STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Edina	6200 Xerxes Avenue South Minneapolis, MN 55423

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review, the facility failed to report alleged violations of abuse was reported immediately, but no later than 2 hours after the allegation is made State Agency for one of one resident (R1) reviewed when a police officer visited the facility to investigate an allegation of abuse. for reporting of alleged violations of mistreatment, exploitation, neglect, or abuse. Law enforcement visited R1 due to allegations of maltreatment and stated to the Director of Nursing (DON) they were there for allegations of maltreatment and the facility did not report the allegations of maltreatment. Findings include: R1's Admission Record printed on 6/10/24 indicated R1 was admitted to the facility on [DATE]. R1's diagnoses include post-traumatic stress disorder, dependence on renal dialysis, need for assistance with personal care, reduced mobility, borderline personality disorder, and major depressive disorder with severe psychotic symptoms. R1's progress note dated 11/3/22 indicated R1 was admitted to the facility with a primary diagnosis of chronic failure renal end stage renal disease dialysis dependent. R1's brief interview for mental status (BIMS) dated 5/14/24 indicated R1 had a score of 14, which indicated R1 was cognitively intact. R1's police report dated 6/6/24 indicated law enforcement went to visit R1 due to reports the nursing staff was grabbing her and jerking her around. The police report indicated R1 stated she did not need emergency medical services (EMS). The police report stated law enforcement spoke with the DON who told the police officer it is typical for R1 to accuse staff of abuse and that she investigates every report of abuse for R1. R1's progress notes indicate no progress note was made on 6/6/24 about allegations of abuse, that the DON, or assistant director of nursing (ADON), or the administrator talked with R1 about the alleged abuse. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with R1 on 6/10/24 at 8:58 a.m., R1 stated she remembers law enforcement visiting her, but she did not know when they visited her or why they visited her. R1 stated men were in her room and they were rough with her during cares. She did not say anything to the men while this was happening because she was dumbfounded. R1 stated she is afraid of the men that come in her room and is afraid to report the abuse because she is afraid the men will increase the severity of the abuse. During an interview with the DON on 6/10/24 at 11:54 a.m., the DON stated law enforcement came to visit R1 last week. The DON stated law enforcement told her they were there because they received a report of abuse to R1. The DON stated she did not start an investigation into abuse because law enforcement stated, she was fine and that R1's family member (FM)-A calls all of the time and alleges things. The DON stated she did not feel it was necessary to start an investigation. During an email correspondence from the DON on 6/10/24 at 3:12 p.m., the DON stated the ADON met with R1 immediately after law enforcement left R1's room and R1 stated she was fine and had no concerns. During an interview with the ADON on 6/10/24 at 3:20 p.m., the ADON stated when law enforcement came out of R1's room, he went into R1's room and asked if she was ok and R1 stated to him that she did not have any concerns. The ADON stated he spoke with the DON and the DON had told him why law enforcement was visiting R1, but the ADON did not remember why law enforcement was visiting R1 at the time of this interview. The ADON stated he did not call R1's guardian. During an email correspondence from the DON on 6/10/24 at 3:21 p.m., the DON stated the administrator followed up with R1. The DON stated the administrator checked in the R1 after law enforcement left and stated R1 had no concerns. During an interview with the DON on 6/10/24 at 4:51 p.m., the DON stated her expectation is abuse, neglect, or abuse should be reported. The DON stated if the facility gets a report on abuse, neglect, or abuse, the facility would assess the resident, they would report the abuse, and then the facility would investigate. The DON stated if the resident is alert and orientated and they tell them no abuse took place, then the facility would not investigate. The DON stated if there is a report of abuse and the resident states abuse happened, then the facility would investigate. The DON stated the administrator and the ADON visited R1 when law enforcement was there. During an interview with the administrator on 6/10/24 at 5:02 p.m., the administrator stated if there is a threat of physical abuse, then the facility would report the allegation first and then investigate after. The administrator stated law enforcement came out to the facility on Friday, 6/7/24 and she found out that they came to speak with R1. The administrator stated she never found out from law enforcement as to why they were at the facility. After law enforcement left, she went to visit R1 and asked if she had any concerns. R1 stated she did not have any concerns. The administrator stated she did not ask R1 specifically about abuse, neglect, or abuse because R1 stated she did not have any concerns. