STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook Rochester West	2215 Highway 52 North Rochester, MN 55901

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to meet resident needs for 2 of 3 residents (R3 and R2), resulting in a pattern of delayed toileting assistance and care needs.Findings include:R3's Face sheet printed 5/13/26, identified diagnoses including Parkinsonism, polyneuropathy, chronic pain syndrome, urge incontinence, Crohn's disease, chronic kidney disease stage 3b, protein-calorie malnutrition, and attention to ileostomy (opening in the abdomen for stool drainage into a bag).R3's 5-day Prospective Payment System (PPS) Minimum Data Set (MDS) dated [DATE], indicated R3's cognition was intact, had impaired range of motion (ROM) in both upper and lower extremities, was dependent for toileting hygiene and transfers, required partial to moderate assistance with rolling in bed, substantial to maximal assistance with lower body dressing, and required a mechanical lift for transfers and a wheelchair for mobility. The MDS further identified R3 had an ostomy appliance and was frequently incontinent of bladder.R3's care plan revised 4/29/26, identified a focus of an activity of daily living (ADL) self-care deficit related to dementia, obesity, limited mobility, and pain. The care plan identified R3 did not walk, pick up objects, or independently propel a wheelchair for 150 feet. An intervention revised 3/27/26 indicated R3 required assistance of two staff for toileting every 2 to 3 hours and as needed (PRN). A separate care plan focus revised 3/24/26, identified mixed bladder incontinence related to impaired mobility, need for assistance with toileting, recurrent cystitis, and dementia. Interventions initiated 6/24/25, indicated staff were to check and offer toileting every 2 hours, provide incontinent care with each episode of incontinence, and change clothing as needed following incontinence episodes.During an observation and interview on 5/13/26 at 1:38 p.m., R3 was observed seated upright in her wheelchair in the dining room. R3 stated staff were respectful, but the facility needed more staff. R3 currently required extensive assistance due to weakness and low blood pressures causing dizziness and passing out. R3 stated it took two staff to assist her with bed mobility and use of the bedpan and required two staff with a mechanical lift to transfer out of bed into her wheelchair. R3 stated call light response times were poor throughout the day and night and she had been left on the bedpan for prolonged periods of time, causing pain to her buttocks. Staff frequently told R3 they did not have enough staff and would answer the call light, turn it off, say they would return, and then not come back for prolonged periods of time. R3 stated she had episodes of urinary incontinence because she had to wait too long for assistance. The issues with delayed call light response had been ongoing for a long time and were very frustrating. R3 stated she did not feel staff were able to respond timely to resident needs.R3's call light log report was reviewed from 5/6/26 through 5/13/26 (7 days) and identified R3's call light remained active for longer than 15 minutes on 36 occasions. Multiple prolonged delays occurred throughout the day and night, including early morning, daytime, evening, and overnight hours. Review identified repeated wait times ranging from 16 minutes to over 2 hours, including delays of 1 hour or longer on 8 occasions. The longest documented wait times included 2 hours and 17 minutes on 5/8/26 and 2 hours and 18 minutes on 5/9/26. Additional prolonged wait times included 1 hour and 30 minutes, 1 hour and 24 minutes, 1 hour and 10 minutes, 1 hour and 8 (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minutes, 1 hour and 3 minutes, and 1 hour.Tuesday, 5/6/26:-12:37 p.m. to 1:37 p.m., for a total wait time of 1 hour.