

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

Minnesota Department of Health

Kumalu Fiske-Downing

Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us



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



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: 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 <u>only a suggestion</u> 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

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 11/28/2022 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	NG		СОМ	COMPLETED			
							C			
		245560	B. WING		_	10/	20/2022			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE					
FDGFRR	OOK CARE CENTER			505 TROSKY ROAD WEST						
LDGLDIN	OOK CAKE CENTER			EDGERTON, MN 56128						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCES		BE	(X5) COMPLETION DATE			
E 000	Initial Comments		E 0	00						
F 000	compliance with Appreparedness Required conducted during a survey. The facility of the facility is enrolled signature is not required page of the CMS-25 correction is required acknowledge receip INITIAL COMMENT. On 10/17/22 through recertification surver facility. A complaint conducted. Your factor compliance with the Subpart B, Required Facilities. The following composubstant Substantiates. The following composubstantiates. The following composubstantiates. The facility's plan of as your allegation of Departments accepted in ePOC, year the bottom of the form. Your electronic be used as verificated.	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents. S gh 10/20/22, a standard by was conducted at your investigation was also cility was found to be NOT in exequirements of 42 CFR 483, ments for Long Term Care laints were found to be H5560041C (MN81781), encies were cited due to do by the facility prior to survey: f correction (POC) will serve f compliance upon the stance. Because you are our signature is not required first page of the CMS-2567 to submission of the POC will	FO	00						
	onsite revisit of you	r facility may be conducted to								
	validate substantial	compliance with the								
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE			(X6) DATE			
Electron	ically Signed						11/18/2022			

(X2) MULTIPLE CONSTRUCTION

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY		
		245560	B. WING			C 20/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 505 TROSKY ROAD WEST EDGERTON, MN 56128	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 554	S483.10(c)(7) The medications if the idefined by §483.21 this practice is clinion. This REQUIREMED by: Based on observative review, the facility of (R32 and R39) obset at their dining table approved to be able medications. Findings include: R32's quarterly Ming 9/6/22, indicated Rand required extenderssing, personal independent for earingluded dementia, gastro-esophageal hypothyroidism (low R32's care plan data).	en attained. in Meds-Clinically Approp 7) right to self-administer nterdisciplinary team, as (b)(2)(ii), has determined that cally appropriate. NT is not met as evidenced tion, interview, and document failed to ensure 2 of 2 residents erved to have medications left s were assessed and e to safely self-administer nimum Data Set (MDS) dated 32 had mild cognitive deficits sive assistance of one staff for hygiene, and toileting and was ting. R32 had diagnoses that	F 0	00	con does not reement by facts the plan of executed y the articipation, ection ation of h section Manual. Stration was R39 are	12/16/22	
	memory loss. Inter- and documenting a decision making ab general awareness cardiovascular stat R32 also had an ad deficit related to de	ventions included monitoring any changes in cognition, bility, memory, recall and R32 also had altered us and high blood pressure. Extivities of daily living (ADL) ementia and episodes of are plan lacked indication R32		2. All residents at the center was elf-administer medication have potential to be affected. Correct was taken and assessments have reviewed and are appropriate. 3. To ensure systemic change all licensed nurses and TMAs educated on the medication	tho ve the ctive action nave been s are made		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		` '	X3) DATE SURVEY COMPLETED		
		245560	B. WING		10/	C 20/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	1072	ZUIZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	R32's morning med-Amlodipine 10 mill pressure -Tylenol extra strent-Pantoprazole 20 mg-Lisinopril 20 mg fog-Oxybutynin 2.5 mg-Levothyroxine 50 mg-Levothyroxine 50 mg-Levothyroxine 20 mg-Levothyroidismg-Furosemide 20 mg-R32's physician ord self-administration material reconstruction cup with observed on the direction cup with obse	l and approved to dications. lers dated 10/20/22, indicated lications included: igrams (mg) for high blood gth 1000 mg for paining for GERD rhigh blood pressure for bladder hyperactivity micrograms (mcg) for g (a diuretic for water retention) lers lacked an order for for any medications.			those 11/28/22. lucted by r or (2) other stration. d every ensure n and sments e g with ensure	
	stated the nurse we medications at her wanted. During an interview	on 10/19/22, at 8:01 a.m. R32 ould always leave her morning table for R32 to take when she on 10/20/22, at 3:05 p.m. N)-B stated some residents				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245560	B. WING	i			C 20/2022
	PROVIDER OR SUPPLIER			50	TREET ADDRESS, CITY, STATE, ZIP CODE 05 TROSKY ROAD WEST DGERTON, MN 56128	1072	2012022
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F 554	the staff would walk were taking them. It should probably have medication form fille leave the medication take later and verific completed. RN-B stated she liked to we medications but soon. During an interview director of nursing (had an evaluation as self-administer medications take their them on a table unated as self-administer medication and the do so, and the residents take their them on a table unated for safe as medication and the do so, the staff must the medication is table unless there were self-administer medication and the do so, the staff must the medication is table unless there were self-administer to the self-administer table unless there were self-administer to do so and the resident swallow.	dedications themselves and a around and make sure they RN-B stated the residents we a self-administration of ed out if she was going to ms on the resident's table to ed R32 did not have one tated they have had residents attions in the past. RN-B further watch the residents take their me "just take a while". on 10/20/22, at 2:17 p.m. the (DON) stated unless a resident and physician order to dications, staff should observe medications and not leave attended. ion: Administration Including dication Aides policy dated a resident had the right to dication if the interdisciplinary med it was safe for the resident and in the resident's care and not leave medications at a was a specific physician order sident had been evaluated for a self-administration of the was not a physician order to set stay with the resident until a ken and they have observed w.		554			
	Medication policy d	it Self-Administration of ated 10/15/21, indicated staff elf-Administration of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 582	could safely administed would determine if the education or accompoself-administer medication would be medication would be would document the would document the self-administration order must be obtained in must indicate the responsibility and when the significant change a Medicaid/Medicare CFR(s): 483.10(g)(17) The (i) Inform each Medicaid of (A) The items and some significant change and when the Medicaid of (A) The items and some significant change and when the Medicaid of (B) Those other items and some significant change and the archanged, and the archanged, and the archanged, and the archanges are made specified in §483.10 (g)(18) The resident before, or a section.	determine if the resident ster medications. The IDT the resident required amodation in-order to dications, where the e stored, where the e administered, and who e administration. The IDT eir determination of the UDA and a physician's ned. The resident's care plant esident is safe to dication and their ability to do luated quarterly or with any assessment. Coverage/Liability Notice 17)(18)(i)-(v)	F 5	582		12/16/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128			
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F 582	services, including covered under Med facility's per diem rate (i) Where changes and services covered Medicaid State plan notice to residents reasonably possible (ii) Where changes items and services facility must inform 60 days prior to imp (iii) If a resident die transferred and doe facility must refund representative, or edeposit or charges per diem rate, for the resided or reserved facility, regardless of discharge notice re (iv) The facility must resident representative and behalf of an individual facility must not conthese regulations. This REQUIREMENT by: Based on interview facility failed to prove Nursing Facility Adversing	lity and of charges for those any charges for services not licare/ Medicaid or by the ate. in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e. are made to charges for other that the facility offers, the the resident in writing at least elementation of the change. It is not return to the facility, the to the resident, resident estate, as applicable, any already paid, less the facility's ne days the resident actually all or retained a bed in the of any minimum stay or quirements. It refund to the resident or ative any and all refunds due 30 days from the resident's	F 5	1. Proper notice was issued for re R15 and R101. 2. All residents at the center with Medicare part A coverage have the potential to be affected. Corrective was taken and additional training/education was provided to	action		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMF	(X3) DATE SURVEY COMPLETED	
		245560	B. WING		10/2) 20/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	10/2		
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F 582	received skilled Me 8/12/22 through 10 services had been prior to benefit days Notice of Medicare been issued. The when the notice had identify the notice had services had been prior to benefit days NOMNC had been contain a date of whice issued and failed to provided within the discharge from Medischarge from Medischarge from Medischarge from Medischarge from the last the requirement was days prior to the last C reported R15's In 10/5/22, and the dosigned 10/4/22, who 2-day notice. She have been dated and documentation in the provided to the residence in the provided to the provided to the residence in the provided to the pr	edical record identified he dicare covered services form /5/22. The form identified discontinued by the facility s being exhausted and a non-coverage (NOMNC) had record did not contain a date of d been issued and failed to ad been provided within the prior to discharge from	F 582	MDS nurses and designees. 3. To ensure systemic changes all MDS Nurses or designee will educated on the Notice of Medic Coverage expectation for timely Nursing Facility Advanced Bene Notice on 11/28/22. 4. Observation audits will be conthe Quality Assurance Coordinatesignee on two random residentimely Skilled Nursing Facility AdBeneficiary Notice. Audits will be weekly x 4 and every other week monthly x 1 to ensure notice is be properly given. Audit results will brought to the monthly QA meet appropriate follow up indicated the solutions are sustained. 5. Completion date: December 1.	be Non-Skilled ficiary ducted by tor or to anced to anced to and being be ing with to ensure		

