre and post weights, vitals signs and if an extra run was completed due to excess fluid. PCT-A indicated R38 does come periodically with the previous dressing still on his fistula site. Dialysis nursing expected it be removed the evening post-dialysis by the facility after assessing and monitoring his site until it can safely be removed. Dialysis	F 698		

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F 698	Continued From page 27 patient's with venous catheters had different expectations. During interview on 10/19/22, at 9:56 a.m., health information management (HIM)-A indicated the last time they received the post-dialysis report from facility staff was on 8/31/22. They scan any information sent to them into the resident's electronic medical record. During interview on 10/19/22, at at 10:41 a.m., the director of nursing (DON) was unsure if staff received a post -dialysis report and was unsure if an assessment was completed by the nursing staff when R38 would return from dialysis treatment. The DON indicated she will check further into this. Further interview on 10/19/22, at 12:15 p.m., with the DON indicated the dialysis company has not been sharing information post-dialysis. The DON confirmed they have no way to know how R38 did through his dialysis treatment or post-treatment and do not know how much fluid was removed or what his current medical information was. The DON indicated staff are completing a pre-dialysis assessment but confirmed the nursing was not completing a post-dialysis assessment or monitoring upon return from dialysis. She further clarified there wasn't a good method of communication between the facility and dialysis. A policy and procedure dated 9/17/21 titled "Dialysis Services" included: -Locations caring for residents receiving dialysis services must have an agreement in place with the provider of the service. -The clinical monitoring titled Dialysis UDA is available in electronic medical record for use in monitoring the resident receiving dialysis.	F 698		

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F 698	Continued From page 28 Review of the self renewing dialysis contract dated 1/21/10 between the facility and Total Renal Care/Pipestone Dialysis included: -Each party agreed to timely furnish the other party, in writing, any and all dialysis-related information pertinent to a resident's skilled nursing facility plan of care, including but not limited to, the areas listed below. Each party also agrees to make itself reasonably available to the other party's staff who may have questions regarding the care of resident's receiving dialysis treatment: -In addition to developing its own plan of care with respect to each resident/client receiving dialysis treatment, provider agrees to cooperate with LTC staff in modifying and maintaining as current, each such resident's skilled nursing facility plan of care. Those areas the LTC plan of care in which Provider shall furnish direction to LTC facility shall include but is not limited to: Procedures for handing medical and non-medical emergencies, including complications, equipment failure and a provider contact in case of emergencies; follow-up care, observation and monitoring; medications; nutritional needs and fluid restrictions and resident education.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 726		12/16/22

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F 726	Continued From page 29 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to esure staff were competent and trained to monitor 1 of 1 resident (R38) for potential complications post-dialysis and have a method of communication with the dialysis facility to ensure consistent continuity of care. Finding include: R38's face sheet 10/29/22, included a diagnosis of chronic kidney disease and diabetes. R38's quarterly Minimum Data Set (MDS) dated 9/13/22, included R38 was cognitively intact, independent with activities of daily living and on	F 726	1. Therefore, education will be completed by all licensed nurses to ensure R38 is monitored post-dialysis. 2. All residents in the center receiving dialysis have the potential to be affected. Corrective action was taken and all licensed nurses were educated. 3. To ensure systemic changes are made all licensed nurses will be educated on the correct policy and procedure titled Dialysis for monitoring post-dialysis care on 11/28/22 by the DNS or designee. 4. Audits will be conducted by the Quality Assurance Coordinator or designee for two random staff regarding competency	

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F 726	Continued From page 30 dialysis. R38's plan of care dated 5/2/22, included R38 needed hemodialysis related to end stage kidney disease with a goal to have no signs and symptoms of complications related to dialysis. Staff were to monitor and document for peripheral edema, hypovolemia (increased pulse, increased respirations, decreased systolic blood pressure, sweating, and anxiousness) or hypervolemia (increased blood pressure, lung crackles, headache, and/or shortness of breath). R38 attended dialysis Mondays, Wednesday and Fridays with Thursdays at the dialysis health care provider discretion. If bleeding was noted to R38's fistula site, staff were to apply immediate pressure and call for nurse. During observation and interview on 10/17/22, at 5:32 p.m., R38 returned to the facility from dialysis and wheeled himself straight to the dining room. An unidentified staff brought him his medications in a cup. No vital signs were completed and the fistula was not visualized or assessed after returning from dialysis.. During observation and interview on 10/17/22, at 6:18 p.m., R38 indicated he has been receiving dialysis for 3 years ever since he moved into this facility. R38 showed his port, which was located in the left upper arm and had two 2x2' gauze pads held on by tape on his fistula which were dry and intact. R38 indicated the staff do not monitor or assess the dialysis site. He usually just removes the dressing himself. R38 indicated he generally takes it off the following day or dialysis staff will take it off other following day when he goes for his next treatment.	F 726	completion regarding post-dialysis monitoring and communication. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure staff education is completed on post-dialysis monitoring and education. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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F 726	Continued From page 31 During an observation and interview 10/18/22, at 3:25 p.m., R38 indicated he removed his bandage this morning around 7:00 a.m., when the nursing assistant (NA) took him to get his bath. R38 indicated nursing staff do not look at his dialysis port or complete any assessment when he returns. During interview on 10/19/22, 7:20 a.m., registered nurse (RN)-A indicated they fax 2 forms which includes a pre-dialysis assessment to the dialysis unit on the morning R38 goes for his dialysis treatment. RN-A indicated when R38 returns he will check in with the nursing staff. RN-A indicated R38 was to notify staff if he is having any bleeding at the site or if there was any trouble after dialysis. RN-A added R38 "likes to manage the fistula site himself". There was no indication the facility had a process to ensure an assessment was performed, or communication was maintained between facility staff and dialysis staff vs. rely on R38 to assess himself. During interview on 10/19/22, at 9:14 a.m., RN-A indicated they receive post-dialysis reports via fax from the dialysis center but was unsure when they actually arrived or were noted. RN-A added if there are any new orders, she felt they would come from R38's medical doctor and not the dialysis facility. During interview on 10/19/22, at 10:13 a.m., dietary personnel (DP)-A indicated dialysis used to send a renal report card for R38 that included most recent lab work, weights before and after dialysis and if they ran extra fluid offload. DP-A reported the registered dietician (RD) had contacted the dialysis facility requesting information but had not received a return call,	F 726		

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	245560	A. BUILDING _____ B. WING _____	C 10/20/2022

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F 726	Continued From page 32 after multiple attempts. DP-A indicated there was not adequate communication being received from the dialysis company. During interview 10/19/22, at 12:33 p.m., patient care technician (PCT)-A from dialysis company indicated she worked with R38 frequently when he received dialysis. R38 frequently arrives with extra fluid onboard and they will do an extra run for dialysis to just pull extra fluid off after his 4 hour dialysis run. PCT-A indicated they used to send his post-dialysis sheet with R38 to give to the facility, but they frequently found it remained in his bag when he returned for his next dialysis visit. PCT-A indicated they now fax the information to the facility since they weren't removing it from his bag. The post-dialysis report included pertinent lab information, pre and post weights, vitals signs and if an extra run was completed due to excess fluid. PCT-A indicated R38 does come periodically with the previous dressing still on his fistula site. Dialysis nursing expected it be removed the evening post-dialysis by the facility after assessing and monitoring his site until it can safely be removed. Dialysis patient's with venous catheters had different expectations. During interview on 10/19/22, at 9:56 a.m., health information management (HIM)-A indicated the last time they received the post-dialysis report from facility staff was on 8/31/22. They scan any information sent to them into the resident's electronic medical record. During interview on 10/19/22, at at 10:41 a.m., the director of nursing (DON) was unsure if staff received a post -dialysis report and was unsure if an assessment was completed by the nursing	F 726		

