

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245275 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>10/31/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Edenbrook of Edina |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6200 Xerxes Avenue South<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579</b></p> <p>Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment and a physician's order was completed to allow a resident to safely administer their own medication for 3 of 4 residents (R263, R15, R54) observed with unattended medication.</p> <p>Findings include:</p> <p>R263's Admission Record dated 10/31/24, identified admission on 10/26/24, with diagnoses including orthopedic aftercare following surgical amputation and type one diabetes mellitus.</p> <p>R263's undated assessments list lacked a SAM evaluation for insulin until 10/28/24.</p> <p>R653's baseline care plan and comprehensive care plan dated 10/26/24, identified he could communicate easily and understand staff, however, lacked an assessment for SAM of home insulin until 10/28/24.</p> <p>R263's progress notes lacked assessment of SAM for home insulin. The progress notes lacked determination of R263's clinical appropriateness to SAM insulin, or involvement of the interdisciplinary team (IDT), including the physician, on the decision for R263 to SAM insulin.</p> <p>R263's behavior tracking dated 10/26/24 through 10/31/24, lacked any refusal of care.</p> <p>R263's Order Summary Report dated 10/31/24, lacked an order to SAM until 10/28/24.</p> <p>R263's Medication Administration Record (MAR) dated 10/26/24 through 10/31/24, identified an admission order for insulin regular (Human) inject six units subcutaneously with meals for diabetes mellitus (DM) and insulin regular (Human) inject per sliding scale if 151 to 200, give 2 units; 201 to 250 give 4 units, 251 to 300 give 6 units, 301 to 350 give 8 units, 351 to 400 give 10 units and call provider. No insulin was documented as administered on 10/26/24.</p> <p>R263's blood sugar summary dated 10/31/24, identified no blood sugars recorded on 10/26/24, on the day of admission. The readings on 10/27/24, ranged from 113 to 324 and on 10/28/24, 186 to 383.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245275   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>10/31/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Edenbrook of Edina   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6200 Xerxes Avenue South<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview and observation on 10/28/24 at 12:21 p.m., R263 was awake and in bed watching TV. A mostly full Humulin R insulin bottle was observed on the bedside table. The bottle was not labeled with a date when opened. There was also small, narrow syringe without markings on it for dosing on the bedside table. His left upper arm had a continuous blood glucose monitor (CBGM). R263 stated he could check his blood sugar readings at any time on the CBGM. R263 stated his goal blood sugar was 120 and he would take 4.5 units of insulin for every 100 that his blood sugar was over 120, which conflicted with the physician's orders on the MAR. R263 stated the insulin and syringe were brought from home, he administered it himself, and that the nurse was aware from his admission on the weekend. R263 stated he had been managing his own diabetes and insulin for [AGE] years. Nursing assistant (NA)-C entered the room, took the urinal which was on the same bedside table as the insulin and syringe, emptied the urinal in the bathroom, rinsed it, returned it to the bedside table right next to the insulin and syringe, bagged garbage and linen and exited the room.</p> <p>During a follow up interview on 10/28/24 1:53 p.m., NA-C was unable to answer the process if she observed medications in a resident's room. When asked if she should let the nurse know, she replied yes.</p> <p>During an interview on 10/28/24 at 1:54 p.m., registered nurse (RN)-B stated he completed R263's admission assessments on 10/26/24. RN-B stated R263 administered his own insulin over the past two days since admission. RN-B stated he would ask R263 what his blood sugar was and how much insulin he administered and would then document those amounts in the MAR. RN-B stated R263 said he knew how to SAM insulin; however, a SAM assessment for safety was not completed and should have been, along with notifying the physician for an order.</p> <p>During a follow up observation on 10/28/24 at 3:12 p.m., the home insulin was no longer on R263's bedside table and syringe was gone.</p> <p>During a follow up interview and observation on 10/28/24 at 5:54 p.m., the director of nursing (DON), obtained the current blood sugar results from R263 and drew up the prescribed dosage of insulin. The DON entered R263's room with his evening insulin and explained the process for SAM while in the facility. The DON completed a SAM assessment with R263 which verified he was able to SAM insulin after nursing set up. The DON stated a R263's SAM assessment should be done and documented prior to actual SAM to assess for safety and ability.