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	01/09/2026

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** Based on interview and document review, the facility failed to timely report to State Agency (SA) falls with serious injury for 2 of 2 residents (R1, R6) who had falls without implementation of appropriate fall interventions to prevent/mitigate risk of recurrent falls. Findings include: R1's face sheet dated 12/31/25, identified diagnoses of Parkinson's disease (a progressive nervous system disorder affecting movement that caused tremors, stiffness, slow movement, and balance issues) with dyskinesia (involuntary, erratic muscle movements), congestive heart failure?(a condition where the heart does not pump blood as well as it should), atrial flutter (a fast heart rhythm), and diabetes mellitus (a condition that affects how the body uses sugar as fuel).? R1's Morse fall scale (fall risk assessment) dated 12/5/25, indicated R1 had not fallen in the past 3 months, had more than one diagnosis, normal gait, and overestimated or forgets her limits. R1 was at?moderate risk for falling.?? R1's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R1?required?substantial?assistance?for transfers,?toileting,?and some activities of daily living. The assessment lacked a cognitive assessment.?? R1's Fall Incident report dated 12/7/25,?identified?R1 had an unwitnessed fall at 4:00 a.m., resident was found lying on the floor with her head on the pillow. No injury was noted. According to FM-A, R1 stated she wanted to use the bathroom, missed a?step?and fell. R1 was only oriented to person. The incident report did not include a comprehensive fall investigation/analysis that would address potential causal factors including the lack of care plan interventions that directed staff of R1's required level of care she needed to complete activities of daily living. R1's progress note dated 12/7/25 at 7:34 a.m.,?indicated?resident was found lying on the floor with her head on a pillow. No injury was noted. According to R1's family member (FM)-A, R1 was trying to use the bathroom, missed a?step?and fell. A head-to-toe assessment was done with neuro checks and vital signs. R1 denied pain and was?assisted?back to bed by a mechanical lift. FM-A and provider were updated. FM-A came to the facility and transferred R1 to the hospital due to the incident.? R1's emergency department hospital medical records, dated 12/7/25,?stated?the patient presents to the emergency department after being found on the floor by nursing staff at 5:00 a.m.?The patient presents from nursing home after falling while?attempting?to walk to the bathroom unassisted. Patient complains of bilateral knee pain,?neck?and back pain post fall.?CT scan shows?acute superior endplate compression fracture with fracture?lucency? visualized along the superior endplate of T12 with burst-type morphology and slight bony retropulsion of?the superior endplate of T12 (spine fracture). R1 required pain management, a spinal brace and physical therapy for treatment. ? R1's progress note dated 12/8/25, indicated R1 discharged home against medical advice. However, there is no indication R1 returned to the facility after being transferred to the ED on 12/7/25. ?Additional record review identified R1's baseline care plan was not initiated/completed until 12/8/25 after R1 transferred/discharged to the hospital. During an interview on 12/31/25 at 8:36 a.m., FM-A stated he had called the facility on 12/7/25 around (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	01/09/2026

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	5:00 a.m., he was told R1 had fallen but was okay. FM-A then drove the facility and stated R1 was in pain and reported she had been on the floor since 2:00 a.m. until 5:00 a.m., FM-A then called 911to have R1 transferred to the hospital.? FM-A further stated at the hospital it was discovered R1 had a broken spine and needed to be hospitalized . During an interview on 12/31/25 at 2:24 p.m., licensed practical nurse (LPN)-A stated she had found R1 on the floor in her room at an unspecified time after hearing R1 screaming. LPN-A stated R1 had not used her call light, had gripper socks on and the last time R1 had been checked R1 was in bed, however, was unable to articulate the exact time of when R1 had been last checked. LPN-A then called FM-A to inform him of R1's fall when FM-A translated for R1 who stated she had been attempting to use the bathroom and missed her step and fell. FM-A came to the facility that morning and wanted to take R1 to the hospital, LPN-A told FM-A it was okay to take R1 to the hospital. LPN-A was unable to articulate how R1 was supposed to transfer or any fall prevention interventions that were supposed to be utilized to prevent R1 from falling. ?? R6 ? R6's face sheet dated 1/7/26, identified diagnosis of hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right side,? epilepsy (brain disorder causing recurrent unprovoked seizures),?Charot's?joint (a severe, progressive condition where nerve damage causes bones and joints to weaken) of left ankle and foot, and dizziness.? ? R6's?Significant Change?MDS dated [DATE], indicated?R6 was independent with transfers. R1 did not have any falls within the last 6 months and did not have any falls with a fracture. R6 had severe cognitive impairment, had no behaviors,?and?was dependent in most activities of daily living. Review of R6's fall incident reports between 7/1/25 and 11/12/25 identified R6 had 3 falls, 7/21/25, 8/3/25, and 10/16/25 where dizziness was repeatedly identified as a causal factor however, the records did not include monitoring of dizziness nor comprehensive assessments that identified individualized fall prevention strategies and/or services that could prevent or mitigate R6's risk for falls related to the identified causal factor of dizziness (SEE F689). ? R6's Incident Report dated 11/13/25,?identified?R6 had a self-reported unwitnessed fall in her room at 2:00 p.m. R6 reported she fell in the bathroom after toileting during a?self-transfer and fell on her left knee.? R6 did not notify nursing staff, she fell on her left knee. The immediate action taken was to assess R6. The left knee was noted to be slightly?swollen. R6 complained of significant pain. The pain provider was updated and saw R6 during the same shift. A different provider was also updated and saw R6 during the shift. A STAT X-ray was ordered to rule out a fracture.?The toileting plan was updated (R6's care plan did not have a toileting plan prior to the fall on 11/13/25). The rest of the sections on the form were left blank.?? ? R6's progress note dated 11/15/26 at 10:04 a.m., identified R6's x-ray results identified a comminuted (a severe break where the bone shatters into three or more places, usually from a high impact trauma like a fall) fracture in the left tibial plateau (on the top surface of the shin bone at the knee joint. R1 had pain 9 out of 10 and was sent to the ED for evaluation and/or treatment. ? R6's hospital Discharge summary dated [DATE], identified R6 had been admitted [DATE] through 11/18/25 due to worsening leg/knee pain following a fall on 11/13/25. R6's x-rays were found to have a moderately displaced and impacted intra-articular fracture of the lateral tibial plateau and probable non-displaced fracture of the medial tibial plateau. R6 underwent arthrocentesis (a procedure where a needle is used to withdraw fluid) in the ED with removal of grossly bloody fluid. During an interview on 1/6/26 at 12:01 p.m., the administrator stated R1 and R6's falls had not been reported to the state agency after knowledge of a serious injury due to the falls being explainable by the resident and did not have an allegation abuse. During a follow up interview on 1/6/26 at 3:33 p.m., the administrator stated she was not aware R1's fall that occurred on 12/7/25 (continued on next page)

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	01/09/2026

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	that R1 had sustained a serious injury; administrator was unaware on R1's admission MDS dated [DATE] that R1's fall had been coded as a fall with major injury. MDS coordinator worked offsite, when she obtained information from the hospital records that identified a major injury, this should have been reported to the administrator immediately and should have been reported to the state agency within two hours. ? The facility policy Vulnerable Adult Abuse and Neglect Prevention last revised 3/25/25, directs?the facility must report to the State Agency if the events that cause the allegation result in serious bodily injury.??