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F 726	Continued From page 33 staff when R38 would return from dialysis treatment. The DON indicated she will check further into this. Further interview on 10/19/22, at 12:15 p.m., with the DON indicated the dialysis company has not been sharing information post-dialysis. The DON confirmed they have no way to know how R38 did through his dialysis treatment or post-treatment and do not know how much fluid was removed or what his current medical information was. The DON indicated staff are completing a pre-dialysis assessment but confirmed the nursing was not completing a post-dialysis assessment or monitoring upon return from dialysis. She further clarified there wasn't a good method of communication between the facility and dialysis. A policy and procedure dated 9/17/21 titled "Dialysis Services" included: -Locations caring for residents receiving dialysis services must have an agreement in place with the provider of the service. -The clinical monitoring titled Dialysis UDA is available in electronic medical record for use in monitoring the resident receiving dialysis. Review of the self renewing dialysis contract dated 1/21/10 between the facility and Total Renal Care/Pipestone Dialysis included: -Each party agreed to timely furnish the other party, in writing, any and all dialysis-related information pertinent to a resident's skilled nursing facility plan of care, including but not limited to, the areas listed below. Each party also agrees to make itself reasonably available to the other party's staff who may have questions regarding the care of resident's receiving dialysis treatment: -In addition to developing its own plan of care with	F 726		

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F 726	Continued From page 34 respect to each resident/client receiving dialysis treatment, provider agrees to cooperate with LTC staff in modifying and maintaining as current, each such resident's skilled nursing facility plan of care. Those areas the LTC plan of care in which Provider shall furnish direction to LTC facility shall include but is not limited to: Procedures for handing medical and non-medical emergencies, including complications, equipment failure and a provider contact in case of emergencies; follow-up care, observation and monitoring; medications; nutritional needs and fluid restrictions and resident education.	F 726		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 812	1. Ice machine was cleaned.	12/16/22

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F 812	Continued From page 35 failed to maintain 1 or 1 ice machine to prevent potential contamination and to ensure food and drinks were served in a safe and sanitary manner during meal service in the dining room. This had the potential to effect 45 of 48 residents who ate breakfast in the dining room. ICE MACHINE During initial tour of the kitchen and interview on 10/17/22, at 12:55 p.m., an ice machine located in the kitchen storage room had white, lumpy deposits present along the lid of the ice container and along the right side of the machine. A yellow light was lite on the top of the machine. The dietary manager (DM) indicated it is lime scale build up and is aware the machine needs to be cleaned routinely. DM indicated maintenance has been notified of it needing to be cleaned. Requested maintenance documents on the ice machine and DM indicated there will not be any as they have experienced turn over in the maintenance department and it hasn't been cleaned in over a year. During interview on 10/19/22, at 12:58 p.m., service department of ice machine manufacturer (Scotsman) was contacted and spoke with SD-A who indicated maintenance is required at a minimum every 6 months but stated it also depends on water quality. If facility has hard water the machine should be cleaned every 3-4 months. SD-A indicated a yellow indicator light will turn on when cleaning is required. SD-A indicated if white scaling substance is on the outside of the machine, it is also on the inside of machine which can contaminate the ice being made. Review of manufacture's recommendations dated	F 812	2. All residents in the center have the potential to be affected. Corrective action was taken in which ice machine was cleaned along with a cleaning schedule was created. 3. To ensure systemic changes are made all maintenance staff, Dietary director, and Housekeeping director will be educated on the correct policy and procedure titled ice machines use and maintenance in maintaining and cleaning the ice machine according to the manufactures direction on 11/28/22 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee to ensure proper cleaning regarding ice machine maintenance. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure ice machine maintenance is being properly completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022. 1. All dietary staff were educated. 2. All residents in the center have the potential to be affected. Corrective action was taken and all dietary staff were educated. 3. To ensure systemic changes are made all dietary staff will be educated on the correct policy and procedure titled food-supply storage and GSS safe serve policy pertaining to cut bananas on 11/28/22 by the DNS or designee. 4. Observation audits will be conducted by	

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F 812	Continued From page 36 January 2015, included: All models have an indicator light that switches on to inform the user that the cleaning interval has been reached. It does not stop the machine from making ice. The clean button drains the reservoir and refills it. The cleaning process is designed to use straight nickel safe ice machine scale remover, added between draining and refilling. The cleaning time is designated by person running the clean cycle and is dependent on cleaning need. A second push of the clean button starts the flush out process. This process should last at least 20 minutes to fully flush out the scale remover and loose scale. After the scale remover has been drained out, the water distributor must be inspected for loose scale and cleaned if any. Removal of the sump cover, pump bracket and curtain is next to be sure those parts have been cleaned. Cycle power to the controller as a final step before restarting ice making. During observation and interview 10/20/22, at 9:48 a.m., the administrator and maintenance (M)-A observed the ice machine. The yellow light remained on the machine and this was confirmed by the administrator. M-A confirmed there was a white, lumpy deposit present on the ice machine and indicated he wasn't aware routine maintenance needed to be completed on this machine. M-A indicated he is unaware of the last maintenance completed on the ice machine. DRINKS R39's admission Minimum Data Set (MDS) dated 9/20/22, indicated R39 had mild cognitive deficits and required extensive assistance of one staff with all activities of daily living (ADLs) and supervision of one staff for eating.	F 812	the Quality Assurance Coordinator or designee to ensure bananas are covered properly. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure bananas are being properly covered. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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F 812	Continued From page 37 During an observation and interview on 10/19/22, at 7:29 a.m. The cook (CK) was observed placing uncovered juice, coffee, water and tea orders and bananas with the ends cut off, on all the tables in the dining room. Of the 45 residents who ate breakfast in the dining room, only three residents were seated at tables. The CK stated the drinks and bananas were always placed on the tables early and although they were not covered, there was no concern for contamination from other residents, staff or visitors walking by. The CK further stated there was no policy requiring the drinks to be covered during dining service. During an observation on 10/19/22, at 7:33 a.m. R39 was observed self-propelling her wheelchair around her assigned table, picking up another banana on the table and comparing the cut end to her banana. R39 decided she preferred her banana and left the second banana at the preset place for another resident who had not arrived yet for breakfast. No staff were present during the incident. During an interview on 10/20/22, at 10:46 a.m. registered nurse (RN)-C stated she had previously seen residents pick up uncovered, cut bananas on the dining tables to compare their ripeness and staff would gladly switch out the bananas if they were asked to. Although there was concern for contamination, RN-C also stated she had not discussed changing the process with anyone because the kitchen was in charge of meal service and delivery. During an interview on 10/19/22, at 11:05 a.m. the dietary director (DD) stated although drinks were served prior to residents entering the dining room,	F 812		