.,	10/20/2	022
GEBROOK CARE CENTER 4) ID SUMMARY STATEME	10/20/2	UZZ
		(X5) IPLETION DATE
R101's last covered day and the Medicare denial and dated on 6/30/22. Ietter should have been if not able to be dated at that date, there should lof verbal issuance in the there was nothing to incomplete they were award give 2-day notice for disservices, and there was of the 3 records reviewed notification had been prodiscontinuation of Medicare Part notified that their coveral providers are responsible notice and requirement and dated to confirm recoption to dispute the denolonger be covered un notice was to be deliver least two calendar days services ended or the service was service wa		
Safe/Clean/Comfortable CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environ The resident has a right comfortable and homelibut not limited to receive		16/22
R101's last covered day and the Medicare denial and dated on 6/30/22. Ietter should have been if not able to be dated at that date, there should lof verbal issuance in the there was nothing to incomported they were award give 2-day notice for disservices, and there was of the 3 records reviewed notification had been prodiscontinuation of Medicare Part notified that their coverage identified received Medicare Part notified that their coverage providers are responsible notice and requirement and dated to confirm recoption to dispute the deno longer be covered un notice was to be deliver least two calendar days services ended or the service if the service was safe/Clean/Comfortable CFR(s): 483.10(i) Safe Environ The resident has a right comfortable and homelice.		12/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245560	B. WING		10/20/2022		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPED TO THE APPROPED DEFICIENCY)	D BE COMPLETION		
F 584	supports for daily li The facility must pr §483.10(i)(1) A safe homelike environm use his or her pers possible. (i) This includes en receive care and se physical layout of th independence and (ii) The facility shall the protection of th or theft. §483.10(i)(2) Hous services necessary and comfortable in §483.10(i)(3) Clear in good condition; §483.10(i)(4) Privar resident room, as s §483.10(i)(5) Adeq levels in all areas; §483.10(i)(6) Comf levels. Facilities init	rovide- e, clean, comfortable, and lent, allowing the resident to onal belongings to the extent suring that the resident can ervices safely and that the he facility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss ekeeping and maintenance of to maintain a sanitary, orderly,	F 584	4			
	sound levels. This REQUIREMED by: Based on observa	ne maintenance of comfortable NT is not met as evidenced tion and interview, the facility e resident environment		1. All affected vents were cleaned 10/24/22.	don		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		` '	(X3) DATE SURVEY COMPLETED			
		245560	B. WING			10/2) 20/2022
EDGEBF	PROVIDER OR SUPPLIER ROOK CARE CENTER SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	505	REET ADDRESS, CITY, STATE, ZIP CODE TROSKY ROAD WEST GERTON, MN 56128 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	(R13, R45, R48, R48, R47, R40, R24 and R7) were maintained. Findings include: During an environm following observation covering of dust, directly at: (1) 7:09 p.m., in the R26's room. (2) 7:10 p.m., in the R35's room and also from the vent slits. (3) 7:12 p.m., the beaddition, a vent local wall had multiple arrust-like deterioration. During facility tour of following residents covered in heavy the and debris: R13, R48, R32, R41, R17, and During a tour with the administrator are confirmed the above need of cleaning. The M-A achipped off and rust R7's room.	esident's bathroom vents 2, R14, R34, R19, R32, R41, R26, R8 and R35, R38, and id in a clean manner. The ental tour on 10/17/22 the ens were made of thick, gray it, and debris was discovered in bathroom vent in R24 and in bathroom vent in R8 and in a clean went in R38's room. The ental tour on the eas of paint chipped off with on of the metal present. The ental tour on 10/17/22 the ental tour on 10/18/22, at 2:01 p.m. the room vents were found to be ick, gray covering of dust, dirt 45, R48, R42, R14, R34, R19,	F 5		2. All residents at the center have the potential to be affected by the deficing practice. Corrective action was taked vents were cleaned along with a cleschedule created. 3. To ensure systemic changes are all maintenance and housekeeping will be educated on standard of light cleaning policy and procedure for maintaining and cleaning the vents according to the manufactures dire on 11/28/2022 by the DNS or designed 4. Observation audits will be conduithe Quality Assurance Coordinator designee 10 random residents regatheir vent is properly cleaned. Audit be done weekly x 4 and every othe x 2 and monthly x 1 to ensure vent cleaning is being properly complete Audit results will be brought to the right QA meeting with appropriate follow indicated to ensure solutions are sustained. 5. Completion date: December 16,	iency en, and eaning made staff nt ction nee. cted by or arding if es will r week ed. monthly up	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245560	B. WING _		_		2 0/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 505 TROSKY ROAD WEST EDGERTON, MN 56128	TE, ZIP CODE	10,2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 584 F 656	Continued From pa requested but none Develop/Implement		F 5				12/16/22
	§483.21(b) Compre §483.21(b)(1) The fimplement a compre care plan for each resident rights set for §483.10(c)(3), that objectives and time medical, nursing, an needs that are idential assessment. The conferment in the resident physical, mental, arrequired under §483.10, includer §483.24, §48 provided due to the under §483.10, includer	chensive Care Plans facility must develop and ehensive person-centered resident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial diffied in the comprehensive omprehensive care plan must ang - t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245560	B. WING _			C 20/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/2	LOILOLL
EDGEBR	OOK CARE CENTER			505 TROSKY ROAD WEST EDGERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on interview facility failed to dever comprehensive car (R15) on a Continual (CPAP) machine (urassist with breathing of not breathing)). Findings include: R15's admission Mine (urassist with breathing). Findings include: R15's admission Mine (urassist with breathing) (urassist wit	ies and/or other appropriate pose. In the comprehensive care e, in accordance with the rth in paragraph (c) of this of the paragraph (c) of this of the paragraph (d) of this of the paragraph (e) of this of the paragraph (f) of the paragraph (f) of this of the paragraph (f) of this of the paragraph (f) of the paragraph (f) of the para	F 65	1. Based on provider order and Rarequest the CPAP has been discor 2. All residents with a CPAP machi have the potential to be affected. Corrective action was taken and lic nurses were educated. 3. To ensure systemic changes are all licensed nurses will be educated comprehensive care plan and care conferences policy and procedure proper documentation regarding a machines within the care plan on 1 by the DNS or designee. 4. No resident has a CPAP current Observation. Any new resident with CPAP, weekly random audits will be initiated for 2 months to ensure accassessment and care planning is completed. Audit results will be brothe monthly QA meeting with approfollow up indicated to ensure soluti sustained. 5. Completion date: December 16,	ensed emade on for CPAP 1/28/22 ly for n a ecurate ought to opriate ons are	
		ed 8/12/22, indicated R15 had				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245560	B. WING			C '20/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	Continued From pa		F 6	56		
	evidenced by weak with exertion. R15 verification and per lights, and disrupt sleep. R15's indication or interver CPAP machine. The instructions for the CPAP machine included and interview registered nurse (R what care areas we had not reviewed R also stated R15's urinterventions should plan to ensure staff. During an interview director of nursing of unaware R15's care the proper use of R The DON also stated including herself and and update residen.					
F 684 SS=D		are plans was not received.	F 6	84		12/16/22
	applies to all treatm	care fundamental principle that ent and care provided to ased on the comprehensive				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ^T A. BUILDI	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245560	B. WING			C 20/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	Continued From pa	age 13 esident, the facility must ensure	F 6	84		
	that residents received accordance with proportice, the compression and the This REQUIREMENT Based on observation review, the facility of medical supplies to a Continuous Position (CPAP- used during breathing) that required addition, the facility were administered standards of praction guidelines for 1 of eye drop administration for the carotid artery, in fibrillation (irregular increased risk of bluing the carotid artery, in fibrillation (irregular increased risk of bluing and covered extensive dressing, toileting, R15's care area as 7/26/22, lacked any respiratory concerns.	ive treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced tion, interview, and document railed to provide necessary of 1 of 1 resident (R15) who had ive Airway Pressure machine g sleep hours to assist with usired distilled water. In railed to ensure eye drops according to professional ce and manufacturer's 1 (R14) residents observed for ation. Inimum Data Set (MDS) dated 15 had intact cognition with used chronic obstructive (COPD, a chronic disease), pneumonia, on and stenosis (hardening) of an and stenosis (hardening) an ood clots) and chronic rhinitis e nasal passages). R15 assistance of one staff for and personal hygiene. Sessment (CAA) dated y indication that R15 had as or required respiratory		1. Based on provider order an request the CPAP has been dis 2. All residents at the center us CPAP have the potential to be Corrective action was taken an staff were educated. 3. To ensure systemic changes all licensed nurses, TMAs, CN, educated on the correct procedutilizing proper medical supplie machines according to the madirection through a review of the non-invasive respiratory policy procedure on 11/28/22 by the Edesignee. 4. No resident has a CPAP cur Observation. Any new resident CPAP, weekly random audits winitiated for 2 months to ensure procedure for utilizing proper in supplies for CPAP machines is Audit results will be brought to QA meeting with appropriate for indicated to ensure solutions a sustained. 5. Completion date: December 1. A competency will be completensure R14 eye drops are admitisted to the completensure R14 eye drops are admitisted and the completensure R14 eye drops are admitisted.	scontinued. sing a affected. Ind nursing are made As will be dure for es for CPAP nufactures ne and DNS or rently for with a vill be e correct nedical sused. the monthly ollow up re 16, 2022.	
	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.			initiated for 2 months to ensure procedure for utilizing proper machines is Audit results will be brought to QA meeting with appropriate for indicated to ensure solutions a sustained. 5. Completion date: December 1. A competency will be completed.	e correct nedical s used. the monthly llow up re 16, 2022. eted to ninistered in	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245560	B. WING			10/2	2 0/2022
EDGEBR	PROVIDER OR SUPPLIER ROOK CARE CENTER SUMMARY STA	TEMENT OF DEFICIENCIES	ID	50	TREET ADDRESS, CITY, STATE, ZIP CODE 05 TROSKY ROAD WEST DGERTON, MN 56128 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE	COMPLETION DATE
F 684	limited physical modevidenced by weak with exertion. R15 vidisturbance related included adjusting to ventilation to promode and pen lights, and disrupt sleep. R15's indication or interver CPAP machine. The instructions for the CPAP machine inclinate machine. R15's physician order and as needed for condication that R15 vas on oxygen and as needed f	ed 8/12/22, indicated R15 had bility related to pneumonia as ness and shortness of breath was also at risk for sleep to insomnia. Interventions he room temperature and one sleep, use of amber lighting decreasing sounds that is care plan lacked any entions for the use of R15's encare plan also lacked proper operation of R15's auding the use of distilled water lers dated 9/7/22, indicated at 4 liters per minute at bedtime COPD. The orders lacked was on CPAP. Secord (TAR) dated August, dicated R15 used CPAP every to 9/30/22. R15's TAR dated ated staff documented R15 follows: The progress rotes of the property (below) The progress rotes of the property (below) The progress rotes of the property (below)	F 6	84	2. All residents in the center received drops have the potential to be affect Corrective action was taken and all licensed nurses and TMA is were educated. 3. To ensure systemic changes are all licensed nurses and TMAs will be educated on the proper procedure storing and administering eye drops according to the manufactures dire through a review of the Medication administration policy on 11/28/22 b DNS or designee. 4. Observation audits will be conducted Quality Assurance Coordinator designee for (R14) and (2) other raresidents regarding eye drop administration. Audits will be done in x 1 to ensure eye drops are being proven. Audit results will be brought monthly QA meeting with appropriate follow up indicated to ensure solutions ustained. 5. Completion date: December 16,	made for steed by or ndom weekly nonthly properly to the steed ons are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245560	B. WING				C 20/2022
	PROVIDER OR SUPPLIER			505	EET ADDRESS, CITY, STATE, ZIP CODE TROSKY ROAD WEST SERTON, MN 56128		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 684	per no distilled H20 -10/10/22 to 10/17/2 any progress notes -10/18/22, "CPAP of During an observation at 1:25 p.m. an unlate orange lid was observation. R15 stated the water, therefore; fair bringing it in for the machine since his a months ago. During an interview FM-A stated R15's brought to the facility 2022. FM-A stated be a short-term resthought it was their water. FM-A stated CPAP machine and store, then pour haling for R15 to use in FM-A further stated notifying him that R During an interview registered nurse (R CPAP required distinused was in a recycland RN-B assumed FM-A had been "take machine water since facility and because R15 knew what was R15 knew R15 k	". 22, staff failed to document regarding R15's CPAP use. In at bedtime". 30 and interview on 10/17/22, abeled, clear jug with an erved on a bookshelf in R15's he facility did not have distilled mily member (FM)-A had been staff to use in R15's CPAP admission to the facility a few on 10/19/22, at 9:44 a.m. personal CPAP machine was by from R15's home in August R15 was initially expected to ident and therefore the family responsibility to provide the R15's girlfriend also used a would get water from the fof the water into the recycled his machine at the facility. The did not recall the facility he did not recall the facility 15 had ever run out of water. 31 on 10/18/22, at 3:06 p.m. 32 N)-B verified, although R15's lled water the water being cled jug, that was unlabeled, it to be distilled. RN-B stated king care" of R15's CPAP e R15 was admitted to the R15 had intact cognition, as going on and therefore, erned about the unlabeled jug		84			

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		245560	B. WING	i			C 20/2022
	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	10/	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	indicated 6 1-gallon water were ordered indication the facility water upon admission. During an interview RN-D stated she wanot know who order RN-D stated when facility in June 2022 the distilled water for the family needed to had been using the in the unlabeled juggiacility. RN-D assured During an interview food and nutrition dordered distilled was staff reported it was or their family should DD stated although machine she did not until an unknown nuwater. The DM there distilled water on 10 the following day, howhere the distilled water on 10 the following staff was an further stated she was been supplying it. To about the unlabeled R15's CPAP, stating involved" and knew During an interview.	o Invoice dated 10/7/22, jugs of Ice Mountain distilled by the facility. There was no y had provided the distilled		384			
		as told the water for R15's					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		` '	(X3) DATE SURVEY COMPLETED	
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F 684	CPAP was dispense grocery store and of The DM stated ther increased bacteria water was not being machine. R14's quarterly minimidicated R14 had extensive assistant hygiene and was in diagnoses that includary and the extensive assistant hygiene and was in diagnoses that includary are causing pain at R14's physician or R14 received Carbo (Optive) ophthalmic times a day. During an observat R14 was in the dinimic when registered nudrop in each of R14 her head back and into the inside, bottoallowing the eye dreeyes. During an interview RN-B stated she prodrops to residents in lying in bed if possion were often already would often administration of the bottom of the dispension of the bottom of the	ge 17 ed from a machine at the could not verify it was distilled. The would be a concern for leading to infection if distilled gused in R15's CPAP imum data set dated 8/9/22, no cognitive deficits, required the of one staff for personal dependent for eating. R14 had used weakness, arthritis, and owing of the structures of the land decreased movement). Iters dated 6/15/20, indicated by each decreased movement. Iters dated 6/15/20, indicated by each decreased movement are solution for dry eyes two ion on 10/19/22, at 7:52 a.m. In groom eating breakfast rese (RN)-B applied one eye last eyes. R14 was unable to tilt RN-B placed the eye dropper om corner of each eye, opper to touch the tissue of the last on 10/20/22, at 3:05 p.m. In the dining room so RN-B ester medications including eye in their room while they were ble, however; the residents in the dining room so RN-B ester medications including eye in RN-B stated R14's eye drops administered by placing one eye lid mucosa without is ue to ensure it covers the and to avoid contamination of		84			

