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 12/31/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to provide a clean, comfortable, and homelike environment for 2 of 3 residents assessed (R1 and R3). R1's room was observed having the bed made over a urine-soiled facility bath blanket. R3's room was cluttered with facility supplies covering up furniture and clean supplies found on the floor. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 10 indicating R1 had moderate cognitive impairment. R1 required maximum assistance with toileting hygiene, dressing, personal hygiene and transferring. R1's pertinent diagnoses were left femur (hip) fracture, chronic respiratory failure, and unspecified intellectual disabilities. R1 was frequently incontinent of bowel and bladder. R1's care plan revision dated 11/13/24 indicated R1 had functional bladder incontinence. Her interventions were to clean peri-area with each incontinent episode. Monitor for signs and symptoms of a urinary tract infection. R1 had a voiding routine to be offered toileting, check, and change at rising, before and after meals at bedtime and as needed. Upon interview on 12/30/24 at 12:37 p.m. R1 stated she often has to pee in her incontinent brief in the night because staff does not answer her call light in time or staff will tell R1 to urinate in her incontinent brief and they will change her, but urine gets on her bedding. R1 stated on 12/29/24 she had to ask the staff three times to change her bedding because it was wet and smelled of urine. The bedding was change on 12/30/24 per R1. Upon interview on 12/30/24 at 1:34 p.m. R1's family member (FM)-A stated she had visited R1, and her room had a urine odor to it. She stated she was not certain where the odor was coming from. Upon interview on 12/30/24 at 1:50 p.m. R1's family member (FM)-B stated R1's bed and blankets smelled of urine when she had visited. She stated she has called the facility to make sure R1 was not put to bed in a bed that smelled of urine. (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: 245275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Edenbrook of Edina		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 Xerxes Avenue South Minneapolis, MN 55423	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon observation and interview on 12/31/24 at 9:05 a.m. R1 asked surveyor to look at her bed because staff had made the bed covering up urine. R1 stated the night staff told her to urinate in her incontinent pad again and that leaves her bed soiled. R1's bed was found to have wet light-yellow urine seeped area approximately 10 inches in circumference on a bath blanket that was folded across the center of R1's bed between her top and bottom sheet. A sheet and comforter were covering the soiled area. A slight odor was noted. Upon observation and interview on 12/31/24 at 9:31 a.m. R1 told nursing assistant (NA)-A that her bed was soiled. NA-A pulled back R1's comforter and top sheet noting the soiled area. Registered nurse (RN)-A was also observing in the room and stated she could see and smell the urine from approximately 12 feet away from the bed. NA-A took the soiled bath blanket off the bed and placed a clean bath blanket in the bed. NA-A did not change the top sheet which had been in contact with the soiled bath blanket. R3's significant change MDS dated [DATE] indicated R3 had a BIMs score of 15 indicating R3 had no cognitive impairment. R3's behavior status indicated he rejected cares 1-3 days out of 7. R3 was totally dependent upon staff for oral hygiene, toileting hygiene, showering, lower body dressing, personal hygiene and transferring. R3 was always incontinent of bowel and bladder. R3's pertinent diagnoses were chronic congestive heart failure, acute respiratory failure, acute pulmonary edema (fluid in the lungs), type II Diabetes, morbid obesity, absence of left foot, contracture (shortening of muscles, tendons or ligaments that limits movement) of the left hand, acquired absence of the right leg below the knee. Upon observation on 12/31/24 at 12:20 p.m. R3 had a large electric wheelchair in front of his bathroom with oxygen tubing laying on the floor. Along the wall on the side of the head of his bed was a chair, a commode (a portable toilet), and a bedside table. On the floor next to the chair was a basin with mail and an old medication box. On the chair was a sterile wound draping cloth, a bath blanket and a plastic basin filled with wound supplies. Underneath the chair were socks and a Chux pad (a disposable under pad for a bed or furniture). Next to the chair was R3's commode, which was covered with two sterile wound drapes, wound supplies, unfolded bed sheets, a facility bed spread, a hanger, a hospital gown and other clothing. Below the commode was an empty plastic gallon jug, a clean incontinence pad and oxygen tubing. Next to the commode was a bedside table piled with incontinence wipes, a razor, incontinence briefs, old medication boxes, rubber gloves and some bottled lotions. On the floor between the bedside table and the bed was a wound care sterile drape and a clean incontinence pad. The wall on that same side of the room was missing paint in area approximately 3 feet x 1 foot, it appeared the paint had been scraped off. On the adjacent side of R3's room was another bedside table with a small refrigerator on top, a plastic laundry bin and another chair. There were three plastic bags on the floor filled with unidentified items. The laundry bin was overflowing with clothing. The chair had dirty laundry on it, the sling used for R3's EZ stand (a machinal lift to stand people) and an empty plastic bin. The wall under the window beside R3's bed had what appeared to be multiple small areas of food stains. Upon interview on 12/31/24 at 12:30 p.m. R1 stated he was not certain if the bedding on the commode was clean or dirty. He stated did not believe the facility was using the oxygen tubing that was on the floor, if he noticed that it was being used, he would have stopped them. He stated he would like his room clean, so his family had a place to sit when they visit. He stated he asked staff about a week ago if his would care items could all be placed in a plastic bin, so they were not spread all over his room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon observation and interview on 12/31/24 at 12:46 p.m. the assistant director of nursing (ADON) stated R3 had been in and out of the hospital frequently and some of the bags on the floor were items from the hospital. The ADON stated she was not certain if the linens on his commode and chair were clean or dirty. She stated the supplies that were on the floor should not have been there. She told R3 that she and housekeeping would clean his room after lunch and any items in question would be laundered. The room was cleaned. Upon interview on 12/31/24 at 2:45 p.m. the Director of Nursing stated beds should not be made if they are soiled. In addition, she stated R3 had the right to have his room the way that he wanted it. She also stated that the facility ADON completed an audit every week and one of the questions to all the residents was if there were anything they would like done in their room and R3 had stated no. The DON stated she was just informed on 12/30/24 that R3 would like a bin for his wound care supplies and was in the process of getting him one. A policy regarding a homelike environment was requested however none was received.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44649