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F 812	Continued From page 38 they were only required to be covered during room tray delivery. The DD further stated there was no concern for contamination of the drinks from other residents or staff walking by or reaching over the drinks. The DD stated, however; a resident picking up uncovered, cut bananas that were intended for other residents would be a concern for contamination and the cut end of the bananas should have been covered. The facility policy on food service was requested but not received.	F 812		

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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 10/17/22 through 10/20/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 0300, 0565, 0830, 1015, 1565, 1695, and	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/22

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2 000	Continued From page 1 1710. The following complaints were found to be SUBSTANTIATED: H5560041C (MN81781), however NO licensing orders were issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000		

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2 000	Continued From page 2 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		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview, observation and document review, the facility failed ensure staff were competent and trained to monitor 1 of 1 resident (R38) for potential complications post-dialysis and have a method of communication with the dialysis facility to ensure consistent continuity of care. Finding include: R38's face sheet 10/29/22, included a diagnosis of chronic kidney disease and diabetes. R38's quarterly Minimum Data Set (MDS) dated 9/13/22, included R38 was cognitively intact, independent with activities of daily living and on	2 300	1. A post dialysis assessment was completed to ensure R38 is monitored. 2. All residents in the facility receiving dialysis have the potential to be affected. Corrective action was taken and all licensed nurses were educated. 3. To ensure systemic changes are in place, all licensed nurses will be educated on the correct GSS policy and procedure titled dialysis for monitoring post-dialysis care and procedure for proper communication to the dialysis facility on 11/28/22 by the DNS or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or	12/16/22

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2 300	Continued From page 3 dialysis. R38's plan of care dated 5/2/22, included R38 needed hemodialysis related to end stage kidney disease with a goal to have no signs and symptoms of complications related to dialysis. Staff were to monitor and document for peripheral edema, hypovolemia (increased pulse, increased respirations, decreased systolic blood pressure, sweating, and anxiousness) or hypervolemia (increased blood pressure, lung crackles, headache, and/or shortness of breath). R38 attended dialysis Mondays, Wednesday and Fridays with Thursdays at the dialysis health care provider discretion. If bleeding was noted to R38's fistula site, staff were to apply immediate pressure and call for nurse. During observation and interview on 10/17/22, at 5:32 p.m., R38 returned to the facility from dialysis and wheeled himself straight to the dining room. An unidentified staff brought him his medications in a cup. No vital signs were completed and the fistula was not visualized or assessed after returning from dialysis.. During observation and interview on 10/17/22, at 6:18 p.m., R38 indicated he has been receiving dialysis for 3 years ever since he moved into this facility. R38 showed his port, which was located in the left upper arm and had two 2x2' gauze pads held on by tape on his fistula which were dry and intact. R38 indicated the staff do not monitor or assess the dialysis site. He usually just removes the dressing himself. R38 indicated he generally takes it off the following day or dialysis staff will take it off other following day when he goes for his next treatment. During an observation and interview 10/18/22, at	2 300	designee for (R38) regarding post-dialysis monitoring and communication. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure post-dialysis monitoring is properly done and proper communication is being given. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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2 300	Continued From page 4 3:25 p.m., R38 indicated he removed his bandage this morning around 7:00 a.m., when the nursing assistant (NA) took him to get his bath. R38 indicated nursing staff do not look at his dialysis port or complete any assessment when he returns. During interview on 10/19/22, 7:20 a.m., registered nurse (RN)-A indicated they fax 2 forms which includes a pre-dialysis assessment to the dialysis unit on the morning R38 goes for his dialysis treatment. RN-A indicated when R38 returns he will check in with the nursing staff. RN-A indicated R38 was to notify staff if he is having any bleeding at the site or if there was any trouble after dialysis. RN-A added R38 "likes to manage the fistula site himself". There was no indication the facility had a process to ensure an assessment was performed, or communication was maintained between facility staff and dialysis staff vs. rely on R38 to assess himself. During interview on 10/19/22, at 9:14 a.m., RN-A indicated they receive post-dialysis reports via fax from the dialysis center but was unsure when they actually arrived or were noted. RN-A added if there are any new orders, she felt they would come from R38's medical doctor and not the dialysis facility. During interview on 10/19/22, at 10:13 a.m., dietary personnel (DP)-A indicated dialysis used to send a renal report card for R38 that included most recent lab work, weights before and after dialysis and if they ran extra fluid offload. DP-A reported the registered dietician (RD) had contacted the dialysis facility requesting information but had not received a return call, after multiple attempts. DP-A indicated there was not adequate communication being received from	2 300		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

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2 300	Continued From page 5 the dialysis company. During interview 10/19/22, at 12:33 p.m., patient care technician (PCT)-A from dialysis company indicated she worked with R38 frequently when he received dialysis. R38 frequently arrives with extra fluid onboard and they will do an extra run for dialysis to just pull extra fluid off after his 4 hour dialysis run. PCT-A indicated they used to send his post-dialysis sheet with R38 to give to the facility, but they frequently found it remained in his bag when he returned for his next dialysis visit. PCT-A indicated they now fax the information to the facility since they weren't removing it from his bag. The post-dialysis report included pertinent lab information, pre and post weights, vitals signs and if an extra run was completed due to excess fluid. PCT-A indicated R38 does come periodically with the previous dressing still on his fistula site. Dialysis nursing expected it be removed the evening post-dialysis by the facility after assessing and monitoring his site until it can safely be removed. Dialysis patient's with venous catheters had different expectations. During interview on 10/19/22, at 9:56 a.m., health information management (HIM)-A indicated the last time they received the post-dialysis report from facility staff was on 8/31/22. They scan any information sent to them into the resident's electronic medical record. During interview on 10/19/22, at at 10:41 a.m., the director of nursing (DON) was unsure if staff received a post -dialysis report and was unsure if an assessment was completed by the nursing staff when R38 would return from dialysis treatment. The DON indicated she will check further into this. Further interview on 10/19/22, at	2 300		

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2 300	Continued From page 6 12:15 p.m., with the DON indicated the dialysis company has not been sharing information post-dialysis. The DON confirmed they have no way to know how R38 did through his dialysis treatment or post-treatment and do not know how much fluid was removed or what his current medical information was. The DON indicated staff are completing a pre-dialysis assessment but confirmed the nursing was not completing a post-dialysis assessment or monitoring upon return from dialysis. She further clarified there wasn't a good method of communication between the facility and dialysis. A policy and procedure dated 9/17/21 titled "Dialysis Services" included: -Locations caring for residents receiving dialysis services must have an agreement in place with the provider of the service. -The clinical monitoring titled Dialysis UDA is available in electronic medical record for use in monitoring the resident receiving dialysis. Review of the self renewing dialysis contract dated 1/21/10 between the facility and Total Renal Care/Pipestone Dialysis included: -Each party agreed to timely furnish the other party, in writing, any and all dialysis-related information pertinent to a resident's skilled nursing facility plan of care, including but not limited to, the areas listed below. Each party also agrees to make itself reasonably available to the other party's staff who may have questions regarding the care of resident's receiving dialysis treatment: -In addition to developing its own plan of care with respect to each resident/client receiving dialysis treatment, provider agrees to cooperate with LTC staff in modifying and maintaining as current, each such resident's skilled nursing facility plan of	2 300		