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		245560	B. WING				C 20/2022
	PROVIDER OR SUPPLIER			50	TREET ADDRESS, CITY, STATE, ZIP CODE 05 TROSKY ROAD WEST DGERTON, MN 56128	107	LOILULL
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	RN-C stated eye dresident's eye or the administration to average dropper or infecting. During an interview director of nursing (follow the manufact R15's CPAP maching DON was unaware supplying the water potential bacterial gobeing used. The DOS should have been so the DON also state touch the eye or su contamination of the infection. The facility Non-inversion policy dated 5/3/22, effective treatment hypercapnic (chronedioxide) COPD resice CPAP as continuous is titrated to blow air keep air passages common treatment during sleep when a the policy lacked in humidified oxygen of the CPAP machine. The facility Oxygen The facility Oxygen of the CPAP machine.	on 10/20/22, at 10:46 a.m. oppers should not touch a e surrounding tissue during roid contaminating the eye the eye. on 10/20/22, at 2:06 p.m. the DON) stated staff should curer's recommendations for the and use distilled water. The R15's family had been and was concerned for rowth if distilled water was not DN further stated the facility supplying R15's distilled water. The eye droppers should not rounding tissue to avoid the eye dropper and possible asive Respiratory Support indicated to provide the most for reducing CO2 in itically high levels of carbon dents. The policy defined as positive airway pressure that it at a constant pressure to open. CPAP is the most for sleep apnea (brief periods a resident will stop breathing). Instructions on the use of or distilled water when using		884			
	required for adminis	stering various levels of					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128		
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F 684	manner, included: he had bottle, if ordered, we filled adequately at the facility Medicat	on and/or humidity in a safe numidifier with distilled water. Is not ructed to fill the humidifier ith distilled water and keep all times.	F 68	34		
	8/24/22, indicated radministered corrections of Accident Harch CFR(s): 483.25(d)(§483.25(d) Accident The facility must en	azards/Supervision/Devices 1)(2) nts.	F 68	39		12/16/22
	§483.25(d)(2)Each supervision and assaccidents. This REQUIREMENT by: Based on observative the facility far appropriate water to below 120 degrees potential burns to review the facility far appropriate water to below 120 degrees potential burns to review the facility far appropriate water to below 120 degrees potential burns to review the facility far appropriate water to below 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 degrees potential burns to review the facility far appropriate water to be low 120 de	resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and record ailed to ensure safe, and emperatures were maintained Fahrenheit to prevent esidents residing in 15 of 36		 Additional outside company to inspect the hot water tank to has proper temperatures. All residents in the center ha potential to be affected. Correct was taken and outside companicalled to ensure proper hot wat temperatures. To ensure systemic changes all maintenance staff will be edithe correct procedure for monit water temperatures according to manufactures direction through of the GSS policy titled Water Temperatures on 11/28/22 by the 	ensure it ve the tive action y was er are made ucated on oring hot to the a review	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	` '	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 689	During tour of the fap.m., the water tem degree of Fahrenhe (1) R13's room wate (2) R45's room wate (3) R48's room wate (4) R42's room wate (5) R14's room wate (6) R41's room wate (6) R41's room wate (7) R41's room wate (8) R41's room wate (9) R41's room wate (10) R41's room wate (room water temperature was acility on 10/18/22, at 2:00 peratures were obtained in eit (F) in the following rooms: er temperature was 129.2 Fer temperature was 127.9 Fer temperature was 130.6 Fer temperature was 125.0 Fer temperature was 125.0 Fer temperature was 127.5 Fer temperature was 123.6 fer temperature was 124, Rand dobservation on 10/19/22, at ministrator and maintenance ms belonging to R24, R8 and	F 68	designee. If water temperatures a within appropriate range all nursis maintenance staff will be notified immediately. Maintenance will adwater heater and a recheck of the temperatures will be completed a water temperatures are within rared. Observation audits will be continued designee for 10 random resident regarding hot water temperature will be done weekly x 4 and every week x 2 and monthly x 1 to ensurate temperatures are within rared. Audit results will be brought to the QA meeting with appropriate folic indicated to ensure solutions are sustained. 5. Completion date: December 16	ng and just intil the lige. ducted by or or s Audits other lire hot lige. e monthly ow up		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245560	B. WING	ì		C 10/20/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 505 TROSKY ROAD WEST EDGERTON, MN 56128	IP CODE	IUIZUIZUZZ	
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F 689	Continued From pa	ge 21	F 6	389			
	temperatures on 10 following room water follows: (1) R48's room water (2) R28's room water (4) R41's room water (5) R1's room water (6) R8 and R35's room water (6) R8 and R35's room water (7) R2's room water (7) R2's room water (8) R45 room water (9) R45 room water (10) R45 room water						
	During interview on	10/20/22, at 8:34 a.m., NA-B					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPM TICIENCY)	BE	(X5) COMPLETION DATE
F 689	over the past month cold". To her knowle related to hot water know to check it" be potentially wash the residents into the be. During interview an 10/20/22, at 9:51 a. indicated they were of temperatures dais sheet than the norm indicated he did che 7:00 a.m. that morn water heater was to did not notify nursin. The administrator he the new water heater it was not installed unaware when it was installed. Review of provided by mainter through 10/19/22 contemperatures ranging. Three temperatures 10/12/22 were note 9/21/22 and 10/5/22 note to be adjusted sheet did not include temperature was chemperature was chemperature.	temperatures have fluctuated a being either "too hot or too edge, no resident had injuries temperatures. Staff "just efore residents would eit hands or before putting athtub. d document review on m., administrator and M-A performing routine monitoring lly, but it is on a separate hal weekly monitoring. M-A eck the water temperature at ing which was too high, so the grad down. M-A indicated he g staff of the hot water issue, ad an invoice dated 9/1/22 for er, but the administrator stated until "after that date" and was as reportedly to have been water temperature monitoring hance included dates 9/1/22 ompleted daily with water ng from 110 to 115 degrees F. on 9/21/22, 10/5/22 and d to be at 120 degrees F. On 2, the water temperatures was. The temperature monitoring e time or location the water necked. interview on 10/20/22, at hinistrator confirmed more perature monitoring and also a staff was imperative to f all residents.		389			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	typically had thinner with brief exposure temperatures was "residents may have limited their ability to recognize that the vithe potential to burriequired to produce degrees F for five nook 1 minute to catemperatures was to more frequently if consure a comfortable residents. Monitoring closest to and further source at least ween The recommended water at the point of 115 degrees F. Door should include the formulation of the specific location of the commended water at the point of 115 degrees formulation of the commended water at the point of 115 degrees formulation of the commended water at the point of 115 degrees formulation of the commended water at the point of 115 degrees formulation of the commended water at the point of 115 degrees formulation of 115 degrees fo	ed 2/2/2022 identified residents in skin so the risk of burns even to unsafe high water substantial". Additionally is medical conditions that to communicate or even water they are exposed to had in them. The exposure time is a third degree burn was 120 minutes. At 127 degrees, it use burns. Monitoring water to be done on a weekly basis or conditions were identified to be and safe environment for any was to include rooms the est away from the water kly per wing or water loop. It temperature range for hot for use, was between 100 and cumenting water temperatures following information: If the person taking the set the monitoring (for example: the monitoring)		98		12/16/22
F 698 SS=E	require dialysis rece with professional st comprehensive per the residents' goals	sure that residents who eive such services, consistent andards of practice, the son-centered care plan, and	F 6	98		12/16/22

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER EDGEBROOK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128					
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F 698	review, the facility for (R38) for potential of have a method of control facility to ensure control fa	dated 5/2/22, included R38 is related to end stage kidney to have no signs and lications related to dialysis. or and document for peripheral fa (increased pulse, increased essed systolic blood pressure, busness) or hypervolemia essure, lung crackles, hortness of breath). R38 ondays, Wednesday and lays at the dialysis health care of the property in the lication was noted to R38 ondays, Wednesday and lays at the dialysis health care of the lication was noted to R38's re to apply immediate		398	1. A post dialysis assessment was completed to ensure R38 is monito 2. All residents in the facility receividialysis have the potential to be afficerective action was taken and all licensed nurses were educated. 3. To ensure systemic changes are place, all licensed nurses will be econ the correct GSS policy and proceitled dialysis for monitoring post-dicare and procedure for proper communication to the dialysis facilit 11/28/22 by the DNS or designee. 4. Observation audits will be conduted Quality Assurance Coordinator designee for (R38) regarding post-monitoring and communication. Aube done weekly x 4 and every othe x 2 and monthly x 1 to ensure post-dialysis monitoring is properly and proper communication is being Audit results will be brought to the results are sustained. 5. Completion date: December 16,	red. ing ected. in ducated edure alysis dits will r week done given. monthly up		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		LE CONSTRUCTION	` ′	E SURVEY PLETED
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(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG			BE	(X5) COMPLETION DATE
F 698	6:18 p.m., R38 indication dialysis for 3 years facility. R38 shower in the left upper arm pads held on by tap and intact. R38 indicates the dressing generally takes it off staff will take it off of goes for his next tree. During an observation 3:25 p.m., R38 indicated nursing assistant (NR38 indicated nursing assistant (NR38 indicated nursing assistant of the dialysis port or complementary to the dialysis unit of the dialysis treatment of the dialysis unit of the dialysis treatment of the dialysis treatment of the dialysis manage the fistulation of the facility assessment was performed in the dialysis of the dial	and interview on 10/17/22, at cated he has been receiving ever since he moved into this d his port, which was located and had two 2x2' gauze be on his fistula which were dry cated the staff do not monitor sis site. He usually just any himself. R38 indicated he of the following day or dialysis other following day when he eatment. Sion and interview 10/18/22, at cated he removed his around 7:00 a.m., when the NA) took him to get his bath. In graff do not look at his plete any assessment when 10/19/22, 7:20 a.m., N)-A indicated they fax 2 as a pre-dialysis assessment on the morning R38 goes for ant. RN-A indicated when R38 k in with the nursing staff. In was to notify staff if he is graft the site or if there was any at the site or if there was any at the site or if there was no around a process to ensure an erformed, or communication ween facility staff and dialysis to assess himself. 10/19/22, at 9:14 a.m., RN-A		398			
	indicated they recei	ve post-dialysis reports via fax					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			` ′	(X3) DATE SURVEY COMPLETED C 10/20/2022	
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NAME OF PROVIDER OR SUPPLIER				STF	REET ADDRESS, CITY, STATE, ZIP CODE	107	LUILULL	
EDGEBROOK CARE CENTER					5 TROSKY ROAD WEST OGERTON, MN 56128			
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	they actually arrived there are any new of come from R38's modialysis facility. During interview on dietary personnel (It to send a renal reported the register contacted the dialysis and if they information but had after multiple attemnot adequate common the dialysis compared to a renal reported the register contacted the dialysis information but had after multiple attemnot adequate common the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the dialysis compared to a renal reported the register contacted the register contacted the register contacted the register contacted the received the receiv	nter but was unsure when d or were noted. RN-A added if orders, she felt they would nedical doctor and not the 10/19/22, at 10:13 a.m., DP)-A indicated dialysis used out card for R38 that included rk, weights before and after ran extra fluid offload. DP-A ered dietician (RD) had sis facility requesting not received a return call, pts. DP-A indicated there was nunication being received from	F 6	98	DEFICIENCY)			
	weights, vitals signs completed due to e R38 does come per dressing still on his expected it be removed by the facility after a	ab information, pre and post and if an extra run was xcess fluid. PCT-A indicated riodically with the previous fistula site. Dialysis nursing exed the evening post-dialysis assessing and monitoring his ly be removed. Dialysis						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER EDGEBROOK CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128			
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F 698	During interview on information manager last time they received from facility staff was information sent to electronic medical electronic medical during interview on the director of nurse received a post -dial an assessment was staff when R38 work treatment. The DO further into this. Further into this formation and the function of the footbally sister and the nurse post-dialysis. The footbally sister and the nurse post-dialysis assessing the footbally sister and the facility and dialysis wasn't a good method the facility and dialysis wasn't a good method the facility and dialysis wasn't and proceed "Dialysis Services" -Locations caring for services must have the provider of the services must have the se	a 10/19/22, at 9:56 a.m., health ement (HIM)-A indicated the wed the post-dialysis report as on 8/31/22. They scan any them into the resident's record. a 10/19/22, at at 10:41 a.m., ing (DON) was unsure if staff alysis report and was unsure if s completed by the nursing ald return from dialysis. N indicated she will check of the interview on 10/19/22, at a DON indicated the dialysis een sharing information DON confirmed they have not as did through his dialysis reatment and do not know how noved or what his current in was. The DON indicated staff re-dialysis assessment but ing was not completing a sment or monitoring upon. She further clarified there and of communication between yeis. Sure dated 9/17/21 titled included: or residents receiving dialysis an agreement in place with	F 6	98			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING	COMPLETED	
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F 698	Continued From pa	ge 28	F 6	98		
	dated 1/21/10 betwood Care/Pipestone Diales - Each party agreed party, in writing, any information pertiner nursing facility plan limited to, the areas agrees to make itse other party's staff wregarding the care treatment: -In addition to deverespect to each restreatment, provider staff in modifying an each such resident's care. Those areas to Provider shall furnish include but is not limited but is not limited but is not limited but in the appropriate competent Nursing CFR(s): 483.35 (a) (a) §483.35 Nursing Seath and practicable physical well-being of each in the appropriate comprovide nursing and practicable physical well-being of each in the appropriate comprovide of each in the appropriate comprovide nursing and practicable physical well-being of each in the appropriate comprovide of each in the approximate comprovide of each in the approximate compro	to timely furnish the other y and all dialysis-related of care, including but not so listed below. Each party also elf reasonably available to the who may have questions of resident's receiving dialysis aloping its own plan of care with ident/client receiving dialysis agrees to cooperate with LTC and maintaining as current, as skilled nursing facility plan of the LTC plan of care in which she direction to LTC facility shall mited to: Procedures for ad non-medical emergencies, ions, equipment failure and a case of emergencies; ervation and monitoring; onal needs and fluid ident education. Staff 3)(4)(c)	F 7	726		12/16/22