Based on interview and document review the facility failed to ensure the comprehensive care plan was developed to implement cares and services for a leg prosthetic for 1 of 1 resident (R3) reviewed. R3's care plan did not have any person-centered details for R3's prosthetic placement or use. In addition, R3's comprehensive assessment did not indicate R3 had a leg prosthetic.

Findings include:

R3's significant change MDS dated [DATE] indicated R3 had a BIMs score of 15 indicating R3 had no cognitive impairment. R3's behavior status indicated he rejected cares 1-3 days out of 7. R3 was totally dependent upon staff for oral hygiene, toileting hygiene, showering, lower body dressing, personal hygiene and transferring. R3 was always incontinent of bowel and bladder. R3 was not on a bowel toileting program. R3's pertinent diagnoses were chronic congestive heart failure, acute respiratory failure, acute pulmonary edema (fluid in the lungs), type II Diabetes, morbid obesity, absence of left foot, contracture (shortening of muscles, tendons or ligaments that limits movement) of the left hand, acquired absence of the right leg below the knee. R3's MDS did not indicate R3 had a leg prosthesis.

R3's care plan with a revision date of 5/14/24 indicated R3 had an activity of daily living performance deficit related to decreased mobility secondary to below the knee amputation of the right leg and trans metatarsal (procedure that removes part of the foot) amputation of the left foot. R3's interventions included: [NAME] (to place on) prosthesis daily as resident allows.

R3's care plan with a revision date of 8/15/24 indicated R3 had a physical mobility related to decreased mobility secondary to below the knee amputation of the right leg and trans metatarsal (part of the foot) amputation of the left toes. R3's interventions included: Ambulation/locomotion - wheelchair - electric independent, no walking, transfer assistant of two staff members with an EZ-stand (a mechanical lift to assist residents from a sitting to standing position).

R3's care plan did not indicate when the prosthesis was to be used, how to place the prosthetic and if the prosthesis was required with the use of the EZ-stand.

R3's Kardex dated 12/31/24 indicated R3 was to ambulate using an electric wheelchair and was independent. He was to transfer with two staff members and the EZ-stand. The Kardex have any documentation regarding R3's prosthetic.