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Vulnerable Adult Abuse and Neglect Prevention policy and procedure revised on 10/4/23 indicated any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, or misappropriation shall intervene to safeguard the resident and then immediately report to the Nursing Home Administrator and then the Administrator would report abuse to the state agency per State and Federal requirements. The policy indicated upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the DON, or designee, will coordinate an investigation, which will include completion of witness statements. The policy indicated the facility must report to the State agency immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than twenty-four hours if the alleged violation involves, neglect, misappropriation of resident property, or exploitation and involves not serious bodily injury. The policy indicated that upon reports of resident maltreatment, each alleged report will be individually investigated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review, the facility failed to investigate a report of abuse for one of one resident (R1) reviewed for response to allegations of abuse when a police officer visited the facility to investigate an allegation of abuse. Findings include: R1's Admission Record printed on 6/10/24 indicated R1 was admitted to the facility on [DATE]. R1's diagnoses include post-traumatic stress disorder, dependence on renal dialysis, need for assistance with personal care, reduced mobility, borderline personality disorder, and major depressive disorder with severe psychotic symptoms. R1's progress note dated 11/3/22 indicated R1 was admitted to the facility with a primary diagnosis of chronic failure renal end stage renal disease dialysis dependent. R1's brief interview for mental status (BIMS) dated 5/14/24 indicated R1 had a score of 14, which indicated R1 was cognitively intact. R1's police report dated 6/6/24 indicated law enforcement went to visit R1 due to reports the nursing staff was grabbing her and jerking her around. The police report indicated R1 stated she did not need emergency medical services (EMS). The police report stated law enforcement spoke with the DON who told the police officer it is typical for R1 to accuse staff of abuse and that she investigates every report of abuse for R1. R1's progress notes indicate no progress note was made on 6/6/24 about allegations of abuse, that the DON, or assistant director of nursing (ADON), or the administrator talked with R1 about the alleged abuse. During an interview with R1 on 6/10/24 at 8:58 a.m., R1 stated she remembers law enforcement visiting her, but she didn't know when they visited her or why they visited her. R1 stated men were in her room and they were rough with her during cares. She did not say anything to the men while this was happening because she was dumbfounded. R1 stated she is afraid of the men that come in her room and is afraid to report the abuse because she is afraid the men will increase the severity of the abuse. During an interview with the DON on 6/10/24 at 11:54 a.m., the DON stated law enforcement came to visit R1 last week. The DON stated law enforcement told her they were there because they received a report of abuse to R1. The DON stated she did not start an investigation into abuse because law enforcement stated, she was fine and that R1's family member (FM)-A calls all of the time and alleges things. The DON stated she didn't feel it was necessary to start an investigation. During an email correspondence from the DON on 6/10/24 at 3:12 p.m., the DON stated the ADON met with R1 immediately after law enforcement left R1's room and R1 stated she was fine and had no concerns. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON on 6/10/24 at 3:20 p.m., the ADON stated when law enforcement came out of R1's room, he went into R1's room and asked if she was ok and R1 stated to him that she didn't have any concerns. The ADON stated he spoke with the DON and the DON had told him why law enforcement was visiting R1, but the ADON did not remember why law enforcement was visiting R1 at the time of this interview. The ADON stated he did not call R1's guardian. During an email correspondence from the DON on 6/10/24 at 3:21 p.m., the DON stated the administrator followed up with R1. The DON stated the administrator checked in the R1 after law enforcement left and stated R1 had no concerns. During an interview with the DON on 6/10/24 at 4:51 p.m., the DON stated her expectation is abuse, neglect, or abuse should be reported. The DON stated if the facility gets a report on abuse, neglect, or abuse, the facility would assess the resident, they would report the abuse, and then the facility would investigate. The DON stated if the resident is alert and orientated and they tell them no abuse took place, then the facility would not investigate. The DON stated if there is a report of abuse and the resident states abuse happened, then the facility would investigate. The DON stated the administrator and the ADON visited R1 when law enforcement was there. During an interview with the administrator on 6/10/24 at 5:02 p.m., the administrator stated if there is a threat of physical abuse, then the facility would report the allegation first and then investigate after. The administrator stated law enforcement came out to the facility on Friday, 6/7/24 and she found out that they came to speak with R1. The administrator stated she never found out from law enforcement as to why they were at the facility. After law enforcement left, she went to visit R1 and asked if she had any concerns. R1 stated she did not have any concerns. The administrator stated she did not ask R1 specifically about abuse, neglect, or abuse because R1 stated she did not have any concerns. The facility's Vulnerable Adult Abuse and Neglect Prevention policy and procedure revised on 10/4/23 indicated any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, or misappropriation shall intervene to safeguard the resident and then immediately report to the Nursing Home Administrator and then the Administrator would report abuse to the state agency per State and Federal requirements. The policy indicated upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the DON, or designee, will coordinate an investigation, which will include completion of witness statements. The policy indicated that upon reports of resident maltreatment, each alleged report will be individually investigated.