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	08/05/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49337 Based on observation, interview and document review, the facility failed to protect a resident while an allegation of abuse was being investigated for 1 of 3 (R1) residents reviewed for abuse. Findings include: R1's Medicare 5 day Minimum Data Set (MDS) dated [DATE], indicated R1 was moderately cognitively impaired, and required the assistance of one staff for eating, transferring, toileting, and bed mobility. R1's Face Sheet undated indicated R1 had diagnoses of type II diabetes, depression, anxiety, cognitive communication deficit, weakness, and dementia. R1's Special Instructions dated 8/5/24, in the electronic health record directed staff to complete Cares in Pairs (two staff present when completing cares). On 8/5/24 at 9:41 a.m., R1 was interviewed. R1 stated staff were rough with him, Yeah they just got real rough. They grabbed me by my shirt and lifted me up. It did hurt. On 8/5/24 at 10:02 a.m., R1's power of attorney (POA) stated a staff member yanked R1 up by his left arm while he was asleep to change his incontinent brief on 7/31/24. R1 told the POA he would be able to identify the staff member. When leadership brought in photos of staff to identify, R1 was unable to identify anyone. On 8/5/24 at 11:01 a.m., R1 was observed in his room. R1 stated he needed to use the bathroom, but he had not put the call light on. Surveyor put the call light on for him. At 11:03 a.m., a nursing assistant (NA)-A came into help. NA-A assisted R1 to use the bathroom without providing Cares in Pairs. On 8/5/24 at 11:34 a.m., NA-A was interviewed. NA-A was not aware staff needed to complete Care in Pairs with R1. (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

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	08/05/2024

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/24 at 1:12 p.m., registered nurse (RN)-A stated R1 alleged a staff member came in and jerked him around. R1 stated the staff member was male. After R1 was shown photos of staff who worked on 7/31/24, R1 was not able to identify the person he believed hurt him. There was only one male working that evening, and R1 did not identify that person as the alleged perpetrator. Following the allegation, Cares in Pairs was implemented. RN-A was unsure when the Cares in Pairs intervention was added to the special instructions. On 8/5/24 at 1:39 p.m., the director of nursing (DON) stated the investigation into the allegation of abuse was still underway, she planned on looking at his recent cognitive scores and interviewing staff to see if R1 had been more confused. Since R1 couldn't identify an alleged perpetrator from staff photos, leadership didn't have to worry about suspending any staff members. The DON was unsure when the Cares in Pairs was implemented. Cares in Pairs wouldn't be a protection for R1, it would be to protect staff from false allegations. On 8/5/24 at 2:36 p.m., the administrator stated R1's safety precautions following the allegation included a skin check and Cares in Pairs. She probably entered in the Cares in Pairs into R1's profile sometime on 8/2/24 but was unsure. The facility policy Vulnerable Adult Abuse and Neglect Prevention revised 10/4/23, directed under the protection of residents during investigation section, ensuring safety and well-being for the vulnerable adult is of utmost priority. Safety, security and support of the resident will be provided.