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	10/15/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49337 Based on observation, interview and document review, the facility failed to provide treatment to a skin tear and documented it had been completed for 1 of 4 residents (R3) reviewed for wound care. In addition, the facility falsely documented wound care was being provided for 2 of 4 residents (R4, R5) reviewed for wound care whose wounds had been resolved. Findings include: R3 R3's Face Sheet indicated R5 had diagnoses of paraplegia (paralysis caused by spinal injury or disease), peripheral vascular disease (abnormal narrowing of arteries other than those that supply the heart or brain), and methicillin resistant staphylococcus aureus infection (MRSA, a type of bacteria that has developed resistance to antibiotics). R3's quarterly Minimum Data Set (MDS) dated [DATE] indicated R3 was cognitively intact and required the assist of two staff for toileting, transfers, and bed mobility. R3's progress note dated 7/20/24, indicated R3 was noted to have a skin tear on his right lower leg. R3 stated it may have been from accidentally hitting a doorway. R3's Physician Orders dated 9/12/24, directed wound care on left lower leg: Cleanse with normal saline and pat dry. Apply a nickel thick Santyl (ointment that removes dead skin) to the wound bed over slough, and cover with foam dressing. Change daily on evening shift and as needed. R3's Wound Evaluation Form dated 10/9/24 indicated his front right lateral lower leg wound was improving. It measured 2.04 centimeters (cm) length by 1.16 cm width. There was no evidence of infection, it had moderate serous exudate define. R3's Wound Evaluation Form dated 10/15/24 indicated his front right lateral lower leg wound was improving. It measured 1.67 cm length by 1.11cm width. There were no signs of infection. There were no other descriptive details documented about the wound. R3's October treatment administration record (TAR) had the following documentation: -Licensed practical nurse (LPN)-C documented she completed wound care on 10/10/24 and 10/11/24. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Registered nurse (RN)-A was scheduled the evening of 10/12/24. The 10/12/24 box was left blank. RN-A documented she completed wound care on 10/13/24 -RN-B documented he completed wound care on 10/14/24. On 10/14/24 at 10:30 a.m., R3 was observed. The date on R3's dressing was 10/10/24. R3 stated the skin tear was from being scraped a few times while being in the shower chair. He stated the last time the dressing was changed was on 10/10/24. On 10/15/24 at 8:43 a.m., R3 was interviewed again. R3 stated he did not receive wound care on the evening of 10/14/24. The bandage was observed to have a date of 10/10/24 on it. On 10/15/24 at 8:55 a.m., director of nursing (DON)-A and DON-B entered the room to provide R3 repositioning and an incontinent brief change. When asked if there were a date or time on the dressing, DON-A verified the dressing had a date of 10/10/24 which indicated it was last changed on 10/10/24. DON-A stated she would have to look at the TAR and ask the nurses what had happened with the wound care. On 10/15/24 at 11:22 a.m., RN-A stated R3 told her the wound care was only supposed to be done once every three days, because the order had recently changed. RN-A stated staff must follow what the resident says if the order was different from the order in the computer. She was not sure who was responsible for managing wound care orders. She left the administration record for the wound care blank on 10/12/24 because there was an issue with the computer, but she did provide the wound care. She was not sure who was responsible for managing wound care orders once the wound was resolved. On 10/15/24 at 11:32 a.m., the medical director (MD) was interviewed. The MD was also responsible for completing wound rounds for R3 and prescribing wound care orders. She stated she had just been to R3's room to assess his wound after the wound care had not been completed for 4 days. R3's wound had continued to improve, it had reduced in size and showed no signs of infection despite wound care treatments not being given. Not following orders was not acceptable. When asked if she had concerns about nurses documenting that wound care orders were completed for wounds that had been resolved, she stated she was honestly not sure what to say. On 10/15/24 at 11:56 a.m., RN-B stated when he charted R3's wound care as being completed when it wasn't, it was an oversight on his part, and he took the blame for it. When a resident had a resolved wound, the nurse should call the physician to discontinue the order, they should not document it as given. R4 R4's annual MDS dated [DATE], indicated R4 was moderately cognitively impaired, and was independent with activities of daily living. R4's Physician Orders dated 8/6/24 directed wound care - right lateral foot: Cleanse with wound cleanser, pat dry, apply antiseptic, cover with foam dressing, once daily. R4's Wound Evaluation Form dated 10/2/24 indicated the wound was surgical and had healed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's October TAR indicated wound care was provided from 10/2/24 through 10/14/24 with the exception on the box being blank on 10/12/24. On 10/14/24 at 1:25 p.m., R4 stated there was no bandage on her right foot. R4 took her sock off, and no dressing or open areas were visible. On 10/15/24 at 9:12 a.m., DON-A assessed R4's foot and verified the surgical incision was healed. R5 R5's quarterly MDS dated [DATE], indicated she was cognitively intact, and had no skin conditions. R5's Physician Orders dated 8/16/24 directed skin tear left arm: cleanse area with generic wound cleanser, pat dry, apply oil emulsion, cover with dry dressing. Complete one time a day every 3 days. R5's October TAR indicated the left arm skin tear wound care was completed on 10/1/24, 10/4/24, 10/7/24, 10/10/24, and 10/14/24. R5's Physician Orders dated 9/24/24 directed skin tear left lower leg: cleanse with wound cleanser, pat dry, apply oil emulsion dressing. Cover with dry dressing. One time a day every Monday, Wednesday and Friday. R5's October administration record indicated the left leg skin tear wound care was completed on 10/2/24, 