Upon interview on 12/31/24 at 12:30 p.m. R3 stated he does refuse to wear his prosthesis when he is in bed and does not wear it when he goes out of the facility for dialysis. He stated he has swelling in his leg and the prosthesis became painful and irritated him. He stated when physical therapy (PT) put the prosthesis on, they do it quickly and it feels right. When the floor staff put it on it takes them a long-time and it does not feel right. R3 stated he had to tell staff how to put the prosthetic on as many do not know to use the prosthetic sock liner.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 12/31/24 at 12:46 p.m. the assistant director or nursing (ADON) stated she stated she was not certain how staff were trained on R3's prosthesis or the details of the care plan. Upon interview on 12/31/24 at 1:08 p.m. nursing assistant, NA-B stated she had worked with R3. NA-B was not certain whether he was required to wear the prosthesis when he was being transferred or not. She stated the answer would be on R3's Kardex. NA-B denied any specific training with R3's prosthesis. She stated she recalled from her nursing assistant course to make sure to lock a prosthesis, but could not recall exactly how to lock R3's. Upon observation interview on 12/31/24 at 1:40 p.m. NA-C stated he knew how to put R3's prosthesis on. He had not been trained specifically through the facility but had been a nursing assistant for many years and had learned at other facilities throughout his career. He stated R3 would direct staff on how to put the prosthetic on by telling them to place his special sock on and how to place the metal parts together forming a clicking sound. NA-C reviewed R3's Kardex on his computer to show the surveyor how the Kardex read for R3's prosthesis and stated R3's prosthetic was not on the Kardex therefor nursing assistant staff would not know exactly what to do. Upon interview on 12/31/24 at 2:20 p.m. the director of physical therapy (PT)-A stated it is understandable that the nursing assistants may not be as quick as the therapies when donning the prosthetic. He stated most prosthetics use a pin system and are straight forward to use, however not all prosthetics are the same. He was not certain how the nursing assistants were trained. He stated a resident with a leg prosthetic would not always need to wear the prosthetic when using the EZ-stand however in R3's case due to balancing concerns with his left hand it is advised and should be on the care plan. Upon interview on 12/31/24 at 2:45 p.m. the Director of Nursing verified R3's prosthetic was not on the nursing assistants Kardex. She stated the reason nursing had not populated it when producing the care plan. In addition, she stated that the care plan identified R3 had a prosthesis and to [NAME] it as resident allows. She stated the nursing assistant staff is taught prosthetic cares in their nursing assistant training course therefor they were aware of how to use, not requiring anything more specific on the care plan. A facility policy titled Care Plan - Baseline and Comprehensive with a revision date of 6/20/23 indicated that each resident was to receive care individualized to him or herself and that that goals and approaches for care are communicated to all parties including caregivers, the resident, and the resident's representative.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to meet a resident needs and choices to perform activities of daily living of toileting for 1 of 3 residents (R3) reviewed when R3 wore an incontinent brief for toileting. R3 had a below the knee leg prosthesis and was unable to use his preferred method of toileting due to staff not able to apply the prosthesis in a timely manner to transfer R3 to the toilet or commode chair (a portable toilet chair) as indicated on R3's care plan. Findings include: R3's significant change MDS dated [DATE] indicated R3 had a BIMs score of 15 indicating R3 had no cognitive impairment. R3's behavior status indicated he rejected cares 1-3 days out of 7. R3 was totally dependent upon staff for oral hygiene, toileting hygiene, showering, lower body dressing, personal hygiene and transferring. R3 was always incontinent of bowel and bladder. R3 was not on a bowel toileting program. R3's pertinent diagnoses were chronic congestive heart failure, acute respiratory failure, acute pulmonary edema (fluid in the lungs), type II Diabetes, morbid obesity, absence of left foot, contracture (shortening of muscles, tendons or ligaments that limits movement) of the left hand, acquired absence of the right leg below the knee. R3 was not receiving amputation/prostheses care from restorative nursing program in training and skill practice. R3's quarterly assessment dated [DATE] indicated R3 was always incontinent of bowel. There were factors/conditions impacting his bowel continence identified. The assessment did not indicate any medications that may affect bowel incontinence. The assessment did not indicate any other contributing factors such as requiring physical assistance to the toilet. R3's perception to defecate was absent. R3 did not have an elimination pattern. R3 was on a toileting program to manage his bowel incontinence and the program was effective. The assessment did not show any documentation of what the toileting plan was. There were not bowel concerns identified. Upon record review of R3's progress notes dated 9/29/24 - 12/30/24 there was no documentation about R3's toileting indicating there were no attempts at alternative measures for R3 to be free from wearing an incontinent brief. R3's care plan dated 1/19/23 indicated R3 had an actual/potential for alteration in elimination related to decreased mobility secondary to below the knee amputation of right leg. R3's interventions included: Incontinence care after each incontinent episode and monitor for signs and symptoms of a urinary tract infection (UTI). R3's care plan dated 4/28/23 indicated R3 had a risk for constipation related to narcotic use. R3's interventions were: -Encourage resident to sit on toilet to evacuate bowels if possible. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure residents feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote ease of evacuation where possible. -Follow facility bowel protocol for bowel movement. -Monitor medications for side effects of constipation. Keep physician informed of any problems. -Monitor/document/report as needed signs and symptoms of constipation. -Record bowel movement pattern each day. Describe the amount, color, and consistency. R3's care plan revision of 5/14/24 indicated R3 had an activity of daily living performance deficit related to decreased mobility secondary to below the knee amputation of the right leg and trans metatarsal (procedure that removes part of the foot) amputation of the left foot. R3's interventions included: Don (to place on) prosthesis daily as resident allows. R3's care plan with a revision date of 8/15/24 indicated R3 had a physical mobility related to decreased mobility secondary to below the knee amputation of the right leg and trans metatarsal (part of the foot) amputation of the left toes. R3's interventions included: Ambulation/locomotion - wheelchair - electric independent, no walking, transfer assistant of two staff members with an EZ-stand. R3's quarterly assessment dated [DATE] indicated R3 was always incontinent of bowels. The factors/conditions impacting bowel continence was obesity and lower extremity amputation. R3 was taking laxatives and narcotics. Other contributing factors included impaired decision-making skills, depression, and anxiety. R3's perception to defecate was diminished. R3 did not have an apparent usual elimination pattern. R3 was not on a toileting program. The question Is current toileting schedule effective in management the resident's bowel continence was answered not applicable N/A. The question if bowel program is not effective: new intervention to be up in place was left blank. There not bowel concerns indicated. The assessment failed to indicate R3's preferences. R3's Kardex dated 12/31/24 indicated R3 was to ambulate using an electric wheelchair and was independent. He was to transfer with two staff members and the EZ-stand. R3 was to have incontinence care after each incontinent episode. Upon interview on 12/31/24 at 12:30 p.m. R3 stated he felt like a baby because the facility puts a diaper on him. He stated he didn't have a choice because he knows when he has to have a bowel movement, but by the time two staff members come to his room and put his prosthesis (a custom-made replacement for an amputated leg) on and place him in the EZ-stand he had soiled himself at times. He does refuse to wear his prosthesis when he is in bed and does not wear it when he goes out of the facility for dialysis. He stated he has swelling in his leg and the prosthesis became painful and irritated him. He stated when physical therapy (PT) put the prosthesis on, they do it quickly and it feels right. When the floor staff put it on it takes them a long-time and it does not feel right. R3 stated he does not get asked if he wants to use the commode in his room or the toilet, I am expected to use the diaper. R3 denied being about a toileting plan or being asked if the toileting plan the facility documented having in place was working for him. R3 had not been offered or tried any other toileting alternatives. (continued on next page)

