

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Edenbrook of Edina		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083</p> <p>Based on interview and document review, the facility failed to awake staff on the overnight shift to provide adequate supervision and care of residents for 1 of 3 residents (R1) when R1 called 911 due to pain and the need to use the bathroom.</p> <p>Findings include:</p> <p>R1's Medical Diagnoses list undated, included surgical aftercare following surgery secondary to malignant neoplasm of the colon (colon cancer) and ileostomy (a surgical opening in the small intestine which drains into an external bag).</p> <p>R1's care plan dated 6/13/24 directed to anticipate resident's need for pain relief, respond immediately to any complaint of pain, and administer medication for pain management. R1's care plan directed two staff to assist to the toilet due to reduced mobility status. The care plan directed R1 used a disposable brief, and staff were to provide incontinence cares after each episode of bladder incontinence.</p> <p>On 6/20/24 at 10:48 a.m., the director of nursing (DON) stated the facility became aware of allegations of staff sleeping on the night shift, when the police were called to the facility on [DATE] around 4:00 a.m. The facility reviewed the police report and spoke with the hospital on 6/17/24. Sleeping on the job was not tolerated, and the staff suspected of sleeping were immediately suspended. She initiated immediate education regarding the requirement to remain awake and working while on duty.</p> <p>On 6/20/24 at 11:05 a.m., the administrator stated the facility video surveillance and police report supported termination of the nursing assistant (NA)-A and licensed practical nurse (LPN)-A who were found to be sleeping on 6/15/24. The administrator stated R1 had called 911 because she wanted to go home. The administrator stated all staff who are working must be awake throughout their shift.</p> <p>On 6/20/24 at 12:43 p.m., LPN-A stated he was working when R1 called 911 on 6/15/24 around 4:00 a.m. He stated he had emptied her ostomy bag around 2:00 a.m. He was in the dining room when the police arrived, I was about to take my break. He denied sleeping. He stated NA-A was sleeping and he told NA-A to get up. He said R1 was not in pain when the police arrived.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/20/24 at 2:10 p.m., NA-A stated he was worked the overnight shift from 6/14/24 to 6/15/24. He stated R1 was yelling all night long. He stated R1 wanted to leave the facility. He stated, She said she needed to go to the bathroom, but I told her she had a catheter for her urine and a colostomy bag. NA-A stated he did not check R1's brief.</p> <p>Observation of police bodycam footage 6/15/24 showed police officers entering the facility on the first floor. A police officer appeared to wake LPN-B. LPN-B was in a completely dark office with the door almost closed. Officers knocked on the door. LPN-B's head was down on the desk. She was covered in a blanket. LPN-B slowly lifted her head and told the officer R1 was on second floor. The officers took the elevator to second floor. They looked around to find two staff sleeping in the dining room. The officers had to shine their flashlights to wake LPN-A and NA-A in the dark dining room. Police explained they were responding to a 911 call from R1 stating she was in pain and needed her bedding changed. As they entered R1's room, she could be heard yelling from down the hall. As they opened the door, R1 stated, Thank God you are here. They don't take care of me. NA-A is observed on the police bodycam footage sitting in the dining room chair with blankets on chair directly in front of him. NA-A stated to the police officer, She has been yelling all night. She was saying she wanted to pee. She already had a catheter. I explain to her. There's nothing I can do. I have other patients. I told the nurse.</p> <p>Observation of facility video surveillance on second floor, 6/15/24 at 3:58 a.m., showed police officer in video on second floor, exiting elevator at 3:58 a.m. Police officer turned to his left, then turned to his right and shined flashlight into the dining room. LPN-A got up from the far left corner of dining room. The dining room was observed to be very dark.</p> <p>The facility Vulnerable Adult Abuse and Neglect Prevention policy dated 10/4/23, directed to provide residents a safe environment that is free from harm. It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment or exploitation. All residents are susceptible to maltreatment and exploitation due to their need for nursing home care. Due to physical, emotional, and mental inabilities, residents may be dependent upon us to meet their needs. It is the policy to enhance the life of all residents through strong programming and appropriate care and treatment. Additionally, residents and staff will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated and residents and staff will be monitored for protection. The facility will strive to educate all participants in techniques to protect all parties. An owner, licensee, administrator, licensed nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or harmfully neglect a resident.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>47083</p> <p>Based on interview and document review, the facility failed to have a designated charge nurse for each shift.</p> <p>Findings include:</p> <p>On 6/20/24 at 12:43 licensed practical nurse (LPN)-A stated there was not a charge nurse assigned the night of 6/14/24. LPN-A stated, Every nurse is in charge.</p> <p>On 6/21/24 at 2:18 p.m., the administrator stated via email, The nurses in the building are in charge. She stated the director of nursing (DON) is on call 24/7 for any clinical concerns.</p> <p>On 6/21/24 at 2:45 p.m., DON stated there was not a designated charge nurse each shift.</p> <p>A policy was requested regarding having a designated charge nurse for each shift. This was not provided.</p>