10/4/24, 10/7/24, 10/11/24, and 10/14/24. R5's Physician Orders dated 9/17/24, directed skin tear to left forearm: cleanse area with generic wound cleanser, pat dry. Apply oil emulsion dressing and cover with dry dressing. Change 3 times per week one time a day. R5's October administration record indicated the left forearm skin tear wound care was completed On 10/2/24, 10/4/24, 10/7/24, 10/9/24, 10/11/24, and 10/14/24. On 10/14/24 at 1:34 p.m., R5 stated all of her skin tears have been healed for a long time, she was unable to remember for how long. On 10/15/24 at 9:16 a.m., DON-A verified all three of R5's skin tears were healed. She thought staff were not feeling empowered to discontinue the wound care orders if the wounds were resolved. Nurses could also reach out to her or DON-B to tell them wounds have been resolved, and they could discontinue orders. Nurses should not sign out wound care was completed when it was not. The facility policy Pressure Injury Prevention and Wound Care Management last revised 3/4/24, directed residents who have a pressure injury or wound will receive care and services to promote healing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49337 Based on observation, interview, and record review, the facility failed to utilize enhanced barrier precautions (EBP) for 2 of 5 residents (R3) observed for personal cares and wound care treatments. Findings include: Per the Centers for Disease Control (CDC) dated 6/28/24: EBP are indicated during high contact care activities for residents with infection or colonization with a CDC targeted multi-drug resistant organisms (MDRO) (when contact precautions do not apply) or for any resident who has a chronic wound and/or indwelling medical device. High-contact resident care activities include dressing, bathing/showering, transferring, toileting, providing hygiene, changing linens or briefs, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care: generally, for residents with a chronic wound(s), not skin breaks or tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing. R3's Face Sheet indicated R5 had diagnoses of paraplegia (paralysis caused by spinal injury or disease), peripheral vascular disease (abnormal narrowing of arteries other than those that supply the heart or brain), and methicillin resistant staphylococcus aureus infection (MRSA, a type of bacteria that has developed resistance to antibiotics). R3's quarterly Minimum Data Set (MDS) dated [DATE] indicated R3 was cognitively intact, and required the assist of two staff for toileting, transfers, and bed mobility. R3's care plan dated 10/14/24, indicated R3 had a history of MRSA and required EBP. R3's Physician Orders dated 9/12/24, directed wound care on left lower leg: Cleanse with normal saline and pat dry. Apply a nickel thick Santyl (ointment that removes dead skin) to the wound bed over slough, and cover with foam dressing. Change daily on evening shift and as needed. On 10/14/24 at 10:16 a.m., licensed practical nurse (LPN)-A entered R3's room to administer a suppository and reposition him. LPN-A donned gloves, but did not donn a gown. R3's door had a sign indicating he required EBP and directed to wear personal protective equipment for high contact care activities. On 10/14/24 at 10:22 a.m., LPN-A stated she went into R3's room to administer a scheduled suppository and repositioned him. LPN-A verified she didn't wear a gown. When asked about the EBP sign on R3's door, LPN-A stated she doesn't wear a gown unless a resident has an active infection, and stated the director of nursing (DON) could answer questions about it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 9:43 a.m., LPN-B was observed wearing a gown and gloves, and providing wound care for R3. LPN-B removed R3's soiled dressing. She cleansed the wound with normal saline, patted it with a sterile dressing, opened the tube of Santyl ointment and applied it to the wound. She touched the trash can and removed the first set of gloves, and was wearing another set of gloves underneath the top set. DON-B entered the room to take a picture of the wound. LPN-B removed the second set of gloves, and without performing hand hygiene, applied a clean dressing without gloves. Outside of R3's room, LPN-B used a hand wipe to cleanse her hands. On 10/15/24 at 10:48 a.m., LPN-B stated hand hygiene should only be completed before and after wound care. LPN-B stated she used double gloves occasionally because she didn't know what to expect, and it was nice to just take the top set of gloves off. On 10/15/24 at 11:14 a.m., DON-B stated hand hygiene should be completed before putting gloves on, when changing gloves, and after soiled items have been touched. Double gloving was not an acceptable practice. On 10/15/24 at 11:22 a.m., registered nurse (RN)-A stated hand hygiene should only be completed before and after wound care was completed. She used double gloves when providing wound care because it was easier than taking gloves on and off. On 10/15/24 at 11:32 a.m., the medical director (MD) stated hand hygiene should be completed when going from dirty to clean, and during every glove change. Double gloving was not an acceptable practice because the second set of gloves would be considered dirty. Staff should follow the EBP signs on the doors, and should be using EBP properly. On 10/15/24 at 1:04 p.m., DON-A stated double gloves were not acceptable and staff had been recently trained in infection control. Hand hygiene should be completed before going into the resident room, when putting new gloves on and removing soiled dressings. Staff had been trained on EBP and should be following policy for wearing gowns. The facility policy Enhanced Barrier Precautions dated 3/26/24 directed EBP will be implemented during high-contact resident care activities when caring for a resident with chronic open wound requiring a dressing or residents with an infection or colonization with and MDRO. The facility policy Pressure Injury Prevention and Wound Care Management last revised 3/4/24, directed to refer to the dressing change policy for detailed policy and procedure for dressing changes. Clean technique for wound and dressing changes are indicated. A policy pertaining to infection control during wound care was requested but not provided.