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2 300	Continued From page 7 care. Those areas the LTC plan of care in which Provider shall furnish direction to LTC facility shall include but is not limited to: Procedures for handing medical and non-medical emergencies, including complications, equipment failure and a provider contact in case of emergencies; follow-up care, observation and monitoring; medications; nutritional needs and fluid restrictions and resident education. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement an appropriate training program for nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300		
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.	2 565		12/16/22

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2 565	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive care plan for 1 of 1 residents (R15) on a Continuous Positive Airway Pressure (CPAP) machine (used during sleep hours to assist with breathing to prevent apnea, (periods of not breathing)). Findings include: R15's admission Minimum Data Set (MDS) dated 8/9/22, indicated R15 had intact cognition with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease), pneumonia, COVID-19, occlusion and stenosis (hardening) of the carotid artery, insomnia, obesity, atrial fibrillation (irregular heartbeat causing an increased risk to form blood clots) and chronic rhinitis (inflammation of the nasal passages). R15 required extensive assistance of one staff for dressing, toileting, and personal hygiene. R15's care area assessment (CAA) dated 7/26/22, lacked any indication that R15 had respiratory concerns and required respiratory equipment including oxygen or a CPAP used during sleep hours to assist with breathing machine at night. R15's care plan dated 8/12/22, indicated R15 had limited physical mobility related to pneumonia as evidenced by weakness and shortness of breath with exertion. R15 was also at risk for sleep disturbance related to insomnia. Interventions included adjusting the room temperature and ventilation to promote sleep, use of amber lighting	2 565	1. Based on provider order and R15 s request the CPAP has been discontinued. 2. All residents with a CPAP machine have the potential to be affected. Corrective action was taken and licensed nurses were educated. 3. To ensure systemic changes are made all licensed nurses will be educated on comprehensive care plan and care conferences policy and procedure for proper documentation regarding a CPAP machines within the care plan on 11/28/22 by the DNS or designee. 4. No resident has a CPAP currently for Observation. Any new resident with a CPAP, weekly random audits will be initiated for 2 months to ensure accurate assessment and care planning is completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022	

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2 565	Continued From page 9 and pen lights, and decreasing sounds that disrupt sleep. R15's care plan lacked any indication or interventions for the use of R15's CPAP machine. The care plan also lacked instructions for the proper operation of R15's CPAP machine including the use of distilled water. During an interview on 10/20/22 at 12:39 p.m., registered nurse (RN)-C stated she did not know what care areas would trigger on a CAA and she had not reviewed R15's care plan recently. RN-C also stated R15's use of a CPAP with appropriate interventions should have been listed on his care plan to ensure staff were aware of it's proper use. During an interview on 10/20/22 at 2:06 p.m., the director of nursing (DON) stated she was unaware R15's care plan lacked an intervention the proper use of R15's CPAP and should have. The DON also stated the management team, including herself and RN- Sarah, would review and update resident care plans. A facility policy for care plans was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures to ensure a comprehensive care plan is developed and implemented for each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 830	Continued From page 10	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary medical supplies to 1 of 1 resident (R15) who had a Continuous Positive Airway Pressure machine (CPAP- used during sleep hours to assist with breathing) that required distilled water. In addition, the facility failed to ensure eye drops were administered according to professional standards of practice and manufacturer's guidelines for 1 of 1 (R14) residents observed for eye drop administration. Findings include: R15's admission Minimum Data Set (MDS) dated 8/9/22, indicated R15 had intact cognition with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease), pneumonia,	2 830	1. Based on provider order and R15 s request the CPAP has been discontinued. 2. All residents at the center using a CPAP have the potential to be affected. Corrective action was taken and nursing staff were educated. 3. To ensure systemic changes are made all licensed nurses, TMAs, CNAs will be educated on the correct procedure for utilizing proper medical supplies for CPAP machines according to the manufactures direction through a review of the non-invasive respiratory policy and procedure on 11/28/22 by the DNS or designee. 4. No resident has a CPAP currently for Observation. Any new resident with a CPAP, weekly random audits will be initiated for 2 months to ensure correct	12/16/22

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2 830	Continued From page 11 COVID-19, occlusion and stenosis (hardening) of the carotid artery, insomnia, obesity, atrial fibrillation (irregular heartbeat causing an increased risk of blood clots) and chronic rhinitis (inflammation of the nasal passages). R15 required extensive assistance of one staff for dressing, toileting, and personal hygiene. R15's care area assessment (CAA) dated 7/26/22, lacked any indication that R15 had respiratory concerns or required respiratory equipment including oxygen or a CPAP machine at night. R15's care plan dated 8/12/22, indicated R15 had limited physical mobility related to pneumonia as evidenced by weakness and shortness of breath with exertion. R15 was also at risk for sleep disturbance related to insomnia. Interventions included adjusting the room temperature and ventilation to promote sleep, use of amber lighting and pen lights, and decreasing sounds that disrupt sleep. R15's care plan lacked any indication or interventions for the use of R15's CPAP machine. The care plan also lacked instructions for the proper operation of R15's CPAP machine including the use of distilled water in the machine. R15's physician orders dated 9/7/22, indicated R15 was on oxygen 4 liters per minute at bedtime and as needed for COPD. The orders lacked indication that R15 was on CPAP. R15's Treatment Record (TAR) dated August, September 2022 indicated R15 used CPAP every night from 8/15/22, to 9/30/22. R15's TAR dated October 2022 indicated staff documented R15 use of his CPAP as follows: -10/1/22, to 10/4/22, "applied"	2 830	procedure for utilizing proper medical supplies for CPAP machines is used. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022. 1. A competency will be completed to ensure R14 eye drops are administered in accordance to medication administration policy. 2. All residents in the center receiving eye drops have the potential to be affected. Corrective action was taken and all licensed nurses and TMA s were educated. 3. To ensure systemic changes are made all licensed nurses and TMAs will be educated on the proper procedure for storing and administering eye drops according to the manufactures direction through a review of the Medication administration policy on 11/28/22 by the DNS or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for (R14) and (2) other random residents regarding eye drop administration. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure eye drops are being properly given. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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2 830	Continued From page 12 -10/5/22, "see progress notes" (below) -10/6/22, "applied" -10/7/22, to 10/9/22, "see progress notes" (below) -10/10/22, to 10/19/22, "applied" R15's progress notes indicated the following: -10/5/22, "No distilled water available, will contact [family]" in AM. -10/7/22, "No distilled water, [family] contacted". -10/8/22, "No distilled water received from (family)". -10/9/22, "Nasal cannula O2 on instead of CPAP per no distilled H20". -10/10/22 to 10/17/22, staff failed to document any progress notes regarding R15's CPAP use. -10/18/22, "CPAP on at bedtime". During an observation and interview on 10/17/22, at 1:25 p.m. an unlabeled, clear jug with an orange lid was observed on a bookshelf in R15's room. R15 stated the facility did not have distilled water, therefore; family member (FM)-A had been bringing it in for the staff to use in R15's CPAP machine since his admission to the facility a few months ago. During an interview on 10/19/22, at 9:44 a.m. FM-A stated R15's personal CPAP machine was brought to the facility from R15's home in August 2022. FM-A stated R15 was initially expected to be a short-term resident and therefore the family thought it was their responsibility to provide the water. FM-A stated R15's girlfriend also used a CPAP machine and would get water from the store, then pour half of the water into the recycled jug for R15 to use in his machine at the facility. FM-A further stated he did not recall the facility notifying him that R15 had ever run out of water. During an interview on 10/18/22, at 3:06 p.m.	2 830		