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	01/09/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to revise the care plan for 2 of 5 residents (R4.R6) who were reviewed for accidents/falls.Findings include:R4's face sheet dated 12/31/25, indicated R4 was admitted on [DATE]. Diagnoses included encounter for orthopedic aftercare, acute respiratory failure with hypoxia, seizures, mechanical complications of indwelling urethral catheter, insomnia, bipolar disorder, obstructive and reflux uropathy, presence of right artificial knee joint, heart failure, bilateral primary osteoarthritis of knee, myalgia (muscle pain), psychoactive substance abuse and reduced mobility. R4 fall focus care plan dated 11/3/25, identified R4 was high-risk for falls related to acute respiratory failure with hypoxia, sepsis, seizures, post-traumatic stress disorder, bipolar disorder, history of pulmonary embolism, benign prostatic hyperplasia without lower urinary tract symptoms. R4's goal was for her injury related to falls will heal without complication by the review date. Interventions as followed: 11/03/25 Review medications with physician or pharmacist. Discontinue un-necessary medications. Evaluate for uncontrolled pain. Consider pain medication regimen. Evaluate for early acute changes in medical condition. Report findings to physician and obtain requested lab or diagnostics. Gripper socks on when up. Ensure the environment is free of clutter. R4's Incident Report dated 11/13/25, indicated R4 had a self-reported unwitnessed fall. A staff went to get R4's vitals when R4 reported she had a fall earlier that day. R4 stated she was trying to transfer from the bed to the wheelchair but did not realize one of the wheelchair brakes was not locked. R4 slid and fell. R4 called for help, an aide came and said he would come back to help but did not return. Later, another staff helped her back to bed. The immediate action taken was to place brightly colored tape on the wheelchair brakes as a reminder to lock the brakes. R4 was encouraged to wait for assistance with transfers. R4's mental status was documented as baseline for individual, oriented to person, place time and situation. R4's fall focus care plan was updated on 11/14/25, to include brightly colored tape to wheelchair brakes to remind R4 to lock them, risk verses benefit discussed and completed regarding self-transfers. During an observation and interview on 1/2/26 at 10:15 a.m., R4's wheelchair did not have colored tape on either of the brakes, however, had anti-roll bars on both wheels. R4 stated the tape has not been on her brakes of her wheelchair for a while since the bars were put on the wheels. During an interview on 1/2/26 at 3:02 p.m., director of nursing (DON) stated R4's wheelchair had anti-roll brakes placed on her wheelchair a while back due to her repeated self-transfers, however, R4's care plan had not been revised to remove the tape on the brakes of her wheelchair nor the antiroll bars and should have been done in a timely manner. R6's face sheet dated 1/7/26, identified diagnosis of hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right side, epilepsy (brain disorder causing recurrent unprovoked seizures), Charot's joint (a severe, progressive condition where nerve damage causes bones and joints to weaken) of left ankle and foot, and dizziness. R6's Significant Change MDS dated [DATE], indicated R6 was independent with transfers, did not have any falls within the last 6 months and did not have any falls with a fracture, however, R6 had a falls in the past 6 months and on 11/13/25 had a fall with fracture. R6 had severe cognitive impairment, had no behaviors, and was dependent in most activities of daily living. R6's mobility focus care plan dated 1/8/25, identified R6 had limited physical mobility related to right sided hemiplegia and Charot's foot. Goal to improve current level of function in bed mobility. Interventions as followed:-transfer: assist of two with total mechanical lift (initiated 11/19/25) During an interview on 1/5/26 at 10:20 a.m., nursing assistant (NA)-A (continued on next page)

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	01/09/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated R6 had been self-transferring to her wheelchair multiple times during the shift, however, when he reviewed R6's care plan he identified R6 needed a total mechanical lift and needed to find the nurse to clarify how R6 was supposed to transfer. During an interview on 1/5/26 at 10:32 a.m., therapy director (TD) stated she believes R6 had been made independent with transfers but would need to review the recommendations. During an interview on 1/5/26 at 10:54 a.m., occupational therapy (OT)-F stated R6's transfer status had been changed to independent on 12/23/25 from a total mechanical lift. OT-F further stated that the recommendations are given to the nursing department once made so nursing can change the transfers status in the care plan in a timely manner. During an interview on 1/5/26 at 2:36 p.m., assistant director of nursing (ADON)-B stated R6's care plan had not been revised to reflect a change in transfer status after receiving a therapy recommendation on 12/23/25 and should have been done in a timely manner so staff are aware of how R6 transfers. Review of the facility's Care Plan - Baseline and Comprehensive Policy dated 7/18/24, indicated the interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly.

