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	01/22/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess for safe self-administration and storage of medications and failed to obtain a physician order for 2 of 3 residents (R24 and R50) reviewed for self-administration of medications.Findings include:R24's quarterly minimum data set (MDS) dated [DATE], included R24 was cognitively intact. R24's diagnoses included respiratory failure, chronic obstructive respiratory failure (a progressive lung disease that damages airways resulting to shortness of breath, mucus production, wheezing and chest tightness).R24's Order Summary Report dated 1/21/26, included an order for an albuterol sulfate inhaler (Ventolin HFA Inhalation Aerosol Solution) with instructions to take 2 puffs every 4 hours as needed.R24's self-administration assessment dated [DATE], included the selection of Not Applicable for the question regarding the resident's ability to store medications securely in his room. The results of the assessment included resident could self-administer medications after set up by a licensed nurse.During observation on 1/20/26 at 11:40 a.m., an inhaler was sitting on R24's bedside table. R24 stated it was his rescue inhaler, and he always had it with him.During interview on 1/21/26 at 9:14 a.m., licensed practical nurse (LPN)-A stated the there is an order in R24's chart that he can self-administer medications after a nurse sets them up. LPN-A stated R24 has always had his rescue inhaler at his bedside, but she was not aware of any other self-administration orders that stated he could store medications in his room.During interview 1/21/26 at 11:32 a.m., assistant director of nursing (ADON)-A stated a resident needed a self-administration assessment and an order from a provider if they wished to have medications in their room. ADON-A stated R24 had an order stating he could self-administer medications after set up by a nurse. ADON-A stated R24 could not keep his inhaler in his room.During interview in R24's room on 1/21/26 at 1:37 a.m., ADON-A confirmed R24 had an inhaler on his bedside table with a label of Ventolin. R24 stated it was his rescue inhaler, and he always had it with him.R50R50's admission MDS dated [DATE], included R50 was cognitively intact. R50's diagnoses included hypertension (high blood pressure), peripheral vascular disease (a narrowing or blockage of blood vessels commonly affecting the legs which could lead to leg pain, coldness, numbness and non-healing wounds), and diabetes.Provider progress note dated 12/10/25, included provider had a discussion with resident about nicotine gum and its effects on blood sugars. Per the note, the provider instructs the R50 she could continue to chew nicotine gum. Provider did not provide an order for nicotine gum during consultation.R50's physician order summary report dated 1/21/26, included an order for nicotine transdermal patch 24 hr with instructions to apply 21 mg transdermally (on the skin) one time a day for smoking cessation. No other nicotine orders were included on order summary. No order for self-administration of medication was identified on the order sheet.R50's care plan reviewed 1/20/26, lacked indication R50 could self-administer medications.R50's medical record lacked assessment of R50's ability to safely self-administer and store medications. During observation on 1/20/26 at 12:21 pm, R50 had a green box of cool mint nicotine gum on her bedside tray table. Staff placed a meal tray on R50's bedside table, which required her to move the box of nicotine gum off to the side.During interview on 1/21/26 at 8:14 a.m., R50 stated she always used nicotine gum and that her nephew brought the gum to her. Resident had a (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	white box of Kirkland brand nicotine gum on her bed.During interview on 1/21/26 at 11:41 a.m., ADON-B stated a resident would need a self-administration assessment, a provider order, and a locked box for safe storage of medications prior to keeping medications in the room, including over the counter medications. ADON-B confirmed there was an order for a nicotine patch for R50, but not an order for nicotine gum. ADON-B stated she was unable to find a self-administration assessment for R50 or a provider order that she could store the nicotine gum in her room. ADON-B stated it was important for the assessment and order prior to self-administration to ensure the resident was able to take and store medications safely, and stated it was important for the provider to know all medications including over the counter medications a resident was taking to ensure they would not interfere with other medications ordered.During interview on 1/21/26 at 1:31 p.m., director of nursing (DON) stated an assessment was to be completed and an order obtained prior to a resident storing medication in their room to ensure they were able to take and store it properly. A lock box would have been provided for storage of the medication. DON stated this was also true for over-the-counter medications resident wished to take and keep in their rooms. The DON stated this was important to make sure there were no contraindications with other medications and to monitor the amount of medication being used.During interview on 1/22/26 at 9:46 a.m., physician assistant (PA)-A stated she was aware R50 was using nicotine gum, but was using it prior to her starting as a PA at the facility, so she was not aware she did not have an order. PA-A confirmed residents should have a provider order for over-the-counter medications.Facility policy for self-administration of medications dated 2/12/24, included a resident would be screened by a licensed nurse for safe administration of medication. A physician order would be needed for those who were self-administering medications.