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2 830	Continued From page 13 registered nurse (RN)-B verified, although R15's CPAP required distilled water the water being used was in a recycled jug, that was unlabeled, and RN-B assumed it to be distilled. RN-B stated FM-A had been "taking care" of R15's CPAP machine water since R15 was admitted to the facility and because R15 had intact cognition, R15 knew what was going on and therefore, RN-B was not concerned about the unlabeled jug of water being used. Review of the Sysco Invoice dated 10/7/22, indicated 6 1-gallon jugs of Ice Mountain distilled water were ordered by the facility. There was no indication the facility had provided the distilled water upon admission. During an interview on 10/19/22, at 1:04 p.m. RN-D stated she was an agency nurse and did not know who ordered the supplies for the facility. RN-D stated when R15 was admitted to the facility in June 2022, she asked staff where to find the distilled water for R15's CPAP but was told the family needed to supply it, therefore: RN-D had been using the water supplied by the family in the unlabeled jug since R15 admitted to the facility. RN-D assumed the water to be distilled. During an interview on 10/18/22, at 3:12 p.m. the food and nutrition director (DD) stated she ordered distilled water for residents when nursing staff reported it was needed, and that residents, or their family should not have to provide it. The DD stated although she knew R15 had a CPAP machine she did not order distilled water for him until an unknown nurse reported R15 was out of water. The DM then ordered 6 1-gallon jugs of distilled water on 10/7/22, which were delivered the following day, however; the DM did not know where the distilled water was being stored or if	2 830		

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2 830	Continued From page 14 nursing staff was aware it was available. The DD further stated she was unaware the family had been supplying it. The DD was not concerned about the unlabeled jug of water being used for R15's CPAP, stating the family was "very involved" and knew what they were doing. During an interview on 10/19/22, at 10:33 a.m. the DD stated she spoke to R15's girlfriend the previous day and was told the water for R15's CPAP was dispensed from a machine at the grocery store and could not verify it was distilled. The DM stated there would be a concern for increased bacteria leading to infection if distilled water was not being used in R15's CPAP machine. R14's quarterly minimum data set dated 8/9/22, indicated R14 had no cognitive deficits, required extensive assistance of one staff for personal hygiene and was independent for eating. R14 had diagnoses that included weakness, arthritis, and carpal tunnel (narrowing of the structures of the wrist causing pain and decreased movement). R14's physician orders dated 6/15/20, indicated R14 received Carboxymethylcellulose-Glycerin (Optive) ophthalmic solution for dry eyes two times a day. During an observation on 10/19/22, at 7:52 a.m. R14 was in the dining room eating breakfast when registered nurse (RN)-B applied one eye drop in each of R14's eyes. R14 was unable to tilt her head back and RN-B placed the eye dropper into the inside, bottom corner of each eye, allowing the eye dropper to touch the tissue of the eyes. During an interview on 10/20/22, at 3:05 p.m. RN-B stated she preferred to administer eye	2 830		

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2 830	Continued From page 15 drops to residents in their room while they were lying in bed if possible, however; the residents were often already in the dining room so RN-B would often administer medications including eye drops during meals. RN-B stated R14's eye drops should have been administered by placing one drop in the bottom eye lid mucosa without touching the eye tissue to ensure it covers the eye surface evenly and to avoid contamination of the eye dropper. During an interview on 10/20/22, at 10:46 a.m. RN-C stated eye droppers should not touch a resident's eye or the surrounding tissue during administration to avoid contaminating the eye dropper or infecting the eye. During an interview on 10/20/22, at 2:06 p.m. the director of nursing (DON) stated staff should follow the manufacturer's recommendations for R15's CPAP machine and use distilled water. The DON was unaware R15's family had been supplying the water and was concerned for potential bacterial growth if distilled water was not being used. The DON further stated the facility should have been supplying R15's distilled water. The DON also stated eye droppers should not touch the eye or surrounding tissue to avoid contamination of the eye dropper and possible infection. The facility Non-invasive Respiratory Support policy dated 5/3/22, indicated to provide the most effective treatment for reducing CO2 in hypercapnic (chronically high levels of carbon dioxide) COPD residents. The policy defined CPAP as continuous positive airway pressure that is titrated to blow air at a constant pressure to keep air passages open. CPAP is the most common treatment for sleep apnea (brief periods	2 830		

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2 830	Continued From page 16 during sleep when a resident will stop breathing). The policy lacked instructions on the use of humidified oxygen or distilled water when using the CPAP machine. The facility Oxygen Administration, Safety, Mask Types policy dated 6/29/22, indicated equipment required for administering various levels of oxygen concentration and/or humidity in a safe manner, included: humidifier with distilled water. The policy further instructed to fill the humidifier bottle, if ordered, with distilled water and keep filled adequately at all times. The facility Medication: Administration Including Scheduling and Medication Aides policy dated 8/24/22, indicated medication was to be administered correctly and effectively. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to ensure staff are providing necessary medical supplies and administering medications appropriately. The director of nursing or designee, could conduct audits of staff competensies for respiratory equipment, oxygen delivery and medication administration. The results of those audits chould be reviewed with QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary	21015		12/16/22

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21015	Continued From page 17 procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain 1 or 1 ice machine to prevent potential contamination and to ensure food and drinks were served in a safe and sanitary manner during meal service in the dining room. This had the potential to effect 45 of 48 residents who ate breakfast in the dining room. ICE MACHINE During initial tour of the kitchen and interview on 10/17/22, at 12:55 p.m., an ice machine located in the kitchen storage room had white, lumpy deposits present along the lid of the ice container and along the right side of the machine. A yellow light was lite on the top of the machine. The dietary manager (DM) indicated it is lime scale build up and is aware the machine needs to be cleaned routinely. DM indicated maintenance has been notified of it needing to be cleaned. Requested maintenance documents on the ice machine and DM indicated there will not be any as they have experienced turn over in the maintenance department and it hasn't been cleaned in over a year. During interview on 10/19/22, at 12:58 p.m., service department of ice machine manufacturer (Scotsman) was contacted and spoke with SD-A who indicated maintenance is required at a minimum every 6 months but stated it also depends on water quality. If facility has hard water the machine should be cleaned every 3-4 months. SD-A indicated a yellow indicator light	21015	1. Ice machine was cleaned . 2. All residents in the center have the potential to be affected. Corrective action was taken in which ice machine was cleaned along with a cleaning schedule was created. 3. To ensure systemic changes are made all maintenance staff, Dietary director, and Housekeeping director will be educated on the correct policy and procedure titled ice machines use and maintenance in maintaining and cleaning the ice machine according to the manufactures direction on 11/28/22 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee to ensure proper cleaning regarding ice machine maintenance. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure ice machine maintenance is being properly completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022. 1. All dietary staff were educated. 2. All residents in the center have the potential to be affected. Corrective action was taken and all dietary staff and educated.	