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	01/09/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the?facility?failed to?implement a fall management program which included development and implementation of care plans, comprehensive fall analysis for root causes, and implementation of?appropriate fall?interventions?to prevent and/or reduce the likelihood of future falls?for? 5 of 5 residents? (R1 had one unwitnessed fall with major injury, R6 who had four unwitnessed falls one with major injury, R2 had 8 unwitnessed falls, R3 had 4 unwitnessed falls, and R4 had 10 unwitnessed falls) who had an identified risk for falls. This resulted in actual harm?for R6 who suffered a?left?tibial fracture?and hospitalization and actual harm for R1 when she sustained a spinal fracture?and hospitalization. Findings include R6 R6's face sheet dated 1/7/26, identified diagnosis of hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right side,? epilepsy (brain disorder causing recurrent unprovoked seizures),?Charot's?joint (a severe, progressive condition where nerve damage causes bones and joints to weaken) of left ankle and foot, and dizziness.? R6's physician orders dated 7/14/25, included an order for Meclizine HCl (Hydrochloric Acid) Oral Tablet 25 milligrams. Give one tablet by mouth two times a day for dizziness. R6's?Significant Change?Minimum Data Set (MDS) dated [DATE], indicated?R6 was independent with transfers, did not have any falls within the last 6 months and did not have any falls with a fracture, however, R6 had four falls in the past 6 months and on 11/13/25 had a fall with fracture. R6 had severe cognitive impairment, had no behaviors,?and?was dependent in most activities of daily living. R6's fall focus care plan dated 11/14/20, identified?R6 was?high risk?for falls related to immobility and traumatic brain injury. Goal to be free from major injury from falls.??Interventions as follows:?? -11/14/20: review medication with medical doctor and/or pharmacist. Discontinue unnecessary medications.?? -11/20/20: evaluate for early acute changes in medical condition. Report findings to medical doctor and obtain requested lab or diagnostics.? -11/20/20: low bed? -2/5/25: therapy to screen for transfer status? -2/21/25: mark floor to show where wheelchair positioning is best for transfer and auto lock/antiroll back for wheelchair.?? -4/14/25: R6 refuses to have help with transfers, refused therapy. Anti-skid tape to floor to?assist?with transfers. Risk verses benefit done on 4/14/25?regarding?independent transfers to and from wheelchair.? -5/13/25: call?do not?fall sign to bathroom wall.?? -6/10/25:?Reacher?to wheelchair.?? -6/9/25: physical therapy evaluation.?? -6/23/25: nursing?encourage?loose clothing as resident allows for easier removal in bathroom.?? -6/26/25: Offer help, but do not force and honor wishes and decisions.??? R6's mobility care plan last revised 1/8/25, identified R6 had limited physical mobility related to history of right foot osteomyelitis (serious bone infection), right sided hemiplegia and Charcot's foot. Goal to improve current level of function in bed mobility. Interventions as followed: -No ambulation per physical therapy. Revised on 6/10/25. -Transfers: IND, assist of 1 with gait belt as allows. Revised on 8/19/25 -Toileting: One-able to alert staff to needs, makes toileting needs known. Revised on 7/8/25. ?R6's Incident Report dated?7/21/25,?identified?R6 had an unwitnessed fall at 4:00 p.m., R6 was found on the floor in her room near the bed/bedside table,?bleeding from the right side of her head with a laceration. R6 stated she?had attempted?a self-transfer when she felt dizzy. Immediate action taken: R6 sent to the emergency department (ED) for evaluation.??? R6's hospital ED After Visit Summary dated 7/21/25,?identified?R6 had a mild concussion and head laceration that?required?stitches.?R6's?Meclizine orders were adjusted to take 1 tablet 12.5 milligrams by mouth three times daily as needed. R6 was provided an as-needed nausea medication. R6's July treatment administration record (TAR) included an order on 7/22/25: Orthostatic?blood pressure (continued on next page)

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	01/09/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	daily for 3 days, will need an?assist?of two to?assist?resident to stand. The?treatment record was not signed off as completed on 7/23/25, 7/24/25 and 7/25/25. ? R6's?IDT Post Fall Review form dated 7/29/25 indicated R4 had an unwitnessed fall on 7/21/25. The root cause of the fall was the resident?stated?she felt dizzy. The intervention put into place was orthostatic blood pressure monitoring. R6's meclizine dosage was increased at the emergency department visit. The question on the form, what is the effectiveness of those interventions put into place after the incident? was answered with No new falls. The resident had a head laceration that?required?staples at the hospital.??Although Post Fall Review indicated potential causal factors of being dizzy and orthostatic blood pressures to be monitored, no blood pressures were obtained and no indication R6's care plan was revised for updated fall prevention interventions that prevented/reduced the risk of the self-transfers and addressed dizziness. R6's Incident Report dated?8/3/25,?identified?R6 had an unwitnessed fall at 5:50 p.m., in her room after self-transferring to bed. R6 reported she felt dizzy at the time of the fall. Immediate action taken of reassurance checks performed for safety (no frequency or duration was defined), offered assist bar on bed to help with transfers to bed as R6 uses bar in bathroom, however, R6 declined. Requested medication review from provider/pharmacist.?R6 had been encouraged to drink, but only drinks Pepsi.?R6's record did not identify any documentation of reassurance checks for safety and no indication R6's care plan was revised. ?Additionally, the report did not identify R6's purpose for self-transferring. R6's Pharmacist Consultation Report dated 8/6/25, identified R6's medications were reviewed due to falls and R6 feeling dizzy. Recommendation as followed: -adjust midodrine administration times to mealtimes (recommend not to administer medications after 6:00 p.m. or after the evening meal, or less than four hours before bedtime.) -perform orthostatic blood pressure assessments daily for one week (or as recommended by the provider) to assess for orthostasis which can cause dizziness. If orthostasis identified, provider may want to titrate (increase) midodrine dose while monitoring orthostatic blood pressures for effectiveness. Review of R6's August MAR and TAR did not identify orthostatic blood pressures had been obtained. The August MAR and TAR had the following order: Midodrine Hydrochloride Oral Tablet 2.5 Milligrams. Give 2.5 Milligrams three times a day for hypertension. Hold for blood pressure greater than 140. Administration times were adjusted to 0800, 1300, 1800 on 8/14/25. R6's Interdisciplinary Team (IDT) Post Fall Review/Summary dated 8/11/25,?identified?R6's 8/3/25 fall had been reviewed with a root cause of dizziness. Interventions in place to encourage to consume more?fluids but?prefers to?only drink pop.?Risk verses?benefit?completed, pharmacist reviewed R6's medications,?offered therapy but R6 declined. ?There was no indication the care plan fall interventions were reviewed for effectiveness or identification orthostatic blood pressures were not obtained according to earlier physician orders. R6's Morse Fall Scale dated 10/16/25, identified?R6 as high risk for falling due to history of falling in the past 3 month and overestimates or forgets her limits. R6's care plan was not revised to identify interventions that addressed the identified risk factor. ?R6's Incident Report dated 10/16/25,?identified?R6 had an unwitnessed fall in her?room at 10:30 a.m.,?R6 was found lying on the floor on her right side. Immediate action taken was an assessment. The provider was updated about her dizziness. R6?frequently?overestimated her physical limitations. Augment chair seating to help R6 stay upright during?dizziness. R6's mental status was?documented?as baseline for individual, oriented to person, place, time and situation.?The predisposing?environmental?factor section was left blank. The predisposing physiological factor section marked gait balance. The predisposing situation factors was marked as none.? R6's fall focus care plan revised on 10/17/25 to included augmented seating by lowering back of chair. R6's IDT Fall Review/Summary dated 10/20/25, identified R6 had an unwitnessed fall on 10/16/25. ?Root cause of fall (continued on next page)