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F 726	diagnoses of the far accordance with the at §483.70(e). §483.35(a)(3) The flicensed nurses had and skill sets neces needs, as identified assessments, and for sidential to resident's needs. §483.35(a)(4) Provilimited to assessing implementing resident to resident's needs. §483.35(c) Proficie The facility must ento demonstrate contechniques necessaneeds, as identified assessments, and of the training of the facility from	e number, acuity and cility's resident population in e facility assessment required facility must ensure that we the specific competencies sary to care for residents' through resident described in the plan of care. Iding care includes but is not g, evaluating, planning and ent care plans and responding ent care plans and responding factors in the plan of care ables are ables are that nurse aides are ables and ary to care for residents'			e R38 is ceiving e affected. nd all d. s are made	
	of chronic kidney di R38's quarterly Min 9/13/22, included R	included a diagnosis sease and diabetes.		correct policy and procedure to for monitoring post-dialysis can 11/28/22 by the DNS or design 4. Audits will be conducted by Assurance Coordinator or design two random staff regarding contracts.	tled Dialysis re on nee. the Quality ignee for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	IPLE CONSTRUCTION IG	` '	E SURVEY PLETED
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F 726	needed hemodialys disease with a goal symptoms of compositions of compositions of compositions, highly and anxious (increased blood propositions) attended dialysis Mattended dialysis and wheeler oom. An unidentification in a curcompleted and the assessed after return dialysis for 3 years facility. R38 shower in the left upper arm pads held on by tapand intact. R38 indialysis for 3 years facility. R38 shower in the left upper arm pads held on by tapand intact. R38 indialysis for 3 years facility. R38 shower in the left upper arm pads held on by tapand intact. R38 indialysis for 3 years facility. R38 shower in the left upper arm pads held on by tapand intact. R38 indialysis for 3 years facility. R38 shower in the left upper arm pads held on by tapand intact. R38 indialysis for 3 years facility. R38 shower in the left upper arm pads held on by tapand intact. R38 indialysis for 3 years facility. R38 shower in the left upper arm pads held on by tapand intact. R38 indialysis for 3 years facility. R38 shower in the left upper arm pads held on by tapand intact. R38 indialysis for 3 years facility.	dated 5/2/22, included R38 is related to end stage kidney to have no signs and lications related to dialysis. or and document for peripheral a (increased pulse, increased used systolic blood pressure, busness) or hypervolemia essure, lung crackles, hortness of breath). R38 ondays, Wednesday and lays at the dialysis health care If bleeding was noted to R38's re to apply immediate or nurse. and interview on 10/17/22, at rned to the facility from d himself straight to the dining ed staff brought him his p. No vital signs were fistula was not visualized or rning from dialysis and interview on 10/17/22, at cated he has been receiving ever since he moved into this d his port, which was located in and had two 2x2' gauze be on his fistula which were dry cated the staff do not monitor is site. He usually just and himself. R38 indicated he if the following day or dialysis other following day when he	F 72	completion regarding post-dialysi monitoring and communication. A be done weekly x 4 and every off x 2 and monthly x 1 to ensure stateducation is completed on post-omonitoring and education. Audit will be brought to the monthly QA with appropriate follow up indicate ensure solutions are sustained. 5. Completion date: December 16	Audits will ner week off lialysis results meeting ed to	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	` ,	TE SURVEY MPLETED
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F 726	Continued From pa	age 31	F 7	26		
	During an observar 3:25 p.m., R38 indicated this morn nursing assistant (R38 indicated nursing assistant (R38 indicated nursing assistant (R38 indicated nursing interview or registered nurse (R5) forms which include to the dialysis treatment returns he will check RN-A indicated R3 having any bleeding trouble after dialys manage the fistula indication the facility assessment was provided was maintained be staff vs. rely on R3. During interview or indicated they recent from the dialysis continued they actually arrive there are any new come from R38's redialysis facility. During interview or dialysis facility.	tion and interview 10/18/22, at icated he removed his ing around 7:00 a.m., when the NA) took him to get his bath. ing staff do not look at his inplete any assessment when 10/19/22, 7:20 a.m., RN)-A indicated they fax 2 es a pre-dialysis assessment on the morning R38 goes for ent. RN-A indicated when R38 ck in with the nursing staff. 8 was to notify staff if he is g at the site or if there was any is. RN-A added R38 "likes to site himself". There was no ty had a process to ensure an erformed, or communication tween facility staff and dialysis 8 to assess himself. 10/19/22, at 9:14 a.m., RN-A ive post-dialysis reports via fax enter but was unsure when d or were noted. RN-A added if orders, she felt they would nedical doctor and not the		20		
	to send a renal reported the register contacted the dialy	ort card for R38 that included ork, weights before and after ran extra fluid offload. DP-A ered dietician (RD) had sis facility requesting not received a return call,				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		1 ` ′	TE SURVEY MPLETED
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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
after multiple attern not adequate committee dialysis compared to a dialysis compared to a dialysis care technician (PC indicated she work he received dialysis extra fluid onboard for dialysis to just phour dialysis run. Personal his post-dialysis the facility, but they in his bag when he visit. PCT-A indicate information to the fremoving it from his included pertinent I weights, vitals significated due to a R38 does come perdomested due to a R38 does come perdomested it be removed by the facility after site until it can safe patient's with venous expected it be removed information. During interview or information managal last time they receif from facility staff was information sent to electronic medical. During interview or the director of nurse director of nurse receipts and the director of nurse receipts	ipts. DP-A indicated there was nunication being received from my. 2/19/22, at 12:33 p.m., patient cT)-A from dialysis company ed with R38 frequently when and they will do an extra run will extra fluid off after his 4 cT-A indicated they used to sis sheet with R38 to give to requently found it remained returned for his next dialysis ed they now fax the acility since they weren't ab information, pre and post and if an extra run was excess fluid. PCT-A indicated riodically with the previous fistula site. Dialysis nursing oved the evening post-dialysis assessing and monitoring his elybe removed. Dialysis us catheters had different 10/19/22, at 9:56 a.m., health ement (HIM)-A indicated the ved the post-dialysis report as on 8/31/22. They scan any them into the resident's record.		26		
•	•				
•	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From parafter multiple atternot adequate commented to dialysis compare During interview 10 care technician (PC indicated she work he received dialysis extra fluid onboard for dialysis to just phour dialysis run. Proceed to dialysis run.	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	PROVIDER OR SUPPLIER OOK CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 32 after multiple attempts. 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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	(` '	E SURVEY PLETED
		245560	B. WING					C 20/2022
	PROVIDER OR SUPPLIER ROOK CARE CENTER SUMMARY STA	TEMENT OF DEFICIENCIES	ID	505	REET ADDRESS, CITY, STATE, ZIP CODE TROSKY ROAD WEST GERTON, MN 56128 PROVIDER'S PLAN OF CORRECT			(X5)
PRÉFIX TAG	`	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)			COMPLETION DATE
F 726	treatment. The DOI further into this. Fur 12:15 p.m., with the company has not be post-dialysis. The Dost-dialysis. The Dost-dialysis. The Dost-dialysis as return fluid was remarked the nursi post-dialysis assess return from dialysis wasn't a good meth the facility and dialy. A policy and proced "Dialysis Services" -Locations caring for services must have the provider of the services must have the provid	ald return from dialysis N indicated she will check of ther interview on 10/19/22, at a DON indicated the dialysis een sharing information DON confirmed they have no 38 did through his dialysis reatment and do not know how hoved or what his current in was. The DON indicated staff re-dialysis assessment but ing was not completing a sment or monitoring upon i. She further clarified there hod of communication between residents receiving dialysis is an agreement in place with increase an agreement in place with service. In agreement in place with service.		26				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	, ,	E SURVEY IPLETED
		245560	B. WING		10/	C / 20/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 812	treatment, provider staff in modifying areach such resident care. Those areas to Provider shall furnish include but is not limited but is not limi	ident/client receiving dialysis agrees to cooperate with LTC and maintaining as current, is skilled nursing facility plan of the LTC plan of care in which is direction to LTC facility shall mited to: Procedures for ad non-medical emergencies, ions, equipment failure and a case of emergencies; ervation and monitoring; onal needs and fluid ident education. Store/Prepare/Serve-Sanitary)(2) fety requirements. Sure food from sources ered satisfactory by federal, rities. In food items obtained directly is, subject to applicable State egulations. In second prohibit or prevent produce grown in facility compliance with applicable pod-handling practices. In solutions of the facility is not preclude residents ods not procured by the facility. The prepare is distribute and dance with professional	F8			12/16/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION VG	` '	E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 812	potential contaminated drinks were served during meal services the potential to effect breakfast in the din ICE MACHINE During initial tour of 10/17/22, at 12:55 printhe kitchen storage deposits present ale and along the right light was lite on the dietary manager (During interview of the dietary manager (During interview of the machine and DM in as they have experimantenance department (Scotsman) was converted department	or 1 ice machine to prevent ation and to ensure food and in a safe and sanitary manner in the dining room. This had ct 45 of 48 residents who ate ing room. The kitchen and interview on o.m., an ice machine located ge room had white, lumpy ong the lid of the ice container side of the machine. A yellow top of the machine. The M) indicated it is lime scale re the machine needs to be DM indicated maintenance has eeding to be cleaned. I ance documents on the ice dicated there will not be any senced turn over in the timent and it hasn't been	F 8	2. All residents in the center had potential to be affected. Correct was taken in which ice machinic cleaned along with a cleaning swas created. 3. To ensure systemic changes all maintenance staff, Dietary of Housekeeping director will be on the correct policy and procesice machines use and mainten maintaining and cleaning the idaccording to the manufactures on 11/28/22 4. Observation audits will be controlled to the Quality Assurance Coordined designee to ensure proper clear regarding ice machine maintenance is be properly completed. Audit resurbrought to the monthly QA mediappropriate follow up indicated solutions are sustained. 5. Completion date: December 1. All dietary staff were educated solutions are systemic changes all dietary staff will be educated. 3. To ensure systemic changes all dietary staff will be educated correct policy and procedure tit supply storage and GSS safe safe safe supply storage and GSS safe safe safe safe safe safe safe safe	ctive action e was schedule s are made director, and educated dure titled ance in ce machine direction and every to ensure eing lts will be eting with to ensure and every to ensure eing eting with to ensure	
	made. Review of manufac	ture's recommendations dated		pertaining to cut bananas on 15 the DNS or designee. 4. Observation audits will be constituted as the constitute of the		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	` '	E SURVEY PLETED
		245560	B. WING			C 20/2022
	PROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 05 TROSKY ROAD WEST DGERTON, MN 56128	•	2012022
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F 812	indicator light that is that the cleaning in does not stop the recease not stop the recease between draining as is designated by per and is dependent of push of the clean between draining as is designated by per and is dependent of push of the clean between draining as is designated by per and is dependent of push of the clean between draining as is designated by per and is dependent of the clean between drained out, the was inspected for loose Removal of the surfurnation of the su	added: All models have an switches on to inform the user terval has been reached. It machine from making ice. The athereservoir and refills it. ess is designed to use straight chine scale remover, added and refilling. The cleaning time erson running the clean cycle on cleaning need. A second outton starts the flush out ess should last at least 20 sh out the scale remover and the scale remover has been atter distributor must be a scale and cleaned if any. In property pump bracket and the sure those parts have been aver to the controller as a final anging ice making. In and interview 10/20/22, at inistrator and maintenance are ice machine. The yellow light achine and this was confirmed for. M-A confirmed there was a sit present on the ice machine asn't aware routine and to be completed on this cated he is unaware of the last oleted on the ice machine. In and interview 10/20/21 at inistrator and maintenance as it present on the ice machine asn't aware routine and this was confirmed to be completed on this cated he is unaware of the last oleted on the ice machine.	F 812	the Quality Assurance Coordinatesignee to ensure bananas are properly. Audits will be done we and every other week x 2 and not one ensure bananas are being proced. Audit results will be brother monthly QA meeting with a follow up indicated to ensure so sustained. 5. Completion date: December	e covered ekly x 4 nonthly x 1 operly ought to propriate blutions are	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		PLE CONSTRUCTION	· /	E SURVEY PLETED
		245560	B. WING	i			C 20/2022
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	10/	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	at 7:29 a.m. The councovered juice, containing an observation of the banana and left the place for another refor breakfast. No strincident. During an interview registered nurse (R previously seen restants and staff where was concern for containing an observation of the din ripeness and staff where was concern for containing an interview registered nurse (R previously seen restants on the din ripeness and staff where was concern for containing an interview registered nurse (R previously seen restants and staff where was concern for containing an interview registered nurse (R previously seen restants and staff where was concern for containing an interview registered nurse (R previously seen restants and staff where was concern for containing an interview registered nurse (R previously seen restants and staff where was concern for containing and staff where was contained and staff where was contained and staff where	ion and interview on 10/19/22, ok (CK) was observed placing ffee, water and tea orders and nds cut off, on all the tables in the 45 residents who ate ing room, only three residents es. The CK stated the drinks always placed on the tables they were not covered, there contamination from other isitors walking by. The CK was no policy requiring the d during dining service. ion on 10/19/22, at 7:33 a.m. self-propelling her wheelchair d table, picking up another and comparing the cut end to ecided she preferred her second banana at the preset esident who had not arrived yet aff were present during the on 10/20/22, at 10:46 a.m. N)-C stated she had idents pick up uncovered, cut ing tables to compare their would gladly switch out the re asked to. Although there ntamination, RN-C also stated sed changing the process with exitchen was in charge of		812			
	dietary director (DD	stated although drinks were dents entering the dining room,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	` ′	E SURVEY PLETED
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	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	10/2	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	room tray delivery. was no concern for from other residents reaching over the d however; a resident bananas that were would be a concern end of the bananas	ge 38 ired to be covered during The DD further stated there contamination of the drinks is or staff walking by or rinks. The DD stated, it picking up uncovered, cut intended for other residents is for contamination and the cut should have been covered. In food service was requested	F 8	812			

Minnesota Department of Health

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED
	00454	B. WING		C 10/20/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
EDGEBROOK CARE CENTER		SKY ROAD W ON, MN 5612		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
2 000 Initial Comments		2 000		
****ATTE	NTION*****			
NH LICENSING	CORRECTION ORDER			
144A.10, this correpursuant to a surve found that the defication are not corrected shall with a schedule of the Minnesota Deposition of watermination of watermination of watermination of the number and MN Rule When a rule contain	hether a violation has been compliance with all rule provided at the tagule number indicated below. ns several items, failure to			
lack of compliance re-inspection with a result in the assess	the items will be considered Lack of compliance upon Iny item of multi-part rule will Isment of a fine even if the item Uring the initial inspection was			
that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.			
licensing survey was your facility by surv Department of Hea found NOT in comp Licensure. The follo	TS: gh 10/20/22, a standard as conducted completed at eyors from the Minnesota Ith (MDH). Your facility was pliance with the MN State owing licensing orders were go 1, 0830, 1015, 1565, 1695, and			