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21015	Continued From page 18 will turn on when cleaning is required. SD-A indicated if white scaling substance is on the outside of the machine, it is also on the inside of machine which can contaminate the ice being made. Review of manufacture's recommendations dated January 2015, included: All models have an indicator light that switches on to inform the user that the cleaning interval has been reached. It does not stop the machine from making ice. The clean button drains the reservoir and refills it. The cleaning process is designed to use straight nickel safe ice machine scale remover, added between draining and refilling. The cleaning time is designated by person running the clean cycle and is dependent on cleaning need. A second push of the clean button starts the flush out process. This process should last at least 20 minutes to fully flush out the scale remover and loose scale. After the scale remover has been drained out, the water distributor must be inspected for loose scale and cleaned if any. Removal of the sump cover, pump bracket and curtain is next to be sure those parts have been cleaned. Cycle power to the controller as a final step before restarting ice making. During observation and interview 10/20/22, at 9:48 a.m., the administrator and maintenance (M)-A observed the ice machine. The yellow light remained on the machine and this was confirmed by the administrator. M-A confirmed there was a white, lumpy deposit present on the ice machine and indicated he wasn't aware routine maintenance needed to be completed on this machine. M-A indicated he is unaware of the last maintenance completed on the ice machine. DRINKS	21015	3. To ensure systemic changes are made all dietary staff will be educated on the correct policy and procedure titled food-supply storage and GSS safe serve policy pertaining to cut bananas on 11/28/22 by the DNS or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee to ensure bananas are covered properly. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure bananas are being properly completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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21015	Continued From page 19 R39's admission Minimum Data Set (MDS) dated 9/20/22, indicated R39 had mild cognitive deficits and required extensive assistance of one staff with all activities of daily living (ADLs) and supervision of one staff for eating. During an observation and interview on 10/19/22, at 7:29 a.m. The cook (CK) was observed placing uncovered juice, coffee, water and tea orders and bananas with the ends cut off, on all the tables in the dining room. Of the 45 residents who ate breakfast in the dining room, only three residents were seated at tables. The CK stated the drinks and bananas were always placed on the tables early and although they were not covered, there was no concern for contamination from other residents, staff or visitors walking by. The CK further stated there was no policy requiring the drinks to be covered during dining service. During an observation on 10/19/22, at 7:33 a.m. R39 was observed self-propelling her wheelchair around her assigned table, picking up another banana on the table and comparing the cut end to her banana. R39 decided she preferred her banana and left the second banana at the preset place for another resident who had not arrived yet for breakfast. No staff were present during the incident. During an interview on 10/20/22, at 10:46 a.m. registered nurse (RN)-C stated she had previously seen residents pick up uncovered, cut bananas on the dining tables to compare their ripeness and staff would gladly switch out the bananas if they were asked to. Although there was concern for contamination, RN-C also stated she had not discussed changing the process with anyone because the kitchen was in charge of meal service and delivery.	21015		

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21015	Continued From page 20 During an interview on 10/19/22, at 11:05 a.m. the dietary director (DD) stated although drinks were served prior to residents entering the dining room, they were only required to be covered during room tray delivery. The DD further stated there was no concern for contamination of the drinks from other residents or staff walking by or reaching over the drinks. The DD stated, however; a resident picking up uncovered, cut bananas that were intended for other residents would be a concern for contamination and the cut end of the bananas should have been covered. The facility policy on food service was requested but not received. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate safe and sanitary delivery and service of food items in the dining areas. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of	21565		12/16/22

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21565	Continued From page 21 care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R32 and R39) observed to have medications left at their dining tables were assessed and approved to be able to safely self-administer medications. Findings include: R32's quarterly Minimum Data Set (MDS) dated 9/6/22, indicated R32 had mild cognitive deficits and required extensive assistance of one staff for dressing, personal hygiene, and toileting and was independent for eating. R32 had diagnoses that included dementia, renal failure, gastro-esophageal reflux (GERD), and hypothyroidism (low functioning thyroid). R32's care plan dated 6/23/22, indicated R32 had impaired cognitive function related to short term memory loss. Interventions included monitoring and documenting any changes in cognition, decision making ability, memory, recall and general awareness. R32 also had altered cardiovascular status and high blood pressure. R32 also had an activities of daily living (ADL) deficit related to dementia and episodes of confusion. R32's care plan lacked indication R32 had been assessed and approved to self-administer medications. R32's physician orders dated 10/20/22, indicated R32's morning medications included: -Amlodipine 10 milligrams (mg) for high blood	21565	1. Assessment for self-administration was completed to ensure R32 and R39 are safe to self-administer medication. 2. All residents at the center who self-administer medication have the potential to be affected. Corrective action was taken and assessments have been reviewed and are appropriate. 3. To ensure systemic changes are made all licensed nurses and TMAs will be educated on the medication administration policy and procedure for administering self-medications to those who are Care Planned for self-administering medication on 11/28/22. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for (R32 and R39) and (2) other random residents regarding self-administer medication administration. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure medication is being properly given and self-administer medication assessments are completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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21565	Continued From page 22 pressure -Tylenol extra strength 1000 mg for pain -Pantoprazole 20 mg for GERD -Lisinopril 20 mg for high blood pressure -Oxybutynin 2.5 mg for bladder hyperactivity -Levothyroxine 50 micrograms (mcg) for hypothyroidism -Furosemide 20 mg (a diuretic for water retention) R32's physician orders lacked an order for self-administration for any medications. R32's medical record lacked a Self-Administration of Medication assessment. During an observation on 10/18/22, at 8:52 a.m. a medication cup with multiple medications was observed on the dining table in front of R32. It was not known how long the medications had been there and no nursing staff was in the dining room. After an unidentified tablemate got a cup of water from the dining kitchenette for R32, R32 began taking her medications with no nursing staff present in the dining room to ensure they were taken safely and completely. During an interview on 10/19/22, at 8:01 a.m. R32 stated the nurse would always leave her morning medications at her table for R32 to take when she wanted. During an interview on 10/20/22, at 3:05 p.m. registered nurse (RN)-B stated some residents liked to take their medications themselves and the staff would walk around and make sure they were taking them. RN-B stated the residents should probably have a self-administration of medication form filled out if she was going to leave the medications on the resident's table to take later and verified R32 did not have one	21565		