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	01/09/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	identified as R6 being dizzy and fell forward out of chair. Intervention put in place to seating augmented to assist resident with staying seated back in chair.? R6's IDT fall review changed seating to assist resident with staying seated in back of chair. ?R6's therapy notes lacked documentation of augmented wheelchair seating had been evaluated.??Although the IDT Fall Review indicated potential causal factors of dizziness there was no comprehensive assessment of the cause of the dizziness. ?R6's fall focus care plan was revised on 10/20/25 to include wheelchair seating?modified?to?assist?with sitting upright in chair.? R6's Incident Report dated 11/13/25,?identified?R6 had an unwitnessed (self-reported) fall in her room at 2:00 p.m. R6 reported she fell in the bathroom after toileting during a?self-transfer and fell on her left knee. ?R6 did not notify nursing staff, she fell on her left knee, got herself up on her own using a grab bar in the bathroom. The immediate action taken was to assess R6. The left knee was noted to be slightly?swollen. R6 complained of significant pain. The pain provider was updated and saw R6 during the same shift. A different provider was also updated and saw R6 during the shift. A STAT X-ray was ordered to rule out a fracture.?The toileting plan was updated (R1's care plan did not identify a historical toileting plan in place at the time of the fall). The rest of the sections on the form were left blank. Although the fall incident report indicated potential causal factors of toileting needs, and the care plan was revised on 11/14/25 included to offer toileting upon rising, before or after meals and at bedtime there was no corresponding comprehensive assessment completed prior to determining toileting schedule. R6's progress note dated 11/13/25 at 10:03 p.m., identified R6 had pain in her left knee from a fall she had in the morning and was administered pain medication. R6's physician progress note dated 11/14/25, identified R6 had pain, bruising, and swelling in left knee following a fall on 11/13/25 and x-ray of left knee ordered to rule out fracture.? Physicians note additionally identified R6 had documented hypotension and required midodrine and had intermittent dizziness for which meclizine was used as needed. R6's progress note dated 11/15/25 at 6:03 a.m., identified R6 was in bed all night, not by choice but because she was unable to get out of bed as she usually does. R6 was having pain 5 out of 10 and unable to use the bathroom by herself hence, she was incontinent of bowel and bladder. R6's progress note dated 11/15/25 at 10:04 a.m., identified R6's x-ray results showed a comminuted (a severe break where the bone shatters into three or more places, usually from a high impact trauma like a fall) fracture in the left tibial plateau (on the top surface of the shin bone at the knee joint. R1 had pain 9 out of 10 and was sent to the ED for evaluation and/or treatment. R6's IDT Fall Review/Summary dated 11/17/25, identified R6 had an unwitnessed fall on 11/13/25 with injury of fracture or tibial plateau, had a root cause of self-transferred at risk-risk verses benefit in place. Intervention of toileting plan reviewed/updated, and effectiveness of interventions put into place after the incident stated effective, however, R6 was hospitalized [DATE] through 11/18/25. R6's hospital Discharge summary dated [DATE], identified R6 had been admitted [DATE] through 11/18/25 due to worsening leg/knee pain following a fall on 11/13/25. R6's x-rays were found to have a moderately displaced and impacted intra-articular fracture (a fracture that extend into the surface of the joint) of the lateral tibial plateau and probable non-displaced fracture of the medial tibial plateau. R6 underwent arthrocentesis (a procedure where a needle is used to withdraw fluid) in the ED for removal of grossly bloody fluid. R6's progress note dated 11/18/25, identified R6 returned to the facility via stretcher, had non-weight bearing status, transferred via total mechanical lift into wheelchair. R6 was impulsive and does not always recognize limitations.?R6's fall focus care plan had not been revised upon return from hospitalization to include any further fall prevention interventions. In review of R6's record there is no indication orthostatic blood pressures had been obtained and evaluated. ?During an interview on (continued on next page)

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	01/09/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	1/5/26 at 11:00 a.m., R6 reported she is currently independent with transfers, but had not fallen recently. Staff have not asked her about her preferences for her care?plan pertaining to daily schedule and activities of daily living. ?She was not involved in the development of her care plan. During a follow up observation and?interview on 1/6/26 at 10:20 a.m., R6's room was?observed?to have one strip of no-skid tape by her toilet but did not have any no-skid tape on the floor on either side of her bed and had a call, don't fall sign in her bathroom. R6 reported she felt dizzy all the time, and staff have not asked her about her dizziness at all. R6 was unable to articulate how, when, and if she communicated to staff about her dizziness and when she needed assistance. When asked what the call, don't fall sign in her bathroom means, she said ish, disgusting., R6 was unable to articulate what the sign meant that was in her bathroom.?R6 was?observed?independently transferring from her bed to her wheelchair. The area where she placed her feet on the ground during the transfer did not have no-skid tape.During an interview on 1/5/26 at 10:10 a.m.,?nursing assistant (NA)-A?stated?he was responsible for caring for R6 on 1/5/26, however, he was unaware what R6's transfer status was and would need to refer to the Kardex (electronic health record).?NA-A was also unsure if R6 had any falls.?After?referencing the computer, he stated R6's care plan had been updated on 11/19/25 to transfer her with a total mechanical lift with the assist of two staff.? During an interview on 1/5/26 at 10:18 a.m., LPN-C?stated?she would need to check R6's care plan to know what her fall interventions were. The unit managers?were?responsible?for?updating care plans with fall interventions.?? During an interview on 1/6/26 at 9:39 a.m., physical therapist (PT)-A stated R6 briefly mentioned her dizziness one time towards the last few days she was on caseload following her tibia fracture. With her aphasia it was hard to know what kind of dizziness it was. R6 was given a quick screen, the dizziness did not seem vestibular in nature. The dizziness was not induced when she turned her head. PT-A indicated she would ask R6 throughout the sessions but wasn't weight bearing and was using the slide board and pivot transfers; R6 reported during the sessions she was not dizzy. PT-A indicated she thought R6 may have enough cognition to report dizziness to staff preemptively, she does convey a lot of information appropriately, but she can't get the words out. Patients are falling when they try to self-transfer it kind of comes down to making sure their needs are met. Why are they trying to get up? During an interview on 1/6/26 at 9:59 a.m., LPN-D was unable to articulate any fall prevention intervention in place for R6 and that R6 reports feeling dizzy every day she works, especially in the morning.?During a follow up interview on 1/6/26 at 10:28 a.m., LPN-D stated R6 ?had no skid strips on the floor in her bathroom, however, did not have any no skid strips next to her bed and they should have been placed there since R6 is independent and could increase the risk of R6 slipping, falling, and? getting hurt. R1 R1's face sheet dated 12/31/25, identified diagnoses of Parkinson's disease (a progressive nervous system disorder affecting movement that caused tremors, stiffness, slow movement, and balance issues) with dyskinesia (involuntary, erratic muscle movements), congestive heart failure?(a condition where the heart does not pump blood as well as it should), atrial flutter (a fast heart rhythm), and diabetes mellitus (a condition that affects how the body uses sugar as fuel).? R1's consultation notes from the hospital medical records, dated 11/29/25-12/5/25,?indicated R1 had?one?fall prior to the hospitalization, on/off episodes of dizziness. history of episodes of frozen balance (a symptom where a person experiences sudden, temporary episodes of being unable to move their feet). R1 was on fall precautions during the hospitalization. R1 reported on and off episodes of dizziness. R1 reported episodes of dyskinetic movements of both upper and lower extremities that could happen at any time.?? ? R1's Morse Fall Scale (a tool used to determine risk for falling) dated 12/5/25, identified R1 was a moderate risk for falling due to overestimating her limits. R1's facility (continued on next page)