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

(X6) DATE TITLE

Electronically Signed

11/18/22

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	` '	E SURVEY PLETED
		00454	B. WING			C 20/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, ST SKY ROAD WI ON, MN 56128	EST		
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2 000	Please indicate in y correction that you and identify the date. Minnesota Department the State Licensing Federal software. The assigned to Minnesota Department of Hearyou electronic State licensing Federal software. The appears in the far lead of the correction orders the findings which a statute after the state as evidence by." For findings are the Sugand Time Period for You have agreed to receipt of State licenthe Minnesota Department of Hearyou electronically, is necessary for State enter the word "CO available for text. You electronic State licenter the word "CO available for text. You	laints were found to be H5560041C (MN81781), ng orders were issued. our electronic plan of have reviewed these orders, e when they will be completed. eent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of the state tement, "This Rule is not met ollowing the surveyor's gested Method of Correction of Correction. participate in the electronic insure orders consistent with artment of Health in 14-01, available at eate.mn.us/divs/fpc/profinfo/infectionsing orders are				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		·			(X3) DATE S	
			7 5012510.		c	;
		00454	B. WING		10/2	0/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
EDGEBR	ROOK CARE CENTER		ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOLICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	the Minnesota Depa is enrolled in ePOC	o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 300	MN Rule 4658.0105	5 Competency	2 300			12/16/22
	are able to demons techniques necessa needs, as identified resident assessmen	ist ensure that direct care staff trate competency in skills and ary to care for residents' through the comprehensive nts and described in the n of care, and are able to ned duties.				
		ent is not met as evidenced				
	review, the facility	observation and document ailed ensure staff were ned to monitor 1 of 1 resident complications post-dialysis and ommunication with the dialysis nsistent continuity of care.		 A post dialysis assessment was completed to ensure R38 is monited. All residents in the facility received dialysis have the potential to be afformed and a licensed nurses were educated. To ensure systemic changes are 	ored. ving fected. II	
	Finding include:			place, all licensed nurses will be e on the correct GSS policy and pro-	ducated cedure	
		0/29/22, included a diagnosis sease and diabetes.		titled dialysis for monitoring post-d care and procedure for proper communication to the dialysis facil		
	9/13/22, included R	imum Data Set (MDS) dated 38 was cognitively intact, ctivities of daily living and on		11/28/22 by the DNS or designee. 4. Observation audits will be conditionated the Quality Assurance Coordinator	J	

Minnesota Department of Health

STATE FORM SFJX11 If continuation sheet 3 of 32

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE : COMPI	
		00454	B. WING		10/2	; 0/2022
					10/2	OIZUZZ
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDGEBR	ROOK CARE CENTER		SKY ROAD V DN, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
2 300	Continued From pa	ge 3	2 300			
2 300	dialysis. R38's plan of care of needed hemodialyst disease with a goal symptoms of complete symptoms of complete symptoms, decreased with a goal symptoms of complete symptoms, decreased blood proposed in the left upper armonal pads held on by tapand intact. R38 indications assess the dialyst removes the dressing generally takes it of the symptom of	dated 5/2/22, included R38 is related to end stage kidney to have no signs and lications related to dialysis. Or and document for peripheral ia (increased pulse, increased ased systolic blood pressure, busness) or hypervolemia ressure, lung crackles, hortness of breath). R38 ondays, Wednesday and lays at the dialysis health care of bleeding was noted to R38's re to apply immediate or nurse. and interview on 10/17/22, at rned to the facility from d himself straight to the dining red staff brought him his p. No vital signs were fistula was not visualized or rning from dialysis and interview on 10/17/22, at cated he has been receiving rever since he moved into this d his port, which was located in and had two 2x2' gauze re on his fistula which were dry cated the staff do not monitor ris site. He usually just ang himself. R38 indicated he fi the following day or dialysis other following day when he		designee for (R38) regarding post monitoring and communication. At be done weekly x 4 and every othe x 2 and monthly x 1 to ensure posmonitoring is properly done and promunication is being given. Auresults will be brought to the mont meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16	udits will er week t-dialysis oper dit hly QA	
	During an observati	ion and interview 10/18/22, at				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE	SURVEY	
		00454	B. WING			C 20/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W DN, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 300	bandage this morninursing assistant (NR38 indicated nursidialysis port or combe returns. During interview on registered nurse (Rforms which include to the dialysis unit of his dialysis treatmereturns he will check RN-A indicated R38 having any bleeding trouble after dialysis manage the fistula indication the facility assessment was pewas maintained between staff vs. rely on R38 During interview on	cated he removed his ng around 7:00 a.m., when the IA) took him to get his bath. ng staff do not look at his plete any assessment when 10/19/22, 7:20 a.m., N)-A indicated they fax 2 as a pre-dialysis assessment on the morning R38 goes for nt. RN-A indicated when R38 k in with the nursing staff. It was to notify staff if he is get the site or if there was any so. RN-A added R38 "likes to site himself". There was no y had a process to ensure an erformed, or communication ween facility staff and dialysis It o assess himself. 10/19/22, at 9:14 a.m., RN-A	2 300	DEFICIENCY)		
	from the dialysis ce they actually arrived there are any new come from R38's many dialysis facility. During interview on	nter but was unsure when or were noted. RN-A added if orders, she felt they would edical doctor and not the				
	to send a renal report most recent lab work dialysis and if they reported the register contacted the dialys information but had after multiple attem	OP)-A indicated dialysis used out card for R38 that included the weights before and after an extra fluid offload. DP-A red dietician (RD) had sis facility requesting not received a return call, pts. DP-A indicated there was nunication being received from				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE COMP	SURVEY		
		00454	B. WING		10/2	2 <mark>0/2022</mark>
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S SKY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 300	care technician (PC indicated she worked he received dialysis extra fluid onboard for dialysis to just phour dialysis run. Persend his post-dialys the facility, but they in his bag when he visit. PCT-A indicate information to the facility after a weights, vitals signs completed due to expected it be removed by the facility after a site until it can safe patient's with venous expectations. During interview on information manager last time they received a post-dial received a post-dial an assessment was staff when R38 woult treatment. The DON	All 19/22, at 12:33 p.m., patient at 17)-A from dialysis company and with R38 frequently when and they will do an extra run all extra fluid off after his 4 ct. A indicated they used to a sheet with R38 to give to a frequently found it remained are turned for his next dialysis and they now fax the acility since they weren't are information, pre and post and if an extra run was access fluid. PCT-A indicated a fiodically with the previous and if an extra run was access fluid. PCT-A indicated a fiodically with the previous and if an extra run was access fluid. PCT-A indicated a fiodically with the previous and if an extra run was access fluid. PCT-A indicated a fiodically with the previous and if an extra run was access fluid. PCT-A indicated a fiodically with the previous and if an extra run was access fluid. PCT-A indicated a fiodically with the previous and monitoring his assessing and monitoring his as	2 300			

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION	COMPLETED	
		00454	B. WING		10/2	; 0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	OOK CARE CENTER	505 TROS	KY ROAD W	/EST		
			ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 300	Continued From pa	ge 6	2 300			
	company has not be post-dialysis. The Dialysis. The Dialysis are treatment or post-treatment or post-treatment information are completing a proconfirmed the nursi post-dialysis assess return from dialysis.	een sharing information ON confirmed they have no 38 did through his dialysis eatment and do not know how oved or what his current was. The DON indicated staff e-dialysis assessment but ng was not completing a sment or monitoring upon She further clarified there od of communication between sis.				
	"Dialysis Services" -Locations caring for services must have the provider of the services available in electron	r residents receiving dialysis an agreement in place with				
	dated 1/21/10 betwee Care/Pipestone Dia -Each party agreed party, in writing, any information pertiner nursing facility plan limited to, the areas agrees to make itse other party's staff wregarding the care of treatment: -In addition to developed the treatment of the party of the care of the treatment of the t	enewing dialysis contract een the facility and Total Renal lysis included: to timely furnish the other and all dialysis-related at to a resident's skilled of care, including but not listed below. Each party also elf reasonably available to the ho may have questions of resident's receiving dialysis oping its own plan of care with ident/client receiving dialysis agrees to cooperate with LTC and maintaining as current, s skilled nursing facility plan of				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				c	;
	00454	B. WING		10/2	0/2022
NAME OF PROVIDER OR SUPPLIER EDGEBROOK CARE CENTER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
Provider shall furn include but is not lib handing medical a including complicate provider contact in follow-up care, obstantions; nutrit restrictions and restrictions and restrictions and restrictions and restrictions and implementated to nursing appropriate training. The administrator oversight is provide competency and on yearly, and as need designee, should reand procedures are and monitoring conthese policies, with brought to the facilic Committee for review the need for further	the LTC plan of care in which sh direction to LTC facility shall mited to: Procedures for and non-medical emergencies, tions, equipment failure and a case of emergencies; servation and monitoring; ional needs and fluid sident education. THOD OF CORRECTION: The esignee could develop and/or ent policies and procedures oversight and implement an group program for nursing staff. For designee should ensure ed to ensure appropriate rientation is provided upon hire, ded. The director of nursing or e-educate staff on the policies and have a system for evaluating asistent implementation of a results of those audits being ity's Quality Assurance ew to determine compliance or				
2 565 MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			12/16/22
•	omprehensive plan of care Il personnel involved in the t.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED
	00454	B. WING		C 10/20/2022
NAME OF PROVIDER OR SUPPLIEDGEBROOK CARE CENT	505 TRO	DDRESS, CITY,	STATE, ZIP CODE VEST	•
LDGLBROOK CARL CLN1	EDGERT	ON, MN 561	28	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
2 565 Continued From	page 8	2 565		
by: Based on intervifacility failed to decomprehensive of (R15) on a Contil (CPAP) machine assist with breat of not breathing) Findings include R15's admission 8/9/22, indicated diagnoses that in pulmonary diseas inflammatory lun COVID-19, occluthe carotid artery fibrillation (irregulincreased risk to rhinitis (inflammater required extensited dressing, toiletin R15's care area 7/26/22, lacked a respiratory conceequipment included uring sleep hour machine at night R15's care plan a limited physical revidenced by we with exertion. R1 disturbance relatincluded adjusting sleep hour machine at night revidenced by we with exertion. R1 disturbance relatincluded adjusting sleep hour machine at night revidenced by we with exertion. R1 disturbance relatincluded adjusting sleep hour machine at night revidenced by we with exertion. R1 disturbance relatingly sleep hour machine at night revidenced by we with exertion. R1 disturbance relatingly sleep hour machine at night revidenced by we with exertion. R1 disturbance relatingly sleep hour machine at night revidenced by we with exertion. R1 disturbance relatingly sleep hour machine at night revidenced adjustingly sleep hour machine at night revidenced by we with exertion. R1 disturbance relatingly sleep hour machine at night revidenced adjustingly sleep hour machine at night revidenced by we with exertion.	Minimum Data Set (MDS) dated R15 had intact cognition with icluded chronic obstructive se (COPD, a chronic g disease), pneumonia, ision and stenosis (hardening) of a, insomnia, obesity, atrial lar heartbeat causing an form blood clots) and chronic ation of the nasal passages). R15 we assistance of one staff for g, and personal hygiene. assessment (CAA) dated any indication that R15 had erns and required respiratory ling oxygen or a CPAP used rs to assist with breathing		1. Based on provider order and R request the CPAP has been disco 2. All residents with a CPAP mach the potential to be affected. Corre action was taken and licensed nurwere educated. 3. To ensure systemic changes an all licensed nurses will be educate comprehensive care plan and carronferences policy and procedure proper documentation regarding a machines within the care plan on by the DNS or designee. 4. No resident has a CPAP curren Observation. Any new resident with CPAP, weekly random audits will initiated for 2 months to ensure acassessment and care planning is completed. Audit results will be brothe monthly QA meeting with approfollow up indicated to ensure solutions sustained. 5. Completion date: December 16	intinued. nine have ctive rses re made ed on e e for a CPAP 11/28/22 Itly for th a be ccurate rought to ropriate tions are