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	245275	A. Building B. Wing	12/31/2024

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 12/31/24 at 12:46 p.m. the assistant director or nursing (ADON) stated R3 had been fitted for a specific type of brief and she believed he wanted to wear incontinent briefs. She stated she was certain he wanted to the wear the briefs to his dialysis appointments because toileting was very difficult there. The ADON stated R3 was aware when he needs to have a bowel movement, but she had witnessed him on a p. m. shift refuse to put the prosthesis on for his transfer to get to the toilet. The ADON denied trying any alternative methods to assist R3 to not having to wear an incontinent pad. Upon interview on 12/31/24 at 1:40 p.m. NA-C stated he knew how to put R3's prosthesis on. He had not been trained specifically through the facility but had been a nursing assistant for many years and had learned at other facilities throughout his career. He stated R3 would direct staff on how to put the prosthetic on by telling them to place his special sock on and how to place the metal parts together forming a clicking sound. He stated R3 wore a brief and would call for assistance when needed to be cleaned up after having a bowel movement. He stated he did not ask R3 if he wanted to use the commode or toilet as he did not think that was R3's wishes. Upon interview on 12/31/24 at 2:45 p.m. the Director of Nursing stated the facilities plan was to have R3 use the toilet or commode, but since R3 would refuse to wear the prosthetic R3 needed to wear an incontinence pad. The DON was not aware of R3's wishes to not wear an incontinence pad for toileting. An email correspondence from the DON dated 1/6/24 at 3:28 p.m. indicated R3's care plan had him listed as incontinent. He had quarterly assessments in September and December which addressed his bowel and bladder status. In September it was noted that his perception of need to defecate was absent. In December, the perception of need to defecate was diminished. Both assessments note he is incontinent. With his preference of not wearing his prosthetic leg during the day and a diminished ability or absent ability to note the need to defecate, staff were not utilizing the commode as it was no longer appropriate. No findings of other alternative methods were sent post survey. A facility policy regarding activities of daily living as requested however none provided.