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	01/09/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	records did not identify a fall prevention care plan had been initiated after R1 had been identified as a moderate fall risk upon admission on [DATE]. ?? R1's physical therapy (PT) evaluation dated 12/6/25, indicated R1 felt unsteady when walking and worried about falling.?? R1's?admission Minimum Data Set (MDS) assessment dated [DATE], indicated R1?needed substantial?assistance?for transfers/toileting, and had one fall since admission with major injury, R1's MDS did not identify a cognitive assessment that had been completed. R1's Fall Incident report dated 12/7/25,?identified?R1 had an unwitnessed fall in her room at 4:00 a.m., was found lying on the floor, head to toe assessment completed and did not identify injury. R1 did not speak English and family member (FM)-A was called and translated for R1 who stated, she needed to use the bathroom and missed a step and fell. R1 was only oriented to person.?The report had other marked under predisposing environmental, physiological, and situational factors, however, lacked any further?description. The report lacked an immediate intervention to prevent further falls.?R1's record did not include a comprehensive fall investigation/analysis that would address potential causal factors including the lack of care plan interventions that directed staff of R1's required level of care she needed to complete activities of daily living. R1's emergency department hospital medical records, dated 12/7/25,?stated?the patient presents to the emergency department after being found on the floor by nursing staff at 5:00 a.m.?The patient presents from nursing home after falling while?attempting?to walk to the bathroom unassisted. Patient complains of bilateral knee pain,?neck,?and back pain post fall.?CT scan shows?acute superior endplate compression fracture with fracture?lucency (a translucent area)?visualized along the superior endplate of T12 with burst-type morphology and slight bony retropulsion of?the superior endplate of T12 (spine fracture). R1 required pain management, a spinal brace and physical therapy for treatment. R1's progress note dated 12/8/25, indicated R1 discharged home against medical advice. However, there is no indication R1 returned to the facility after being transferred to the ED on 12/7/25. ?Additional record review identified R1's baseline care plan was not initiated/completed until 12/8/25 after R1 transferred/discharged to the hospital. During an interview on 12/31/25 at 8:36 a.m., FM-A stated he had called to the facility on [DATE] around 5:00 a.m., to check on R1 when he was told R1 had fallen but was okay. FM-A then drove the facility and stated R1 was in pain and reported to him she had been on the floor since 2:00 a.m. until 5:00 a.m., FM-A then called 911to have R1 transferred to the hospital.? FM-A further stated at the hospital it was discovered R1 had a broken spine and needed to be hospitalized . Previously, FM-A had requested a fall mat on the floor next to R1's bed because she was at risk for falls, but the request was never completed. According to the facility call light log between 12/6/25 at 10:00 p.m. through 12/7/25 R1's call light had only been activated one time at 4:45 a.m., for 39 seconds.? During an interview on 1/2/26 at 10:43 a.m., trained medication aid (TMA)-A?stated?on 12/6/25-12/7/25 around 11:00 p.m. to 12:00 a.m., TMA-A had helped R1 on the bedpan and did a brief change and had left the call light next to her. At around 4:00 a.m., the nurse found R1 on the ground and had asked TMA-A to assist because R1 said she had slid off the bed. When TMA-A entered R1's room, the call light was on, and her bed was in the low position. TMA-A and the nurse helped R1 back to bed, her brief was dry. After her fall, R1 called TMA-A for a few requests such as putting something on her head. TMA-A stated R1 was refusing some services but did not explain which services. During an interview on 12/31/25 at 2:24 p.m., licensed practical nurse (LPN)-A stated she had found R1 on the floor in her room at an unspecified time after hearing R1 screaming. LPN-A stated R1 had not used her call light, had gripper socks on and the last time R1 had been checked R1 was in bed, however, LPN-A was unable to articulate the exact time of when R1 had been last checked. LPN-A then called FM-A to inform him of R1's fall when FM-A translated for R1 who stated she had been (continued on next page)