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		(X3) DATE COMP	SURVEY LETED	
		00454	B. WING	_	10/2) 0/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	disrupt sleep. R15's indication or interver CPAP machine. The instructions for the CPAP machine including an interview registered nurse (R what care areas wo had not reviewed R also stated R15's us interventions should plan to ensure staff. During an interview director of nursing (unaware R15's care the proper use of R The DON also state including herself an and update resident. A facility policy for of SUGGESTED MET The director of nursing review and revise pensure a comprehe and implemented in the director of nursing system to educate monitoring system to eare as directed by	decreasing sounds that care plan lacked any ntions for the use of R15's e care plan also lacked proper operation of R15's uding the use of distilled on 10/20/22 at 12:39 p.m., N)-C stated she did not know uld trigger on a CAA and she 15's care plan recently. RN-C se of a CPAP with appropriate have been listed on his care were aware of it's proper use. on 10/20/22 at 2:06 p.m., the DON) stated she was e plan lacked an intervention 15's CPAP and should have. Set the management team, d RN- Sarah, would review	2 565			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
·	.		A. BUILDING:				
		00454	B. WING			C 10/20/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, §	STATE, ZIP CODE			
EDGEBR	ROOK CARE CENTER		SKY ROAD W ON, MN 5612				
240 15			1			0.45	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 10	2 830				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			12/16/22	
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensity of the comprehensity of the comprehensive as designed.	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident in bed.					
	Based on observation review, the facility farmedical supplies to a Continuous Position (CPAP- used during breathing) that requaddition, the facility were administered standards of practicing guidelines for 1 of 1 eye drop administration. Findings include: R15's admission Mit 8/9/22, indicated R1 diagnoses that included pulmonary disease.	inimum Data Set (MDS) dated 15 had intact cognition with uded chronic obstructive		 Based on provider order and R1 request the CPAP has been discored. All residents at the center using have the potential to be affected. Corrective action was taken and notaff were educated. To ensure systemic changes are all licensed nurses, TMAs, CNAs we educated on the correct procedure utilizing proper medical supplies for machines according to the manufaction through a review of the non-invasive respiratory policy and procedure on 11/28/22 by the DNS designee. No resident has a CPAP current Observation. Any new resident with CPAP, weekly random audits will be initiated for 2 months to ensure contact. 	ntinued. a CPAP ursing e made will be a for cr CPAP actures d s or tly for th a be		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		00454	B. WING		C 10/20	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EDOEDE		505 TROS	KY ROAD V	VEST		
EDGEBR	ROOK CARE CENTER	EDGERTO	ON, MN 561	28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCED)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	the carotid artery, in fibrillation (irregular increased risk of bloom (inflammation of the required extensive dressing, toileting, and the standard standar	on and stenosis (hardening) of asomnia, obesity, atrial heartbeat causing an ood clots) and chronic rhinitis nasal passages). R15 assistance of one staff for and personal hygiene.		procedure for utilizing proper med supplies for CPAP machines is us results will be brought to the mont meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16	ed. Audit hly QA	
	7/26/22, lacked any respiratory concern	sessment (CAA) dated indication that R15 had sor required respiratory oxygen or a CPAP machine		 A competency will be completed ensure R14 eye drops are administ accordance to medication administ policy. All residents in the center received. 	stered in stration	
	limited physical modevidenced by weak with exertion. R15 with disturbance related included adjusting the ventilation to promode and pen lights, and disrupt sleep. R15's indication or intervence CPAP machine. The	ed 8/12/22, indicated R15 had bility related to pneumonia as ness and shortness of breath was also at risk for sleep to insomnia. Interventions he room temperature and the sleep, use of amber lighting decreasing sounds that a care plan lacked any entions for the use of R15's the care plan also lacked proper operation of R15's		drops have the potential to be affective action was taken and a licensed nurses and TMA is were educated. 3. To ensure systemic changes and Ilicensed nurses and TMAs will educated on the proper procedure storing and administering eye drop according to the manufactures directly through a review of the Medication administration policy on 11/28/22 to DNS or designee.	e made be for ection	
	CPAP machine inclin the machine. R15's physician ord R15 was on oxygen and as needed for indication that R15 R15's Treatment R6 September 2022 inclining the from 8/15/22,	ers dated 9/7/22, indicated 4 liters per minute at bedtime COPD. The orders lacked was on CPAP. ecord (TAR) dated August, dicated R15 used CPAP every to 9/30/22. R15's TAR dated ated staff documented R15 follows:		 4. Observation audits will be conditated the Quality Assurance Coordinator designee for (R14) and (2) other residents regarding eye drop administration. Audits will be done x 4 and every other week x 2 and x 1 to ensure eye drops are being given. Audit results will be brought monthly QA meeting with appropriation follow up indicated to ensure solut sustained. 5. Completion date: December 16 	r or andom weekly monthly properly to the ate ions are	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP		SURVEY		
		00454	B. WING		10/2	C 2 0/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	R15's progress note-10/5/22, "No distille [family]" in AM10/7/22, "No distille (family)"10/8/22, "No distille (family)"10/9/22, "Nasal caper no distilled H20-10/10/22 to 10/17/2 any progress notes-10/18/22, "CPAP of During an observat at 1:25 p.m. an unla orange lid was obseroom. R15 stated the water, therefore; fait bringing it in for the machine since his amonths ago. During an interview FM-A stated R15's brought to the facility 2022. FM-A stated be a short-term resthought it was their water. FM-A stated CPAP machine and store, then pour half jug for R15 to use it FM-A further stated notifying him that R	ress notes" (below) 7, "see progress notes" (below) 722, "applied" res indicated the following: red water available, will contact red water, [family] contacted". red water received from red nula O2 on instead of CPAP ". 22, staff failed to document regarding R15's CPAP use.	2 830			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED	
		00454	B. WING		10/2) 20/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
2 830	CPAP required distitused was in a recycland RN-B assumed FM-A had been "take machine water since facility and because R15 knew what was RN-B was not concof water being used indicated 6 1-gallon water were ordered indication the facility water upon admissional During an interview RN-D stated she was not know who order RN-D stated when facility in June 2022 the distilled water for the family needed to had been using the in the unlabeled jugifacility. RN-D assumed and nutrition dordered distilled was staff reported it was or their family should DD stated although machine she did not until an unknown nuwater. The DM there distilled water on 10 the following day, he in the following day.	N)-B verified, although R15's lled water the water being cled jug, that was unlabeled, it to be distilled. RN-B stated sing care" of R15's CPAP e R15 was admitted to the R15 had intact cognition, a going on and therefore, erned about the unlabeled jug.	2 830			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
		00454	B. WING		10/2	20/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	further stated she was been supplying it. Tabout the unlabeled R15's CPAP, stating involved" and knew During an interview the DD stated she sprevious day and was CPAP was dispensed grocery store and control of the DM stated ther increased bacterial water was not being machine. R14's quarterly minimidicated R14 had restensive assistant hygiene and was included and was included R14 had restensive assistant hygiene and was included R14 received Carbot (Optive) ophthalmic times a day. R14's physician ord R14 received Carbot (Optive) ophthalmic times a day. During an observation of R14 her head back and into the inside, botto allowing the eye droeyes.	yare it was available. The DD yas unaware the family had he DD was not concerned I jug of water being used for go the family was "very what they were doing. on 10/19/22, at 10:33 a.m. spoke to R15's girlfriend the as told the water for R15's ed from a machine at the ould not verify it was distilled. It would be a concern for leading to infection if distilled go used in R15's CPAP imum data set dated 8/9/22, no cognitive deficits, required the end decreased movement of the end decreased movement. It is a dated 6/15/20, indicated by the end decreased movement of the end of the eyes. R14 was unable to tilt RN-B placed the eye dropper of the eyes. R14 was unable to tilt RN-B placed the eye dropper of the eyes. R14 was unable to tilt RN-B placed the eye dropper of the eyes. R14 was unable to tilt RN-B placed the eye dropper of the eyes. R14 was unable to tilt RN-B placed the eye dropper of the eyes. R14 was unable to tilt RN-B placed the eye dropper of the eyes. R14 was unable to tilt RN-B placed the eye dropper of the eyes. R14 was unable to tilt RN-B placed the eyes dropper of the eyes. R14 was unable to tilt RN-B placed the eyes dropper of the eyes.				
	RN-B stated she pr	eferred to administer eye				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00454	B. WING		10/2) 2 0/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	lying in bed if possil were often already would often administ drops during meals should have been a drop in the bottom touching the eye tis eye surface evenly the eye dropper. During an interview RN-C stated eye dresident's eye or the administration to avidropper or infecting. During an interview director of nursing (follow the manufact R15's CPAP machin DON was unaware supplying the water potential bacterial green being used. The DOS should have been so the DON also state touch the eye or surcontamination of the infection. The facility Non-inversion policy dated 5/3/22, effective treatment hypercapnic (chron dioxide) COPD resion CPAP as continuous is titrated to blow as keep air passages of the possible pas	n their room while they were ble, however; the residents in the dining room so RN-B ster medications including eye. RN-B stated R14's eye drops idministered by placing one eye lid mucosa without sue to ensure it covers the and to avoid contamination of on 10/20/22, at 10:46 a.m. oppers should not touch a e surrounding tissue during roid contaminating the eye				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00454	B. WING		10/2) 0/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	10/2	0/2022
EDGEBR	OOK CARE CENTER		KY ROAD W			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	The policy lacked in humidified oxygen of the CPAP machine. The facility Oxygen Types policy dated required for administ oxygen concentration manner, included: In the policy further in bottle, if ordered, wifilled adequately at the facility Medicat Scheduling and Me 8/24/22, indicated in administered correct SUGGESTED MET The Director of Nurpolicies and proced implement measure necessary medical medications appropor designee, could competensies for redelivery and medications appropriately appr	a resident will stop breathing). Istructions on the use of or distilled water when using Administration, Safety, Mask 6/29/22, indicated equipment stering various levels of on and/or humidity in a safe numidifier with distilled water. Istructed to fill the humidifier ith distilled water and keep all times. Ion: Administration Including dication Aides policy dated nedication was to be only and effectively. HOD OF CORRECTION: sing or designee could review ures, train staff, and es to ensure staff are providing supplies and administering oriately. The director of nursing conduct audits of staff espiratory equipment, oxygen ation administration. The lits chould be reviewed with compliance or the need for	2 830			
21015	(21) days.	Subp. 7 Dietary Staff	21015			12/16/22
	•	conditions. Sanitary				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
		00454	B. WING		C 10/20	/2022
	PROVIDER OR SUPPLIER	505 TROS	ORESS, CITY, KY ROAD V ON, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPORTION (CROSS-REFERENCE))	D BE	(X5) COMPLETE DATE
21015	the operation of the times. This MN Requirement	ge 17 Inditions must be maintained in dietary department at all ent is not met as evidenced	21015			
	by: Based on observation failed to maintain 1 potential contaminated drinks were served during meal services the potential to effect breakfast in the dinference of 10/17/22, at 12:55 printhe kitchen storage deposits present all and along the right light was lite on the dietary manager (Douild up and is awardleaned routinely. It been notified of it not need to be a storage of the machine and DM in as they have experimated and the particular of the potential of t	on and interview, the facility or 1 ice machine to prevent tion and to ensure food and in a safe and sanitary manner in the dining room. This had ct 45 of 48 residents who ate ing room. The kitchen and interview on o.m., an ice machine located ge room had white, lumpy ong the lid of the ice container side of the machine. A yellow top of the machine. The M) indicated it is lime scale re the machine needs to be DM indicated maintenance has eeding to be cleaned. In ance documents on the ice dicated there will not be any enced turn over in the timent and it hasn't been		 Ice machine was cleaned. All residents in the center have potential to be affected. Corrective was taken in which ice machine w cleaned along with a cleaning schewas created. To ensure systemic changes are all maintenance staff, Dietary directly directly directly and procedure timachines use and maintenance in maintaining and cleaning the ice machines use and maintenance in maintaining and cleaning the ice machine quality Assurance Coordinator designee to ensure proper cleaning regarding ice machine maintenance Audits will be done weekly x 4 and other week x 2 and monthly x 1 to ice machine maintenance is being properly completed. Audit results who brought to the monthly QA meeting appropriate follow up indicated to solutions are sustained. Completion date: December 16 	e action as edule e made ctor, and cated on tled ice nachine ection ucted by r or g ce. I every ensure will be g with ensure	
	who indicated main minimum every 6 m depends on water of water the machine s	ntacted and spoke with SD-A tenance is required at a nonths but stated it also uality. If facility has hard should be cleaned every 3-4 cated a yellow indicator light		 All dietary staff were educated. All residents in the center have potential to be affected. Corrective was taken and all dietary staff and educated. 	action	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE S	
		00454	B. WING		10/2	; 0/2022
					10/2	0/2022
NAIVIE OF I	PROVIDER OR SUPPLIER		KY ROAD W	STATE, ZIP CODE		
EDGEBR	ROOK CARE CENTER		ON, MN 5612			
(VA) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE	COMPLETE DATE
21015	Continued From pa	ge 18	21015			
	will turn on when claindicated if white so outside of the mach machine which can made. Review of manufact January 2015, incluindicator light that is that the cleaning into does not stop the modes not stop the modes and is dependent on push of the clean by periodesis. This procominutes to fully flust loose scale. After the drained out, the was inspected for loose Removal of the sun curtain is next to be cleaned. Cycle power step before restarting During observation 9:48 a.m., the admit (M)-A observed the remained on the material power indicated he was maintenance needed machine. M-A indicated indicated he was maintenance needed machine. M-A indicated indicat	eaning is required. SD-A saling substance is on the nine, it is also on the inside of contaminate the ice being ture's recommendations dated ded: All models have an witches on to inform the user serval has been reached. It nachine from making ice. The the reservoir and refills it. as is designed to use straight hine scale remover, added not refilling. The cleaning time rson running the clean cycle in cleaning need. A second autton starts the flush out less should last at least 20 h out the scale remover has been the distributor must be scale and cleaned if any. In property pump bracket and a sure those parts have been were to the controller as a final night ice making. and interview 10/20/22, at nistrator and maintenance ice machine. The yellow light achine and this was confirmed the machine in the ice machine.		3. To ensure systemic changes and all dietary staff will be educated on correct policy and procedure titled supply storage and GSS safe serv pertaining to cut bananas on 11/28 the DNS or designee. 4. Observation audits will be conditing the Quality Assurance Coordinator designee to ensure bananas are oproperly. Audits will be done week and every other week x 2 and mor to ensure bananas are being propic completed. Audit results will be brothe monthly QA meeting with approfollow up indicated to ensure solut sustained. 5. Completion date: December 16	the food- e policy 3/22 by ucted by or or overed ly x 4 athly x 1 erly ought to opriate ions are	
	DRINKS					