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the skilled nursing facility Advanced Beneficiary Notice (SNFABN-10055) was provided to 1 or 3 residents (R59) reviewed for Beneficiary notifications. Findings include:R59's Perspective payment system Part A Discharge Minimum Data Set (MDS) dated [DATE], indicated R59 was admitted on [DATE] and Medicare Part A discharge date of 8/13/25.R59's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN), informed R59 services would end on 8/14/25. However, this notice was given outside of the 48 hours prior to services ending requirement and was provided on 9/22/25.On 1/22/26 at 1:14 p.m. the MDS Coordinator (MDSC) stated the facility had struggled to identify the correct payer source for the resident and once they did, they had R59 sign an SNFABN, however they were unable to locate the form and had R59 sign a new SNFABN on 9/22/25. The MDSC confirmed it was outside the required 48 hours prior to the end of services.On 1/22/25 at 10:18 a.m. the administrator stated their expectation was for the beneficiary notices to be provided to the residents 48 hours prior to the end of their services, and they were important to provide so the residents are aware of their payment changes, and they may be responsible for payment.The facility policy was requested and was provided an undated document titled Beneficiary Notice Guidelines which indicated R59 should have received an SNFABN.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure ordered as needed (PRN) psychotropic medications were limited to a 14-day time period for 1 or 5 residents (R34) reviewed for unnecessary medications. Findings include:R34's admission Minimum Data Set (MDS) dated [DATE], indicated R34 was admitted on [DATE], was severely cognitively impaired and had the following diagnoses: hypertension, renal insufficiency, hyperlipidemia, dementia, anxiety, and depression. R34's order summary report dated 1/22/26, indicated R34 was currently prescribed Lorazepam 0.5mg (milligrams) orally every 1-hour PRN with a start date of 12/17/25. The order lacked an end date. R34's medical record lacked evidence of rationale to continue past the required 14-day timeframe for psychotropic medications.On 1/22/26 at 1:15 p.m. the director of nursing confirmed they were aware of the 14-day time frame for psychotropic medications and stated they missed it with R34 and were currently working on a new process to ensure it does not happen again. The DON stated the importance of addressing the medications rationale within the 14-day time period to ensure the medications were addressed appropriately and per regulations.The facility Psychotropic Medication Policy last revised 5/1/25, indicated PRN orders for psychotropic drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN orders to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow physician orders for 1 of 2 residents (R3) reviewed for nutrition.Findings include:R3's admission minimum data set (MDS) dated [DATE], included R3 was severely cognitively impaired. R3 had diagnoses of diabetes, hyponatremia (happens when excessive water accumulates relative to sodium), and hypertension (high blood pressure).R3's physician order summary report dated 1/22/26, included an order for daily weights due to heart failure with instruction to update the provider with a weight gain of 3 pounds (lbs) or greater in 24 hours or 5 pounds in one week unless otherwise directed by a provider. Order was started on 10/25/25.R3's weights outside of these parameters were as follows:10/28/25: 218.0 lbs10/29/25: 228.4 lbs11/18/25: 212.2 lbs11/19/25: 221.1 lbs11/28/25: 204.9 lbs11/30/25: 213.8 lbs12/7/25: 201.0 lbs12/8/25: 208.6 lbs12/10/25: 206.0 lbs12/12/25: 214.1 lbs12/24/25: 200.2 lbs12/26/25: 245.6 lbs1/20/26: 187.5 lbs1/21/26: 203.0 lbs Review of R3's medical records failed to include updates to the provider for weight changes as instructed in R3's orders.During interview on 1/21/26 at 11:19 a.m., licensed practical nurse (LPN)-A stated she would typically called a provider if someone had an order to monitor weights and they were outside of the parameters. LPN-A stated she would put a progress note in the resident's chart when she updated the provider.During interview on 1/21/26 at 11:21 a.m., assistant director of nursing (ADON)-A stated floor nurses were supposed to monitor the daily weights when an order is in place and update the provider when a resident is outside of the ordered parameters. ADON-A confirmed he was unable to find progress notes or provider notes when R3 had weight changes outside of the provider parameters. ADON-A stated the resident was at risk for fluid overload which could lead to hospitalization if a provider was not updated when a weight monitoring order was in place.During interview 1/21/26 at 1:37 p.m., director of nursing (DON) stated it was the nurse managers or ADON's responsibility to be monitoring weights and updating a provider as needed. The DON stated the floor nurse should enter the weight and update the nurse manager or ADON with any concerns they noticed. DON stated the provider could then adjust medication or parameters if the resident's condition indicated the need for changes.During interview on 1/22/26 at 9:46 a.m., physician assistant (PA)-A stated she would have wanted to be updated on any weight changes that were outside of ordered parameters. PA-A stated early adjustment to medications is important because it becomes harder to manage fluid changes with medication the longer it goes untreated. PA-A stated it was the goal to prevent hospitalization with early intervention. PA-A stated she would complete an visit note on all reviews of weight changes she completed.Facility policy for weight monitoring requested and not provided.