</p> <p>48299</p> <p>R15's quarterly Minimum Data Set (MDS) 8/12/24, indicated R15 was cognitively intact and varied from set-up to dependent assistance with activities of daily living (ADLs).</p> <p>R15's medical record lacked assessment for self-administration of medications.</p> <p>R15's physician's orders did not indicate R15 was able to self-administer medications.</p> <p>R15's care plan printed 10/31/24, directed staff to administer medications as ordered and did not indicate R15 self-administered medication.</p> <p>(continued on next page)</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245275  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>10/31/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Edenbrook of Edina   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6200 Xerxes Avenue South<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During observation on 10/29/24 at 8:22 a.m., R15 sat in the dining room eating breakfast with multiple medications in a cup next to his plate. Two dining services staff plated food and served residents. Multiple dining services staff and NAs entered and exited the dining room and served other residents in dining room or obtained a tray for delivery to a resident room.</p> <p>When interviewed on 10/29/24 at 8:35 a.m., NA-A stated nurses brought residents medications and made sure they were taken. NA-A confirmed medications were next to R15 without licensed staff, and R15 started to take his medications independently.</p> <p>When interviewed on 10/29/24 at 1:59 p.m., R15 stated staff usually left him with his medications and water, and R15 took his medications after he finished breakfast.</p> <p>When interviewed on 10/29/24 at 2:02 p.m., licensed practical nurse (LPN)-A stated residents required an order and care plan to leave medications with them. LPN-A stated R15 preferred to take his medications in the dining area and had been his routine for months. LPN-A did not know if R15 had an order or care plan for self-administration of medications. LPN-A verified they left the medications with R15 at breakfast and stated R15 got anxious when staff watched him take medications. R15 stated self-administration assessments were important for resident safety.</p> <p>When interviewed on 10/31/24 at 2:27 p.m., assistant director of nursing (ADON)-C stated residents needed a self-administration assessment and order from the provider for medications to be left with a resident. ADON-C stated it was important to assess a resident before leaving them to take medication without licensed staff supervision to ensure resident was able to swallow their medication without choking or dropping on floor. ADON-C confirmed R15 did not have orders, care plan, or assessment for self-administration of medications.</p> <p>On 10/31/24 at 4:36 p.m., the DON, expected staff giving medication to stay with resident until medications taken unless resident had an assessment, orders, and care plan for self-administration of medications. DON stated R15 did not like nursing standing over him, and staff should have followed proper procedure.</p> <p>49617</p> <p>R54's admission MDS dated [DATE], indicated she had intact cognition and was not receiving any scheduled or as needed (PRN) pain medications. Additionally, the MDS indicated R54 rarely had pain that interfered with her daily activities or sleep. R54's medical diagnoses included heart failure, atrial fibrillation (an irregular heartbeat), high blood pressure, kidney failure, and chronic obstructive pulmonary disease (COPD, or a group of lung diseases that causes breathing difficulties by restricting airflow to the lungs).</p> <p>R54's functional abilities Care Area Assessment (CAA) dated 9/23/24, indicated she had physical limitations resulting in a need for assistance with self-care.</p> <p>R54's electronic health record was reviewed on 10/28/24 and lacked documentation of a self-administration of medication assessment.</p> <p>R54's order summary, printed 10/31/24, lacked documentation of orders for Icy Hot pain relief roll-on as well as an order for self-administration of medications.</p> <p>(continued on next page)</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245275  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>10/31/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Edenbrook of Edina   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6200 Xerxes Avenue South<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During observation on 10/28/24 at 5:05 p.m., R54 sat in her room next to her bed. There was a bottle of Icy Hot roll-on pain reliver in the bag attached to her walker. R54 stated the previous night or two ago, she had pain in her legs overnight and she requested nursing staff to help her apply the Icy Hot. She stated it was effective at relieving her pain.