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Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		00454	B. WING			C 20/2022	
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21015	9/20/22, indicated F and required extens with all activities of supervision of one superv	inimum Data Set (MDS) dated R39 had mild cognitive deficits sive assistance of one staff daily living (ADLs) and					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00454	B. WING		10/2) 0/2022
NAME OF PROVIDER OR SUPPLIER EDGEBROOK CARE CENTE	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612			
PREFIX (EACH DEFICIENCE)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21015 Continued From p	age 20	21015			
dietary director (Diserved prior to restrict they were only rectrom tray delivery was no concern for from other resider reaching over the however; a resider bananas that were would be a concerned of the bananas	on 10/19/22, at 11:05 a.m. the D) stated although drinks were idents entering the dining room, uired to be covered during. The DD further stated there or contamination of the drinks ats or staff walking by or drinks. The DD stated, at picking up uncovered, cut intended for other residents on for contamination and the cut is should have been covered.				
The dietary manager, administrator coulable. The policies and proceed these changes and dietary manager, administrator coulaudit findings to the Performance Improved.	THOD OF CORRECTION: ger, registered dietician, or ld ensure appropriate safe and nd service of food items in the facility could update or create dures and educate staff on d perform competencies. The registered dietician, or d perform audits and report le Quality Assurance rovement (QAPI) for further or to determine compliance.				
TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21565 MN Rule 4658.13 Medications Self	25 Subp. 4 Administration of Admin	21565			12/16/22
self-administer me	ninistration. A resident may edications if the comprehensive ent and comprehensive plan of				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION :	(X3) DATE S COMPL	
		00454	B. WING		10/2	; 0/2022
					10/2	OIZUZZ
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDGEBR	ROOK CARE CENTER		KY ROAD V			
		EDGERTO	DN, MN 561	28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 21	21565			
	4658.0405 indicate is a written order from	parts 4658.0400 and this practice is safe and there om the attending physician.				
	Based on observation review, the facility for (R32 and R39) observations at their dining tables approved to be ablest approved to be ablest medications. Findings include: R32's quarterly Min 9/6/22, indicated R3 and required extensions dressing, personal independent for eatincluded dementia, gastro-esophageal	ent is not met as evidenced on, interview, and document ailed to ensure 2 of 2 residents erved to have medications left is were assessed and it to safely self-administer imum Data Set (MDS) dated 32 had mild cognitive deficits sive assistance of one staff for hygiene, and toileting and was ting. R32 had diagnoses that renal failure, reflux (GERD), and v functioning thyroid).		1. Assessment for self-administrate completed to ensure R32 and R39 safe to self-administer medication 2. All residents at the center who self-administer medication have the potential to be affected. Corrective was taken and assessments have reviewed and are appropriate. 3. To ensure systemic changes and Il licensed nurses and TMAs will educated on the medication administrated policy and procedure for administrated policy and procedure for administrated policy and procedure for administration and 11/28/22. 4. Observation audits will be conducted the Quality Assurance Coordinator designed for (R32) and R320	e made be nistration ering Care dication ucted by r or	
	impaired cognitive to memory loss. Intervand documenting a decision making about general awareness cardiovascular state R32 also had an acceptance of the deficit related to deficit related to design the deficit related to design the design that design the design the design to design the design that design the	• •		designee for (R32 and R39) and (a random residents regarding self-administer medication administer weekly x 4 and other week x 2 and monthly x 1 to medication is being properly given self-administer medication assess are completed. Audit results will be brought to the monthly QA meeting appropriate follow up indicated to solutions are sustained. 5. Completion date: December 16	stration. I every ensure and ments e g with ensure	
	R32's morning med	lers dated 10/20/22, indicated lications included: igrams (mg) for high blood				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00454	B. WING		10/2) 0/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21565	-Pantoprazole 20 mg -Lisinopril 20 mg for -Oxybutynin 2.5 mg -Levothyroxine 50 mg hypothyroidism -Furosemide 20 mg R32's physician ord self-administration for self-administration for self-Administration During an observation medication cup with observed on the direct was not known how been there and no more room. After an unid water from the dinimited began taking her medications at her for staff present in the were taken safely and the staff would walk wanted. During an interview registered nurse (Ruliked to take their mathematication form filled leave the medication form filled leave the medication form filled leave the medication.	gth 1000 mg for pain g for GERD high blood pressure for bladder hyperactivity nicrograms (mcg) for (a diuretic for water retention) ers lacked an order for for any medications. Indicated a of Medication assessment. Indicated a multiple medications was a multiple medications was a multiple medications had nursing staff was in the dining entified tablemate got a cup of a kitchenette for R32, R32 edications with no nursing dining room to ensure they				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00454	B. WING		10/2) 20/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	1 1 1 1	0,2022
		505 TROS	KY ROAD W			
EDGEB	ROOK CARE CENTER	EDGERTO	ON, MN 5612	28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 23	21565			
21565	completed. RN-B stated she liked to a medications but some director of nursing (had an evaluation a self-administer medicated take their them on a table unated a self-administer medicated a self-administer medicated (IDT) determined it was document plan, and a physicial policy also indicated table unless there we to do so and the resident staff must be do so, the staff must be do so, the staff must be do so, the staff must be do so.	tated they have had residents ations in the past. RN-B further watch the residents take their me "just take a while". on 10/20/22, at 2:17 p.m. the DON) stated unless a resident and physician order to dications, staff should observe medications and not leave attended. ion: Administration Including dication Aides policy dated a resident had the right to dication if the interdisciplinary ned it was safe for the resident attended in the resident's care and not leave medications at a was a specific physician order sident had been evaluated for a lf the resident had not been self-administration of the was not a physician order to st stay with the resident until				
	the resident swallov	ken and they have observed v.				
	Medication policy day must complete a Se Medications UDA to could safely administ would determine if t education or accomp self-administer medication would b medication would b	•				

Minnesota Department of Health

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU	IMBED:	IPLE CONSTRUCTION NG:	(X3) DATE COMP	SURVEY
		D WING			2
	00454	B. WING _		10/2	20/2022
NAME OF PROVIDER OR SUP	PLIER	STREET ADDRESS, CIT			
EDGEBROOK CARE CE	NTER	505 TROSKY ROAL EDGERTON, MN 5			
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY OR LSC IDENTIFYING INFORM	Y FULL PREFIX	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21565 Continued Fro	m page 24	21565			
would docume self-administrator order must be must indicate self-administe so would be resignificant characteristic administrator, designee coul administration evidence base staff could be importance of administering quarterly, annotation resident's phy Nursing staff ophysician's or nurse/medicate The DON or designed for further the policy of the pol	Int their determination of ation on the UDA and a place obtained. The resident's the resident is safe to medication and their above valuated quarterly or wange assessment. METHOD OF CORRECT director of nursing (DON direview and revise policity of medication according directors of nursing (DON direview and revise policity of medication according directors and the resident is designed as necessary to their own medications initially, or with a change to sical or mental ability to discal a could also ensure there is ler in place, prior to a sion aide administering measignee, could audit any/lical records, to ensure cate medication administrative compliance and determine compliance and determine compliance and determine the compliance and determined the compliance	hysician's care plan ility to do with any TION: The or ies for self to hursing the capable of tially, a lo so. It is a lo so is a lo s			
21695 MN Rule 4658 Housekeeping	.1415 Subp. 4 Plant , Operation, & Maintenar	21695 nce			12/16/22
provide house necessary to comfortable in	sekeeping. A nursing hokeeping and maintenanch naintain a clean, orderly, terior, including walls, flo ers, fixtures, equipment,	e services and oors,			

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B. WING		C 10/20/2022
		10/20/2022
RESS, CITY, S	STATE, ZIP CODE	
N, MN 5612	28	
ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
21695		
	2. All residents at the center have potential to be affected by the deficiency practice. Corrective action was take vents were cleaned along with a cleaning with a cleaning changes are all maintenance and housekeeping will be educated on standard of ligicleaning policy and procedure for maintaining and cleaning the vents according to the manufactures dire on 11/28/2022 by the DNS or designed 4. Observation audits will be conducted the Quality Assurance Coordinator designee 10 random residents register vent is properly cleaned. Aud be done weekly x 4 and every other x 2 and monthly x 1 to ensure vent cleaning is being properly completed Audit results will be brought to the QA meeting with appropriate followindicated to ensure solutions are sustained.	the ciency en, and eaning made staff ht section gnee. ucted by or arding if its will er week ed. monthly v up
F < N	RESS, CITY, S Y ROAD W I, MN 5612 ID PREFIX TAG	PRESS, CITY, STATE, ZIP CODE TY ROAD WEST I, MN 56128 ID PREFIX TAG 1. All affected vents were cleaned 10/24/22. 2. All residents at the center have potential to be affected by the defic practice. Corrective action was tak vents were cleaned along with a cl schedule created. 3. To ensure systemic changes are all maintenance and housekeeping will be educated on standard of lig cleaning policy and procedure for maintaining and cleaning the vents according to the manufactures dire on 11/28/2022 by the DNS or desig 4. Observation audits will be conducted the Quality Assurance Coordinator designee 10 random residents reg their vent is properly cleaned. Audit be done weekly x 4 and every other x 2 and monthly x 1 to ensure vent cleaning is being properly completed Audit results will be brought to the QA meeting with appropriate follow indicated to ensure solutions are

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00454 B. WING 10/20/202	22
	-
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
EDGEBROOK CARE CENTER 505 TROSKY ROAD WEST EDGERTON, MN 56128	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	X5) PLETE ATE
21695 Continued From page 26 21695	
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.	
MN Rule 4658.1415 Subp. 7 Plant 21710 Housekeeping, Operation, & Maintenance	6/22
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 1. Additional outside company was called	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
		00454	B. WING		C 10/20/2022	
			DDEGG GITY	0.TA.TE ZID 0.0DE	10/20/2022	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EDGEBR	ROOK CARE CENTER		SKY ROAD V DN, MN 561			
(V.A) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	<u>, </u>	PROVIDER'S PLAN OF CORRECTION)NI (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLET	
21710	Continued From pa	ge 27	21710			
	review the facility far appropriate water to below 120 degrees potential burns to recome observed in potential to affect at the facility. Findings include: During a tour of the p.m., the water tendegree of Fahrenhe were as follows: (1) R24's room wate (2) R8 and R35's round R36's room wate (3) R45's room wate (4) R42's room wate (5) R14's room wate (6) R41's room wate (7) R45's room wate (8) R45's room wate (9) R45's room wate (10) R45's room wate (11) R13's room wate (12) R45's room wate (13) R48's room wate (14) R42's room wate (15) R14's room wate (16) R41's room wate (17) R45's room wate (18) R45's room	ailed to ensure safe, and emperatures were maintained Fahrenheit to prevent esidents residing in 15 of 36 the facility. This had the II 48 residents who resided in eit (F). The following rooms er temperature was 124.0 Form water temperature was room water temperature was room water temperature was excility on 10/18/22, at 2:00 peratures were obtained in eit (F) in the following rooms: er temperature was 129.2 For temperature was 127.9 For temperature was 127.9 For temperature was 125.0 For temperature was 127.5 For temperature was 123.6 For temperature was 1		to inspect the hot water tank to en has proper temperatures. 2. All residents in the center have potential to be affected. Corrective was taken and outside company we called to ensure proper hot water temperatures. 3. To ensure systemic changes an all maintenance staff will be educated the correct procedure for monitoring water temperatures according to the manufactures direction through a sof the GSS policy titled Water Temperatures on 11/28/22 by the designee. If water temperatures at within appropriate range all nursing maintenance staff will be notified immediately. Maintenance will adjuster heater and a recheck of the temperatures will be completed unwater temperatures are within range 4. Observation audits will be conditing the Quality Assurance Coordinator designee for 10 random residents regarding hot water temperature. Will be done weekly x 4 and every week x 2 and monthly x 1 to ensure water temperatures are within range results will be brought to the montemeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 16	the action vas e made ated on a hot are review ONS or re not and ast ust til the ge. ucted by or Audits other re hot ge. Audit aly QA	
	10:05 a.m. with adn	d observation on 10/19/22, at ninistrator and maintenance ms belonging to R24, R8 and				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00454	B. WING		10/2) 0/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (ENCY)	D BE	(X5) COMPLETE DATE
21710	degrees F. The adrived recently purchased currently having difficomfortable parame administrator indical monitoring temperatures company to resolve had turned down the due to temperatures no indication the ador had educated stareached high temperatures on 10 following room water follows: (1) R48's room water (2) R28's room water (3) R48's room water (4) R41's room water (5) R1's room water (6) R8 and R35's round R32.2 F (7) R2's room water (6) R8 and R35's round R16, and R45 in 19/21/22 at 10:00 and R16, and R45 in 19/21/22 at 2:00 and R14 had water F. 3) 10/12/22 at 2:00 and R22, and R43 in to be 120 F.		21710			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00454	B. WING			C 2 0/2022	
NAME OF	PROVIDER OR SUPPLIER		, ,	TATE, ZIP CODE			
EDGEB	ROOK CARE CENTER		SKY ROAD W ON, MN 5612				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21710	During interview on nursing assistant (Neither "too hot or to weeks. NA-A indicated have been no injurit temperatures and weeks and the potential to burn. During interview on indicated the water over the past month cold". To her knowle related to hot water know to check it" be potentially wash the residents into the base of temperatures dais sheet than the norm indicated they were of temperatures dais sheet than the norm indicated he did che 7:00 a.m. that morn water heater was to did not notify nursing the administrator has the new water heater it was not installed unaware when it was installed. Review of provided by mainter through 10/19/22 contemperatures ranging the provided by mainter through 10/19/22 contemperatures ranging through 10/19/22 contemperatures r	heater. There was no taff were alerted to the sed risk of resident burns. 10/20/22, at 8:32 a.m., NA)-A indicated water was o cold"over the past few ated to her knowledge there es related to the water was not educated on what to tures were too high and had a residents. 10/20/22, at 8:34 a.m., NA-B temperatures have fluctuated a being either "too hot or too edge, no resident had injuries temperatures. Staff "just efore residents would eir hands or before putting					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
				C	;
	00454	B. WING		10/2	0/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EDGEBROOK CARE CENTE	R	SKY ROAD W ON, MN 5612			
PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21710 Continued From p 10/12/22 were not 9/21/22 and 10/5/2 note to be adjusted sheet did not include temperature was a frequent water termonal communication when sure the safety A policy and procedured the policy and procedured the safety A policy and procedured the safety Temperatures was residents may have limited their ability recognize that the the potential to but required to produce degrees F for five took 1 minute to contain the safety of the safety safe	age 30 ed to be at 120 degrees F. On 22, the water temperatures was d. The temperature monitoring de time or location the water checked. It interview on 10/20/22, at ministrator confirmed more aperature monitoring and also th staff was imperative to	21710			
•	_				