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21565	Continued From page 23 completed. RN-B stated they have had residents pocket their medications in the past. RN-B further stated she liked to watch the residents take their medications but some "just take a while". During an interview on 10/20/22, at 2:17 p.m. the director of nursing (DON) stated unless a resident had an evaluation and physician order to self-administer medications, staff should observe residents take their medications and not leave them on a table unattended. The facility Medication: Administration Including Scheduling and Medication Aides policy dated 8/24/22, indicated a resident had the right to self-administer medication if the interdisciplinary team (IDT) determined it was safe for the resident and it was documented in the resident's care plan, and a physician's order was required. The policy also indicated not to leave medications at a table unless there was a specific physician order to do so and the resident had been evaluated for self-administration. If the resident had not been evaluated for safe self-administration of medication and there was not a physician order to do so, the staff must stay with the resident until the medication is taken and they have observed the resident swallow. The facility Resident Self-Administration of Medication policy dated 10/15/21, indicated staff must complete a Self-Administration of Medications UDA to determine if the resident could safely administer medications. The IDT would determine if the resident required education or accommodation in-order to self-administer medications, where the medication would be stored, where the medication would be administered, and who would document the administration. The IDT	21565		

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21565	Continued From page 24 would document their determination of self-administration on the UDA and a physician's order must be obtained. The resident's care plan must indicate the resident is safe to self-administer medication and their ability to do so would be re-evaluated quarterly or with any significant change assessment. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting,	21695		12/16/22

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21695	Continued From page 25 and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure the resident environment including 15 of 17 resident's bathroom vents (R13, R45, R48, R42, R14, R34, R19, R32, R41, R17, R40, R24 and R26, R8 and R35, R38, and R7) were maintained in a clean manner. Findings include: During an environmental tour on 10/17/22 the following observations were made of thick, gray covering of dust, dirt, and debris was discovered at: (1) 7:09 p.m., in the bathroom vent in R24 and R26's room. (2) 7:10 p.m., in the bathroom vent in R8 and R35's room and also had loose debris hanging from the vent slits. (3) 7:12 p.m., the bathroom vent in R38's room. (4) 7:13 p.m., the bathroom vent in R7's room. In addition, a vent located next to the toilet on the wall had multiple areas of paint chipped off with rust-like deterioration of the metal present. During facility tour on 10/18/22, at 2:01 p.m. the following residents' room vents were found to be covered in heavy thick, gray covering of dust, dirt and debris: R13, R45, R48, R42, R14, R34, R19, R32, R41, R17, and R40. During a tour with the administrator and maintenance (M-A) on 10/20/22, at 10:20 a.m., the administrator and maintenance director confirmed the above-mentioned vents were in need of cleaning. They would make sure all	21695	1. All affected vents were cleaned on 10/24/22. 2. All residents at the center have the potential to be affected by the deficiency practice. Corrective action was taken, and vents were cleaned along with a cleaning schedule created. 3. To ensure systemic changes are made all maintenance and housekeeping staff will be educated on standard of light cleaning policy and procedure for maintaining and cleaning the vents according to the manufactures direction on 11/28/2022 by the DNS or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee 10 random residents regarding if their vent is properly cleaned. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure vent cleaning is being properly completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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21695	Continued From page 26 residents in the facility would have their vents cleaned. The M-A also verified there was paint chipped off and rust was present on the vent in R7's room. A policy and procedure on cleaning of vents was requested but none was received. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation, interview and record	21710	1. Additional outside company was called	12/16/22

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21710	Continued From page 27 review the facility failed to ensure safe, and appropriate water temperatures were maintained below 120 degrees Fahrenheit to prevent potential burns to residents residing in 15 of 36 rooms observed in the facility. This had the potential to affect all 48 residents who resided in the facility. Findings include: During a tour of the facility on 10/17/2,2 at 7:10 p.m., the water temperatures were obtained in degree of Fahrenheit (F). The following rooms were as follows: (1) R24's room water temperature was 124.0 F (2) R8 and R35's room water temperature was 123.8 F (3) R20 and R36's room water temperature was 124.2 F During tour of the facility on 10/18/22, at 2:00 p.m., the water temperatures were obtained in degree of Fahrenheit (F) in the following rooms: (1) R13's room water temperature was 129.2 F (2) R45's room water temperature was 127.9 F (3) R48's room water temperature was 130.6 F (4) R42's room water temperature was 125.0 F (5) R14's room water temperature was 127.5 F (6) R41's room water temperature was 123.6 F Review of the 3/20/12, Consumer Product Safety Commission at https://www.cpsc.gov/s3fs-public/5098-Tap-Water-Scalds.pdf identified water temperatures should be maintained at less than 120 degrees to prevent burns. During interview and observation on 10/19/22, at 10:05 a.m. with administrator and maintenance (M)-A and M-B, rooms belonging to R24, R8 and	21710	to inspect the hot water tank to ensure it has proper temperatures. 2. All residents in the center have the potential to be affected. Corrective action was taken and outside company was called to ensure proper hot water temperatures. 3. To ensure systemic changes are made all maintenance staff will be educated on the correct procedure for monitoring hot water temperatures according to the manufactures direction through a review of the GSS policy titled Water Temperatures on 11/28/22 by the DNS or designee. If water temperatures are not within appropriate range all nursing and maintenance staff will be notified immediately. Maintenance will adjust water heater and a recheck of the temperatures will be completed until the water temperatures are within range. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for 10 random residents regarding hot water temperature. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure hot water temperatures are within range. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

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21710	Continued From page 28 R35, R2, R20 and R7 identified water temperatures at that time ranged from 98 to 104 degrees F. The administrator indicated the facility recently purchased a new water heater and was currently having difficulty maintaining safe and/or comfortable parameters of temperature. The administrator indicated maintenance had been monitoring temperatures and working with the company to resolve the issue. M-A indicated he had turned down the water heater on 10/18/22 due to temperatures being "too high". There was no indication the administrator had a plan in place or had educated staff on what to do when water reached high temperatures 120 degrees or higher to prevent potential burns for all 48 residents. During observation and recheck of water temperatures on 10/20/22, at 8:20 a.m. the following room water temperatures were as follows: (1) R48's room water temperature was 132.0 F (2) R28's room water temperature was 130.0 F (4) R41's room water temperature was 127.2 F (5) R1's room water temperature was 130.0 F (6) R8 and R35's room water temperature was 132.2 F (7) R2's room water temperature was 128.0 F During record review on 10/20/22, at 8:42 a.m., a copy of the facility monitoring included on: 1) 9/21/22 at 10:00 a.m., rooms belonging to R6 and R16, and R45 had water temperature to be 120 F. 2) 10/5/22 at 11:00 p.m. rooms belonging to R28 and R14 had water temperatures noted to be 120 F. 3) 10/12/22 at 2:00 p.m. rooms belonging to R27 and R22, and R43 had water temperatures note to be 120 F. Each time staff noted the high temperature and	21710		