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	01/09/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	attempting to use the bathroom and missed her step and fell. FM-A came to the facility that morning and wanted to take R1 to the hospital, LPN-A told FM-A it was okay to take R1 to the hospital. LPN-A was unable to articulate how R1 was supposed to transfer or any fall prevention interventions that were supposed to be utilized to prevent R1 from falling.? During an interview on 1/5/26 at 3:57 p.m., assistant director of nursing (ADON)-A stated he thought R1's needs were met during her stay at the facility. ADON-A verified the baseline care plan was not completed since it was a new admission over the weekend. ADON-A could not verify when he became aware of R1's injury from the fall. The ADON's role after falls includes making sure there was a fall report completed with an immediate intervention, make sure all relevant parties were informed, and the care plan was updated. Later there is a root cause analysis completed. ADON-A stated not having a care plan for R1 increased her risk of falls. ADON-A did not think there was an investigation into R1's fall since she went to the hospital right away and did not return to the facility. ADON-A stated he didn't think the care plan being in place could have prevented the fall since R1 was impulsive and the nurses did not know the full extent of her ambulation.?? During an interview on 1/2/26 at 3:00 p.m., the director of nursing (DON) verified R1 had not had baseline care plan to include any fall prevention interventions even though R1 was identified as a moderate fall risk. The DON was unsure whether R1 had an injury from her fall on 12/7/25.??Did she say anything about their admission process and why the careplan hadn't been initiated? ? ? R2 ? R2's face sheet dated 12/31/25, identified diagnoses of cerebral infarction (stroke), type II diabetes mellitus, diabetic retinopathy with macular edema (vision issue), epilepsy (seizures),?hemiplegia?and hemiparesis?affecting the right dominant side (partial paralysis), gout (joint pain),?and?foot drop. ? R2's Medicare?5-day?MDS assessment dated [DATE], indicated R2 needed?substantial/maximal assistance for transfers, had a fall in the last month prior to admission, was mildly cognitively impaired and?required?substantial?assistance?with activities of daily living.?? ? R2's Morse fall scale assessment dated [DATE], indicated R2 was at?high risk?for falling.?? ? R2's fall focus care plan dated 12/31/25, identified R2 was a moderate fall risk related to dysarthria (motor speech disorder) following cerebral infarction, type II diabetes with retinopathy, syncope and collapse, need for?assistance?with personal care and cognitive communication deficit. Goal to be free from?serious injury?related to falls. Interventions were as followed: -Review medications with physician or pharmacist. Discontinue un-necessary medications, evaluate for uncontrolled pain, consider scheduled pain medication regimen. Provide/offer snacks in between meals or?with signs of restlessness. Physical therapy and occupational therapy to evaluate and treat. Ensure environment is clear of clutter.?Initiated 10/12/25.?? R2's Incident Report dated?10/12/25,?indicated R2 had an un-witnessed fall at 4:15 p.m. ?R2 had been found sitting on the floor in front of her bed, had gripper socks on, and stated she was trying to transfer herself from bed to her wheelchair but slipped and fell. Immediate action taken?as followed: place call light within reach, putting the bed in the lowest position, therapy evaluated R2 and changed transfer status from independent to assist of one. R2's mental status was?documented?as oriented to person,?place,?and time. The predisposing environmental factors was left blank. The predisposing physiological factors was left blank. The predisposing?situation?factors?was?documented?as admitted within the last 72?hours. ? R2's mobility focus care plan revised on 10/12/25, that R2?required?the?assistance?of one staff for transfers,?used a wheelchair for ambulation. R2 could also ambulate with the assist of two staff,?with the gait belt and wheelchair to follow.??The fall care plan was updated on 10/13/25 to include patient educated to?participate?with plan of care, will work with therapy to regain maximum strength. ? R2's IDT Post Fall Review form dated?10/16/25 indicated R2 had an unwitnessed fall on 10/12/25. The root cause of the fall was?documented?as (continued on next page)

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	01/09/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	new admit from community, used to being independent, attempted to?self-transfer?and fell. The immediate intervention was to encourage and educate R2 to request?assistance?and?participate?in her plan of care. R2 will receive multiple therapies to maximize strength and independence. R2 agreed.?The question on the form, what is the effectiveness of those interventions put into place after the incident? was answered with No new falls.?There was?no?indication?of a comprehensive analysis to?identify?causal factors was completed. ? R2's Incident Report dated 10/30/25, indicated R2 had an unwitnessed fall in her room. R2 was sitting on the floor with her back laying against her bed. R2 stated she was?lying?in bed when her call light fell and landed underneath the bed. R2 tried to get out of bed to get the call light and slipped and fell on the floor.?Immediate action taken was to complete an assessment and encourage R2 to?call for help at all times. A clip was placed on?the call light.? R2's IDT Post Fall Review form dated 11/4/25 indicated R2 had an unwitnessed fall on 10/30/25. The root cause of the fall was documented as R2 tried to get out of bed and slipped on the floor. R2 stated she was trying to get her call?light. The immediate intervention was to replace the clip on the call light.?The question on the form, what is the effectiveness of those interventions put into place after the incident? was answered with No new falls.?There was?no?indication?of a comprehensive analysis to?identify?causal factors was completed and no?indication?R2's care plan was revised.??? ? R2's Incident Report dated 11/8/25, indicated R2 had an un-witnessed fall in her room. A staff heard a loud thud, R2 was found in her room on the floor by the door. R2 stated she was trying to get up. R2 was assessed, no pain or injuries were noted. Immediate action taken was to encourage patient to ask for help when she needs to get up.?Staff to put the wheelchair next to the bed to discourage patient from independent walking. R2's mental status was documented as baseline for individual. Predisposing environmental factors were documented as not applicable. Predisposing?physiological?factors was left blank.?Predisposing situation factors was listed as ambulating without assistance. R2's care plan was not revised until 11/10/25 for the wheelchair placement intervention. ? During an interview on 1/5/26 at 10:20 a.m., nursing assistant (NA)-A was unaware that R2's wheelchair was supposed be left next to her bed and the only other fall prevention was to check on R2 frequently, however, was unable to specify how often R2 was supposed to be checked on while she is in her room.? NA-A further stated R2 continues to self-transfer at times. ? R2's IDT Post Fall Review form dated 11/17/25 indicated R2 had an unwitnessed fall on?11/08/25 reviewed (9 days after fall).?The root cause of the fall was documented as walking independently when R2 was care planned to have?assistance. The immediate intervention put into place was to put her wheelchair next to the bed?to discourage independent walking. The question on the form, what is the effectiveness of those interventions put into place after the incident? was answered with No new falls.? ? R2's Incident Report dated?11/21/25,?indicated R2 had an un-witnessed fall in her room. Staff told writer that R2 had a fall. The writer went to R2's room, R2 said she was?trying?to transfer herself to bed and fell on the floor. Resident was assessed with no injuries noted. She was encouraged to use the call light and?call for help at all times. Immediate action taken was to?administer?Tylenol?and put on?gripper?socks.?R2's mental status was documented as oriented to person, place,?time?and situation. Predisposing environmental factors was documented as not applicable. Predisposing physiological factors was documented as none and impaired?memory. Predisposing situation factors was documented as none. The?physician?and family member were notified. There was?no?indication?of a comprehensive analysis to?identify?causal factors. R2's care plan was not revised to have grippers socks on when not wearing shoes until 12/2/25. ?R2's Incident Report dated 11/22/25, indicated R2 had an unwitnessed fall in her room. Staff heard a squeal in the hallway. R2 was found on the floor. R2 said she was trying to put her shoes on and she slid and fell. No (continued on next page)