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	I OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPI	
		00454	B. WING		10/2	; 0/2022
	PROVIDER OR SUPPLIER	505 TROS	DRESS, CITY, S KY ROAD W ON, MN 5612		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21710	The administrator, redesignee could ensigned accurately reflect or maintenance sched on a routine basis. policies and proced changes and performaintenance is adefacility could report assurance performations committee for further ongoing compliance.	HOD OF CORRECTION: maintenance supervisor, or ure a preventative am was developed to ngoing preventative luled or needed in the facility The facility should review ures, educate staff on these m environmental dically to ensure preventative equately completed. The those findings to the quality ance improvement (QAPI) er recommendations to ensure	21710			

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PRINTED: 12/06/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	` ′	(X3) DATE SURVEY COMPLETED	
		245560	B. WING _		10/	18/2022	
	NAME OF PROVIDER OR SUPPLIER EDGEBROOK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUNDS CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	ΓS	K 0	00			
	conducted by the M Public Safety, State 10/18/2022. At the Edgebrook Care Ce compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe edition of National F (NFPA) 99, Health Car NFPA 99, Health Car NFPA 99, Health Car NFPA 99, Health Car NFPA 99, Health Car SIGNATURE AT TH PAGE OF THE CM USED AS VERIFICA UPON RECEIPT O ONSITE REVISIT OF CONDUCTED TO N SUBSTANTIAL COR REGULATIONS HA ACCORDANCE WI	enter was found not in a requirements for participation id at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 e and the 2012 edition of are Facilities Code. OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY TAGS) TO:					
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION).					
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE	

(YP) DAIE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	` ′	E SURVEY IPLETED
		245560	B. WING _		10/	18/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUSE FOLLOWING INFO. 1. A detailed described taken or planned to a sure the sure to ensure the sustained. 3. Indicate how the future performance sustained. 4. Identify who is actions and monito a sustained. 5. The actual or puthe remedy. Edgebrook Care Cohas a partial basen The original building.	pections Division Suite 145 1-5145, OR @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: cription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. de facility plans to monitor to ensure solutions are responsible for the corrective ring of compliance. proposed date for completion of enter is one-story in height, nent, and is fully sprinklered. g was built in 1968, with	K 00			
	The original building building additions in determined to be of 2003 building additions and offices. height, has no base protected and was II(111) construction	g was built in 1968, with 1992 and 1997. All were f Type II(111) construction. The ion, which includes a meeting The addition is one-story in ement, is fully fire sprinkler determined to be of Type				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´´	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
	245560				10/18/2022		
NAME OF PROVIDER OR SUPPLIER EDGEBROOK CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION CORRE	ULD BE	(X5) COMPLETION DATE	
	and meet the constensiting buildings, to one building. The building is protosystem. The facility full corridor smoke the corridors that is department notifical. The facility has a capacity has a capa	same type of construction ruction type allowed for he facility was surveyed as ected by a full fire sprinkler has a fire alarm system with detection and spaces open to monitored for automatic fire tion. apacity of 52 beds and had a time of the survey.	K 35			12/16/22	
SS=F	Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspendintained in a sector available. a) Date sprinkler sector b) Who provided sector c) Water system sector REMARI	supply source KS information on coverage for partial automatic sprinkler					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´´	MULTIPLE CONSTRUCTION UILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245560	B. WING _		10/1	8/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 353	by: K-TAG: 353 Based on a review and staff interview, inspect the fire spri (2012 edition), Life and NFPA 25 (2011 Inspection, Testing, Water-Based Fire F4.1.1 and 5.1.1.2. Thave a widespread within the facility. Findings include: On 10/18/2022 between during documentation the annual fire spring occurred within the frame. The last inspection interview with the spring occurred within the frame. The last inspection interview with the spring occurred within the spring occurre	of available documentation the facility failed to test and nkler system per NFPA 101 Safety Code, section 9.7.5 edition), Standard for the and Maintenance of Protection Systems, sections his deficient condition could impact on the residents. Ween 10:00 AM to 12:00 PM, fon review, it was revealed that nkler inspection had not required 12 month time pection took place on the Facility Admininstrator on at the time of discovery.	K 35	Preparation and execution of this response and plan of correction do constitute an admission or agreem the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan correction is prepared and/or executions of federal and state law the purposes of any allegation that center is not in substantial complia with federal requirements of particiting this response and plan of correction constitutes the center sallegation compliance in accordance with secution 7305 of the State Operations Manual. 1. An outside company was called inspect the system on 10/24/22 2. All residents in the center have the potential to be affected. Corrective was taken and an outside has inspect the system. 3. To ensure systemic changes are all maintenance staff will be educated the correct GSS policy and proceding fire Extinguishment and Fire Supp for maintaining and ensuring the procompany completes the annual inson 11/28/22 by the Administrator of designee. 4. Observation audits will be conducted the Quality Assurance Coordinator designee to ensure proper sprinkle maintenance. Audits will be done we and every other week x 2 and month of the conduction of the	ent by che		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245560	B. WING			10/	18/2022	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>		
EDGEBR	OOK CARE CENTER				5 TROSKY ROAD WEST			
				EL	DGERTON, MN 56128			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 353			K 3		being properly completed. Audit reswill be brought to the monthly QA monthly appropriate follow up indicated ensure solutions are sustained. 5. Completion date: December 16,	neeting I to		
	Portable Fire Exting CFR(s): NFPA 101	uishers	K 3	55			12/16/22	
	inspected, and main NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.12 This REQUIREMENT by: K-TAG: 355 Based on a review and staff interview, inspect the fire extinedition), Life Safety 9.7.4.1 and NFPA 1 Portable Fire Extinguishers.	ntained in accordance with for Portable Fire 2, NFPA 10 NT is not met as evidenced of available documentation the facility failed to test and aguishers per NFPA 101 (2012) Code, sections 19.3.5.12 and 0 (2010 edition), Standard for juishers, section 7.2.1.2. This could have an isolated impact			 All fire extinguishers were been inspected on 10/24/22. All residents in the center have the potential to be affected. Corrective was taken and all fire extinguishers been inspected and a schedule has created. To ensure systemic changes are all maintenance staff will be educated the correct GSS policy and procedure. 	he action have been made ed on are title		
	during the inspection portable fire extingular received a monthly. An interview with the	veen 10:00 AM to 12:00 PM, n it was observed that a hisher in the laundry had not inspection since 05/25/2022. The Facility Admininstrator on at the time of dicsovery.			Fire Extinguishment and Fire Suppler for maintaining and ensuring the proportable fire extinguishers inspection 11/28/22 by the Administrator or de 4. Observation audits will be conducted the Quality Assurance Coordinator designee to ensure timely portable extinguishers inspection. Audits will done weekly x 4 and every other we and monthly x 1 to ensure portable extinguishers inspections are being properly completed. Audit results we	oper on on signee. cted by or fire l be eek x 2 fire		

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 ` ′	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
	245560	B. WING _		10/18/2022	
			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128		
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE COMPLETION	
Continued From pa	ge 5	K 3	brought to the monthly QA meeti appropriate follow up indicated to solutions are sustained.	ensure	
HVAC CFR(s): NFPA 101		K 52	21	12/16/22	
comply with 9.2 and accordance with the specifications.	d shall be installed in e manufacturer's				
This REQUIREMEN	NT is not met as evidenced				
and staff interview, test and inspect sn NFPA 101 (2012 ed sections 19.5.2.1 at (2012 edition), Stan Air-Conditioning and 5.4.8.1, and NFPA 8 Fire Doors and Oth section 19.4.1.1. The a widespread impactacility. Findings include: On 10/18/2022 beta	the facility failed to maintain, noke and fire dampers per lition), Life Safety Code, and 8.5.5.4.1, and NFPA 90A adard for the Installation of d Ventilating Systems, section 80 (2010 edition), Standard for er Opening Protectives, his deficient finding could have cot on the residents within the even 10:00 AM and 12:00 PM,		outside company was contacted with education provided to maintastaff. 2. All residents in the center have potential to be affected. Corrective was taken and education provide maintenance staff. 3. To ensure systemic changes a all maintenance staff will be educated the correct GSS policy and proceed titled general HVAC maintenance ensure the maintaining and ensure proper smoke and fire dampers in on 11/28/22 by the Administrator designee. 4. Observation audits will be contacted to the Quality Assurance Coordinate.	along enance e the ve action ed to are made cated on edure e to uring the inspection or ducted by or or	
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa HVAC CFR(s): NFPA 101 HVAC Heating, ventilation comply with 9.2 and accordance with the specifications. 18.5.2.1, 19.5.2.1, 9 This REQUIREMEN by: K-TAG: 521 Based on a review and staff interview, test and inspect sn NFPA 101 (2012 ed sections 19.5.2.1 an (2012 edition), Star Air-Conditioning an 5.4.8.1, and NFPA 8 Fire Doors and Oth section 19.4.1.1. Th a widespread impar facility. Findings include: On 10/18/2022 beta	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 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.	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 K 35 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,	This REQUIREMENT is not met as evidenced by: K-TAG: 521 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 19.5.1. and NFPA 80 (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 19.4.1.1. This deficient finding could have a widespread impact on the residents within the facility. On 10/18/2022 between 10.00 AM and 12.00 PM, To REQUIREMENT is not met as 245560 SITREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128 SCHANGE TO STATE AND SEAL AN	A BUILDING 01 - MAIN BUILDING 01 245560 B WING STREET ADDRESS. CITY. STATE. ZIP CODE 605 TROSKY ROAD WEST EDERTON, MN 56128 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 This REQUIREMENT is not met as evidenced by: K-TAG: 521 This REQUIREMENT is not met as evidenced by: K-TAG: 521 This REQUIREMENT is not met as evidenced by: K-TAG: 521 This REQUIREMENT is not met as evidenced by: K-TAG: 521 2. All residents in the center have the potential to be affected. 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. 3. To ensure systemic changes are made all maintenance staff. 3. To ensure systemic changes are made all maintenance staff. 3. To ensure systemic changes are made all maintenance staff. 3. To ensure systemic changes are made all maintenance staff. 3. To ensure systemic changes are made all maintenance staff. 3. To ensure systemic changes are made all maintenance staff. 3. To ensure systemic changes are made all maintenance staff. 3. To ensure systemic changes are made all maintenance staff. 3. To ensure systemic changes are made all maintenance staff. 4. Surecet GSS policy and procedure titled general HVAC maintenance to ensure the maintaining and ensuring the proper smoke and fire dampers inspection on 11/28/222 by the Administrator or designe. 4. Observation audits will be conducted by the Calmity assurance Coordinator or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245560	B. WING _		10/	18/2022	
NAME OF PROVIDER OR SUPPLIER EDGEBROOK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 TROSKY ROAD WEST EDGERTON, MN 56128				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
K 521	Continued From page 6 documentation that an inspection record could not be provided indicating that a fire and smoke		K 52	extinguishers inspection. Audits will be done weekly x 4 and every other week x 2			
	damper inspection years. An interview with Fa	had occurred within the last 4		and monthly x 1 to ensure smoke dampers inspection are being processed completed. Audit results will be be the monthly QA meeting with approximation.	perly rought to		
	Maintenance Direct finding at the time of	or verified this deficiency of discovery.		follow up indicated to ensure solution sustained. 5. Completion date: December 10	tions are		
	Electrical Systems - CFR(s): NFPA 101	- Essential Electric Syste	K 9	18		12/16/22	
	Maintenance and To The generator or or and associated equipment of a service within 10 services within 10 services shall be process shall be processed and the transfer switches are under load 30 minured ay intervals, and emonths for 4 continuated cold start transfer of all EES I competent personn stored energy power accordance with NF circuit breakers are program for periodic components is estamanufacturer required.	ther alternate power source ipment is capable of supplying conds. If the 10-second during the monthly test, a ovided to annually confirm this esafety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised tes 12 times a year in 20-40 xercised once every 36 years include a complete and automatic or manual oads, and are conducted by el. Maintenance and testing of er sources (Type 3 EES) are in EPA 111. Main and feeder inspected annually, and a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER EDGEBROOK CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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)		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
	circuits are marked separate from norm the possibility of da source is a design of installations. 6.4.4, 6.5.4, 6.6.4 (I 111, 700.10 (NFPA This REQUIREMEN by: K-TAG: 918 Based on a review and staff interview, inspect the emerge (2012 edition), Hea section 6.4.4.1.1.4 Standard for Emerg Systems, section 8 could have a wides within the facility. Findings include: On 10/18/2022 between the determined that the recieved any training a monthly 30 minute emergency generated. An interview with the section of the se	ES electrical panels and readily identifiable, and hal power circuits. Minimizing mage of the emergency power consideration for new NFPA 99), NFPA 110, NFPA 70) NT is not met as evidenced of available documentation the facility failed to test and ncy generator per NFPA 99 of the Care Facilities Code, and NFPA 110 (2010 edition), gency and Standby Power 4.8. This deficient condition pread impact on the residents of the residents of the property conduct generator on the new eload test on the new	K 9 ²	1. An outside company was called inspect the system on 10/28/22 2. All residents in the center have to potential to be affected. Corrective was taken and an outside company contacted to inspect and train maintenance staff. 3. To ensure systemic changes are all maintenance staff will be educat the correct GSS policy and proced titled Emergency and Stand by Possystems for maintaining and testing emergency generator on 11/28/22. Administrator or designee. 4. Observation audits will be conducted Quality Assurance Coordinator designee to ensure timely emergency generator transfer of power inspect Audits will be done weekly x 4 and other week x 2 and monthly x 1 to emergency generator transfer of poinspections are being properly come Audit results will be brought to the QA meeting with appropriate follow indicated to ensure solutions are sustained. 5. Completion date: December 16,	the action y was made ted on ure wer new er			



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

Minnesota Department of Health

Kumalu Fiske Downing

Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us