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	00454	A. BUILDING: _____ B. WING _____	C 10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21710	Continued From page 29 adjusted the water heater. There was no indication nursing staff were alerted to the potential for increased risk of resident burns. During interview on 10/20/22, at 8:32 a.m., nursing assistant (NA)-A indicated water was either "too hot or too cold"over the past few weeks. NA-A indicated to her knowledge there have been no injuries related to the water temperatures and was not educated on what to do if water temperatures were too high and had the potential to burn residents. During interview on 10/20/22, at 8:34 a.m., NA-B indicated the water temperatures have fluctuated over the past month being either "too hot or too cold". To her knowledge, no resident had injuries related to hot water temperatures. Staff "just know to check it" before residents would potentially wash their hands or before putting residents into the bathtub. During interview and document review on 10/20/22, at 9:51 a.m., administrator and M-A indicated they were performing routine monitoring of temperatures daily, but it is on a separate sheet than the normal weekly monitoring. M-A indicated he did check the water temperature at 7:00 a.m. that morning which was too high, so the water heater was turned down. M-A indicated he did not notify nursing staff of the hot water issue. The administrator had an invoice dated 9/1/22 for the new water heater, but the administrator stated it was not installed until "after that date" and was unaware when it was reportedly to have been installed. Review of water temperature monitoring provided by maintenance included dates 9/1/22 through 10/19/22 completed daily with water temperatures ranging from 110 to 115 degrees F. Three temperatures on 9/21/22, 10/5/22 and	21710		

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	00454	A. BUILDING: _____ B. WING _____	C 10/20/2022

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21710	Continued From page 30 10/12/22 were noted to be at 120 degrees F. On 9/21/22 and 10/5/22, the water temperatures was note to be adjusted. The temperature monitoring sheet did not include time or location the water temperature was checked. During subsequent interview on 10/20/22, at 11:30 a.m., the administrator confirmed more frequent water temperature monitoring and also communication with staff was imperative to ensure the safety of all residents. A policy and procedure titled "Water Temperatures" dated 2/2/2022 identified residents typically had thinner skin so the risk of burns even with brief exposure to unsafe high water temperatures was "substantial". Additionally residents may have medical conditions that limited their ability to communicate or even recognize that the water they are exposed to had the potential to burn them. The exposure time required to produce a third degree burn was 120 degrees F for five minutes. At 127 degrees, it took 1 minute to cause burns. Monitoring water temperaures was to be done on a weekly basis or more frequently if conditions were identified to ensure a comfortable and safe environment for residents. Monitoring was to include rooms closest to and furthest away from the water source at least weekly per wing or water loop. The recommended temperature range for hot water at the point of use, was between 100 and 115 degrees F. Documenting water temperatures should include the following information: - Name or initials of the person taking the temperature - Specific location of the monitoring (for example: room number) - Date and time of the monitoring - Temperature of the water.	21710		

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	00454	A. BUILDING: _____ B. WING _____	C 10/20/2022

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21710	Continued From page 31 SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility should review policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST** **EDGERTON, MN 56128**

(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/18/2022. At the time of this survey, Edgebrook Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/18/2022

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

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	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2022**

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Edgebrook Care Center is one-story in height, has a partial basement, and is fully sprinklered. The original building was built in 1968, with building additions in 1992 and 1997. All were determined to be of Type II(111) construction. The 2003 building addition, which includes a meeting room and offices. The addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.
Because the original building and the (3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2022**

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EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST** **EDGERTON, MN 56128**

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K 000	Continued From page 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		12/16/22

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	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2022**

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K 353	Continued From page 3 This REQUIREMENT is not met as evidenced by: K-TAG: 353 Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5 and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.1 and 5.1.1.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/18/2022 between 10:00 AM to 12:00 PM, during documentation review, it was revealed that the annual fire sprinkler inspection had not occurred within the required 12 month time frame. The last inspection took place on 10/01/2021 An interview with the Facility Admininstrator verified this condition at the time of discovery.	K 353	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. An outside company was called in to inspect the system on 10/24/22 2. All residents in the center have the potential to be affected. Corrective action was taken and an outside has inspected the system. 3. To ensure systemic changes are made all maintenance staff will be educated on the correct GSS policy and procedure title Fire Extinguishment and Fire Suppression for maintaining and ensuring the proper company completes the annual inspection on 11/28/22 by the Administrator or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee to ensure proper sprinkler maintenance. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure sprinkler maintenance is	

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	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2022**

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EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST** **EDGERTON, MN 56128**

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K 353	Continued From page 4	K 353	being properly completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: K-TAG: 355 Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1 and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.1.2. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 10/18/2022 between 10:00 AM to 12:00 PM, during the inspection it was observed that a portable fire extinguisher in the laundry had not received a monthly inspection since 05/25/2022. An interview with the Facility Admininstrator verified this condition at the time of dicsovery.	K 355	1. All fire extinguishers were been inspected on 10/24/22. 2. All residents in the center have the potential to be affected. Corrective action was taken and all fire extinguishers have been inspected and a schedule has been created. 3. To ensure systemic changes are made all maintenance staff will be educated on the correct GSS policy and procedure title Fire Extinguishment and Fire Suppression for maintaining and ensuring the proper portable fire extinguishers inspection on 11/28/22 by the Administrator or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee to ensure timely portable fire extinguishers inspection. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure portable fire extinguishers inspections are being properly completed. Audit results will be	12/16/22

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K 355	Continued From page 5	K 355	brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: K-TAG: 521 Based on a review of available documentation and staff interview, the facility failed to maintain, test and inspect smoke and fire dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 8.5.5.4.1, and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.8.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 19.4.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/18/2022 between 10:00 AM and 12:00 PM, it was revealed by a review of available	K 521	1. Corrective action was taken and an outside company was contacted along with education provided to maintenance staff. 2. All residents in the center have the potential to be affected. Corrective action was taken and education provided to maintenance staff. 3. To ensure systemic changes are made all maintenance staff will be educated on the correct GSS policy and procedure titled general HVAC maintenance to ensure the maintaining and ensuring the proper smoke and fire dampers inspection on 11/28/22 by the Administrator or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee to ensure timely portable fire	12/16/22

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K 521	Continued From page 6 documentation that an inspection record could not be provided indicating that a fire and smoke damper inspection had occurred within the last 4 years. An interview with Facility Director and Maintenance Director verified this deficiency finding at the time of discovery.	K 521	extinguishers inspection. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure smoke and fire dampers inspection are being properly completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		12/16/22

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	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2022**

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K 918	Continued From page 7 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: K-TAG: 918 Based on a review of available documentation and staff interview, the facility failed to test and inspect the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.8. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/18/2022 between 10:00 AM to 12:00 PM, during the inspection and staff interview it was determined that the maintenance staff had not recieved any training on how to properly conduct a monthly 30 minute load test on the new emergency generator. An interview with the Facility Administrator verified this condition at the time of discovery.	K 918	1. An outside company was called in to inspect the system on 10/28/22 2. All residents in the center have the potential to be affected. Corrective action was taken and an outside company was contacted to inspect and train maintenance staff. 3. To ensure systemic changes are made all maintenance staff will be educated on the correct GSS policy and procedure titled Emergency and Stand by Power Systems for maintaining and testing emergency generator on 11/28/22 by the Administrator or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee to ensure timely emergency generator transfer of power inspections. Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure emergency generator transfer of power inspections are being properly completed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16, 2022.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 5, 2023

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

Re: Reinspection Results
Event ID: SFJX12

Dear Administrator:

On December 20, 2022 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 October 20, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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