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	01/09/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	injuries were noted. The immediate action taken?was Pt encouraged to call for help to put on?footwear. R2's mental status was documented as baseline for individual. Predisposing environmental factors was?left blank. Predisposing physiological factors was documented as impaired memory. Predisposing situation factors was documented as?reaching/bending.?There was?no?indication?of a comprehensive analysis to?identify?causal factors nor indication R2's care plan was revised. ? R2's Incident Report dated?12/2/25,?indicated R2 had an un-witnessed fall in her room. R2 was found on the floor, sitting by the foot of her bed. R2 said she was trying to put her shoes on. R2 denied a?head strike, her range of motion was within her baseline. R2 did not report pain, she was?assisted?up by two staff and seated in her chair. The immediate action taken was to remove her shoes and put in the closet when she is in?bed,?so the visual cue is not present.?The predisposing?environmental?factors, predisposing physiological factors and predisposing physiological factors were all left blank.?? ? R2's IDT Post Fall Review form dated 12/6/25 indicated R2 had an unwitnessed fall on 12/2/25. The root cause of the fall was balance. The immediate intervention put into place was removal of visual cues. The question on the form, what is the effectiveness of those interventions put into place after the incident? was answered with Effective. Although the IDT Post Fall Review indicated potential causal factors balance, there was no care plan revision to include intervention regarding balance issues. The care plan was revised on 12/3/25 to include Remove shoes and put in closet when put in bed so visual cue is not present. ? R2's Incident Report dated 12/13/25, indicated R2 had an un-witnessed fall in her room. R2 stated she was trying to transfer herself from the wheelchair to her recliner. The immediate intervention put into place was a Call don't fall sign was placed in her room. The report?indicated?she was a

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	01/09/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded to increase in resident falls by developing and implementing action plans for process improvement. This had the potential to affect all 60 residents that resident in the facility. Findings include:Based on review of facility records, Quality Review minutes, QAPI documentation, incident reports, and staff interviews, the facility failed to implement its QAPI program in accordance with its written plan, including failure to identify falls as a high-risk and problem-prone area, failure to initiate and sustain Performance Improvement Projects, failure to conduct comprehensive root cause analysis, and failure to develop, implement, and monitor effective corrective actions to prevent recurrence. Findings include The facility's QAPI Plan states that Edenbrook of Edina will conduct Performance Improvement Projects (PIPs) that are designed to take a systematic approach to revise and improve care or services in areas that we identify as needing attention and that these projects will lead to changes and guide corrective actions in our systems, which cross multiple departments. The Plan further states that the QAA committee will review data and input on a monthly basis to look for potential topics for PIPs and that factors considered include high-risk, high-volume, or problem-prone areas that affect health outcomes, quality of care and services. The Plan also requires that PIP teams use root cause analysis to ensure that the root cause and contributing factors are identified, and that to prevent future events and promote sustained improvement our campus develops actions to address the identified root cause and/or contributing factors of an issue/event that will affect change at the systems level. In addition, the Plan requires the facility to identify and use data to monitor our performance, establish goals and thresholds, systematically analyze underlying causes of systemic problems and adverse events, and develop corrective action or performance improvement activities. The facility provided documents labeled Quality Assurance Performance Improvement minutes and Quality Review minutes discussion. The documents identified the following: Review of the facility's corporate quality metrics identified that the facility's internal Quality Measure dashboard reflected triggers related to falls with major injury. Specifically, the Percentage of Residents Experiencing One or More Falls with Major Injury measure generated one trigger in Quarter 2 and one trigger in Quarter 3. According to the facility's QAPI Plan, performance data and thresholds are used by the Quality Assurance and Assessment Committee to identify high-risk, high-volume, and problem-prone areas and to determine potential topics for Performance Improvement Projects. Despite these triggers, the facility's Quality Assurance and Performance Improvement documentation did not reflect initiation of a sustained Performance Improvement Project, completion of comprehensive root cause analysis, or implementation and monitoring of system-wide corrective actions related to falls with major injury. Review of the facility's Quality Review documentation dated 6/6/25 identified the facility tracked fall rates per 1,000 resident days with an established goal of 5. The minutes documented the following monthly fall rates and counts: March 2025 - Rate 4.2 (9 falls), April 2025 - Rate 15.1 (31 falls), and May 2025 - Rate 5.9 (12 falls), with April and May exceeding the facility's stated goal. The Quality Review documentation included data tables and graphs that tracked cumulative fall totals and categorized falls by location, shift, and witness status. The graphs identified a total of 52 falls, including 46 unwitnessed falls. The location data identified that 37 falls occurred in resident rooms and 9 occurred in resident bathrooms. The Quality Review minutes and accompanying documentation did not reflect discussion of underlying causal factors, completion of a comprehensive root cause analysis, initiation of a Performance Improvement Project, or development and monitoring of (continued on next page)