</p> <p>During observation of morning cares on 10/30/24 at 7:44 a.m., NA-B reported NAs could apply barrier creams and lotions to residents but could not apply prescription creams or other topical agents. NA-B stated for topical pain relief medications, even over-the-counter (OTC), needed to be applied by a nurse. NA-B said if NAs saw any medications, topical agents or otherwise, they should be taken out of a resident's room and given to the nurse. NA-B confirmed there was a bottle of Icy Hot pain relief roll-on on R54's bedside table and stated she could apply that herself but sometimes would ask for staff's assistance. NA-B stated belief that the Icy Hot was a PRN and was not worried about the bottle being left in R54's room, and said, that is okay here.</p> <p>During observation and interview on 10/30/24 at 8:44 a.m., licensed practical nurse (LPN)-B prepared medications for administration and knocked on R54's door, introduced self and the task. LPN-B verified R54 had the Icy Hot pain relief roll-on at her bedside. After exiting the room, LPN-B reviewed R54's medical record and verified there was no order for the Icy Hot. LPN-B knocked on R54's door again, entered and retrieved the bottle of Icy Hot and returned to the medication cart. LPN-B reviewed the medical record and verified R54 did not have a self-administration assessment, nor did she have a provider's order for self-administration of medications. LPN-A stated if R54 wanted to apply the Icy Hot herself, she would need to be assessed for self-administration of medications before the facility obtained a provider's order that she was okay to self-administer medications.</p> <p>During interview on 10/31/24 at 2:38 p.m., the DON stated staff were expected to complete a self-administration screening, obtain a provider's order for self-administration, then update the resident's care plan if a resident wanted to self-administer any medication, including OTC products like Icy Hot. The DON stated the struggle the facility faced was residents and guests bringing in outside medications and not notifying nursing staff. The DON expected staff to remove medications, including OTC products and topical agents, from a resident's room and bring them to the nurse.</p> <p>A facility policy titled Medication Self Administration last revised 2/12/24, directed licensed staff to complete a screen to determine factors that may impact safe administration of medications. If the resident was deemed appropriate to self-administer medications, staff were guided to obtain a physician order and care plan the self-administration of medications with interventions specific to the individual resident.</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245275  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>10/31/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Edenbrook of Edina   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6200 Xerxes Avenue South<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48299</p> <p>Based on observation and interview, the facility failed to provide a homelike environment for 1 of 1 resident (R27) reviewed who had an unclean tube feeding pole.</p> <p>Findings include:</p> <p>R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 was severely cognitively impaired, dependent on staff for all activities of daily living, had diagnoses of traumatic brain injury and dementia, and indicated they had a feeding tube through which they received more than 50% of their nutrition.</p> <p>During observation on 10/28/24 at 2:14 p.m., R27 was in his room with tube feeding running. The tube feeding pump was attached to a pole, which had smudged areas down most of the pole. The legs of the base had multiple drops and streaks of tannish colored substance which were scattered and approximately covered a quarter of the surface area of two legs. One of the legs of the base had a thick area approximately three by two and a half inches of crusted tannish colored substance, and the floor had four tannish colored drops approximately three quarters of an inch</p> <p>When interviewed on 10/28/24 at 3:53 p.m., registered nurse (RN)-A stated staff cleaned the tube feeding pole when they noticed it was dirty and did not document. RN looked at R27's tube feeding pole, base, and floor and verified cleaning was needed. RN-A stated there were infection concerns and added the tube feeding pole was not a good picture.</p> <p>When interviewed on 10/31/24 at 12:36 p.m., licensed practical nurse (LPN)-B stated they did not clean tube feeding poles on day shift, did not know what the routine was, and different shifts completed different tasks. LPN-B stated they wiped down tube feeding poles if they saw it was needed. LPN-B stated tube feeding poles were cleaned for infection control and resident dignity.</p> <p>When interviewed on 10/31/24 at 4:36 p.m., director of nursing (DON) expected staff to clean tube feeding poles.</p> |  |  |