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	01/09/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	system-wide corrective actions related to the identified fall patterns. Review of the facility's Quality Review documentation dated 7/18/25 identified the facility tracked fall rates per 1,000 resident days with an established goal of 5. The minutes documented the following monthly fall rates and counts: April 2025 - Rate 15.1 (31 falls), May 2025 - Rate 5.9 (12 falls), and June 2025 - Rate 9.0 (17 falls), with April and June exceeding the facility's stated goal. The Quality Review documentation further identified one fall with major injury (R6). The Quality Review documentation included data tables and graphs that tracked cumulative fall totals and categorized falls by location, shift, and witness status. The graphs identified a total of 62 falls, of which 55 were unwitnessed. The location data identified that 43 of the 62 falls occurred in resident rooms and 9 occurred in resident bathrooms. Comparison of the June and July reporting periods identified an increase in cumulative documented falls from 52 to 62. Even though comparison of the June and July reporting periods identified an increase in cumulative documented falls from 52 to 62 and identified one fall with major injury (R6), the Quality Review minutes and accompanying documentation did not reflect discussion of contributing factors, completion of a comprehensive root cause analysis, initiation of a Performance Improvement Project, or development and monitoring of system-wide corrective actions related to fall prevention. Review of the facility's Quality Review documentation dated 8/8/25 identified the facility tracked fall rates per 1,000 resident days with an established goal of 5. The minutes documented the following monthly fall rates and counts: May 2025 - Rate 5.9 (12 falls), June 2025 - Rate 9.0 (17 falls), and July 2025 - Rate 3.1 (6 falls), with May and June exceeding the facility's stated goal. The Quality Review documentation included data tables and graphs that tracked cumulative fall totals and categorized falls by location, shift, and witness status. The graphs identified a total of 35 falls, of which 30 were unwitnessed. The location data identified that 22 of the 35 falls occurred in resident rooms and 6 occurred in resident bathrooms. Although the cumulative fall data reflected a decrease during this reporting period, the Quality Review minutes and accompanying documentation did not reflect analysis of the factors, interventions, or changes in practice that may have contributed to the decrease, nor did they reflect efforts to evaluate, formalize, or sustain any practices associated with improved outcomes. The documentation also did not reflect completion of a comprehensive root cause analysis, initiation of a Performance Improvement Project, or development and monitoring of system-wide corrective actions related to fall prevention. Review of the facility's Quality Review documentation dated 9/5/25 identified the facility tracked fall rates per 1,000 resident days with an established goal of 5. The minutes documented the following monthly fall rates and counts: June 2025 - Rate 9.0 (17 falls), July 2025 - Rate 3.1 (6 falls), and August 2025 - Rate 8.5 (17 falls), with June and August exceeding the facility's stated goal. The Quality Review documentation included data tables and graphs that tracked cumulative fall totals and categorized falls by location, shift, and witness status. The graphs identified a total of 40 falls, of which 34 were unwitnessed. The location data identified that 26 of the 40 falls occurred in resident rooms. Although the cumulative fall total increased compared to the previous reporting period and August reflected a return to elevated fall rates following the July decrease, the Quality Review minutes and accompanying documentation did not reflect discussion of underlying causal factors, completion of a comprehensive root cause analysis, initiation of a Performance Improvement Project, or development and monitoring of system-wide corrective actions related to the identified fall patterns. Review of the facility's Quality Review documentation dated 10/10/25 identified the facility tracked fall rates per 1,000 resident days with an established goal of 5. The minutes documented the following monthly fall rates and counts: July 2025 - Rate 3.1 (6 falls), August 2025 - Rate 8.5 (17 falls), and September 2025 - Rate 8.3 (continued on next page)

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	01/09/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(16 falls), with August and September exceeding the facility's stated goal. The Quality Review documentation included data tables and graphs that tracked cumulative fall totals and categorized falls by location, shift, and witness status. The graphs identified a total of 42 falls, of which 36 were unwitnessed. The location data identified that 31 of the 42 falls occurred in resident rooms. Comparison of the September and October reporting periods identified an increase in cumulative documented falls from 40 to 42. Even though comparison of the September and October reporting periods identified an increase in cumulative documented falls from 40 to 42 , the Quality Review minutes and accompanying documentation did not reflect discussion of contributing factors, completion of a comprehensive root cause analysis, initiation of a Performance Improvement Project, or development and monitoring of system-wide corrective actions related to fall prevention. Review of the facility's Quality Review documentation dated 11/14/25 identified the facility tracked fall rates per 1,000 resident days with an established goal of 5. The minutes documented the following monthly fall rates and counts: August 2025 - Rate 8.5 (17 falls), September 2025 - Rate 8.3 (16 falls), October 2025 - Rate 6.1 (13 falls), and November 2025 - 12 falls month to date (Rate 5.7), with all reviewed months exceeding the facility's stated goal. The report identified R7 had a fall with major injury; the date of the fall and injury was not identified. A clarifying interview with DON on 1/26/26 at 10:30 a.m. verified R7's fall with major injury occurred on 8/18/25. At the time of the report was generated (11/14/25) R6's second major injury was not accounted for because the facility became aware on 11/15/25 after an X-ray was obtained. The facility had their quality meeting on 11/17/25, however R6's injury was not accounted for in the minutes. The Quality Review documentation included data tables and graphs that tracked cumulative fall totals and categorized falls by location, shift, and witness status. The graphs identified a total of 58 falls, of which 51 were unwitnessed. The location data identified that 47 of the 58 falls occurred in resident rooms. Comparison of the October and November reporting periods identified an increase in cumulative documented falls from 42 to 58. Even though comparison of the October and November reporting periods identified an increase in cumulative documented falls from 42 to 58 and minutes should have reflected one fall resulting in major injury, the Quality Review minutes and accompanying documentation did not reflect discussion of contributing factors, completion of a comprehensive root cause analysis, initiation of a Performance Improvement Project, or development and monitoring of system-wide corrective actions related to fall prevention Review of facility provided fall incident report log for the month of November 2025, identified the facility had a total 23 falls for the month of November, which demonstrated an accumulative increase of the number of falls from October. SEE F689:Based on observation, interview, and document review the?facility?failed to?implement a fall management program which included development and implementation of care plans, comprehensive fall analysis for root causes, and implementation of?appropriate fall?interventions?to prevent and/or reduce the likelihood of future falls?for? 5 of 5 residents? (R1 had one unwitnessed fall with major injury, R6 who had four unwitnessed falls one with major injury, R2 had 8 unwitnessed falls, R3 had 4 unwitnessed falls, and R4 had 10 unwitnessed falls) who had an identified risk for falls. This resulted in actual harm?for R6 who suffered a?left?tibial fracture?and hospitalization and actual harm for R1 when she sustained a spinal fracture?and hospitalization. During an interview on 1/7/26 at 1:51 p.m., director of nursing (DON) stated the quality committee meets monthly, however, did not meet in December because of the holidays.? ?she began working at the facility first part of December 2025 and quickly identified the facility had a concern with falls.? DON stated the fall rate to her was high for the month of November 2025, however, had not brought her concerns to the quality committee to begin an action plan to investigate the reason for the concern for falls. (continued on next page)

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	01/09/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/7/26 at 2:49 p.m., regional director of clinical services (RDCS) stated that the facility relies on their quality metrics to flag a concern. The metrics did not flag for the month of November for falls due to having a higher census that month, therefore the facility did need to create an action plan to correct this, however, RDCS identified the fall rate of 5.7 which exceeded the fall rate goal.? ? During an interview on 1/6/26 at 3:04 p.m., medical director (MD) stated he is part of the QAPI committee and had not been informed of any concern with an increase in falls at the facility.