-1:41 p.m. to 2:00 p.m., for a total wait time of 19 minutes.-2:07 p.m. to 2:25 p.m., for a total wait time of 18 minutes.-10:55 p.m. to 12:25 a.m., for a total wait time of 1 hour and 30 minutes.Wednesday, 5/7/26:-7:00 a.m. to 7:24 a.m., for a total wait time of 24 minutes.-12:07 p.m. to 12:49 p.m., for a total wait time of 42 minutes.-1:11 p.m. to 1:53 p.m., for a total wait time of 42 minutes.-2:02 p.m. to 2:21 p.m., for a total wait time of 19 minutes.-8:47 p.m. to 9:11 p.m., for a total wait time of 24 minutes.Thursday, 5/8/26:-7:48 a.m. to 8:35 a.m., for a total wait time of 47 minutes.-1:56 p.m. to 2:12 p.m., for a total wait time of 16 minutes.-4:39 p.m. to 6:56 p.m., for a total wait time of 2 hours and 17 minutes.-8:35 p.m. to 9:38 p.m., for a total wait time of 1 hour and 3 minutes.-10:03 p.m. to 10:34 p.m., for a total wait time of 31 minutes.Friday, 5/9/26:-1:57 a.m. to 2:15 a.m., for a total wait time of 18 minutes.-9:00 a.m. to 9:29 a.m., for a total wait time of 29 minutes.-6:53 p.m. to 7:13 p.m., for a total wait time of 20 minutes.-7:52 p.m. to 10:10 p.m., for a total wait time of 2 hours and 18 minutes.Saturday, 5/10/26:-9:48 a.m. to 10:18 a.m., for a total wait time of 30 minutes.-2:21 p.m. to 2:39 p.m., for a total wait time of 18 minutes.-2:51 p.m. to 3:10 p.m., for a total wait time of 19 minutes.-4:57 p.m. to 6:21 p.m., for a total wait time of 1 hour and 24 minutes.-6:23 p.m. to 6:41 p.m., for a total wait time of 18 minutes.-8:06 p.m. to 8:29 p.m., for a total wait time of 23 minutes.-8:53 p.m. to 9:37 p.m., for a total wait time of 44 minutes.-9:42 p.m. to 10:23 p.m., for a total wait time of 40 minutes.Sunday, 5/11/26:-3:33 a.m. to 3:52 a.m., for a total wait time of 19 minutes.-5:41 a.m. to 6:49 a.m., for a total wait time of 1 hour and 8 minutes.-8:23 a.m. to 8:46 a.m., for a total wait time of 23 minutes.-11:16 a.m. to 12:26 p.m., for a total wait time of 1 hour and 10 minutes.-4:39 p.m. to 5:07 p.m., for a total wait time of 28 minutes.-7:08 p.m. to 7:28 p.m., for a total wait time of 20 minutes.-10:11 p.m. to 10:37 p.m., for a total wait time of 26 minutes.Monday, 5/12/26:-11:58 a.m. to 12:17 p.m., for a total wait time of 19 minutes.-8:50 p.m. to 9:08 p.m., for a total wait time of 18 minutes.Tuesday, 5/13/26:-10:30 a.m. to 10:47 a.m., for a total wait time of 17 minutes. R2's face sheet printed 5/13/26 identified R2 had diagnoses including chronic diastolic congestive heart failure, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, morbid obesity, unsteadiness on feet, generalized muscle weakness, diabetic neuropathy, chronic kidney disease stage 3b, atrial fibrillation, urinary retention, and dependence on supplemental oxygen.R2's quarterly MDS dated [DATE], indicated R2's cognition was intact, required substantial to maximal assistance with toileting hygiene and toilet transfers, used a wheelchair for mobility, and had impaired range of motion in both upper and lower extremities. R2 was frequently incontinent of bladder, continent of bowel, and received a diuretic medication.R2's care plan revised on 4/6/25, identified a focus of an activities of daily living (ADL) self-care performance deficit related to weakness. The care plan identified R2 required an EZ stand lift for transfers and did not ambulate. An intervention initiated on 4/6/25 identified R2 required toilet use assistance of one staff member. Separate care plan focuses revised on 4/6/25 and 11/24/25 identified limited physical mobility related to weakness and functional bladder incontinence related to impaired mobility and urinary retention. Interventions initiated on 4/6/25 identified R2 required bed mobility assistance of one staff member, transfer assistance of two staff using a stand-up lift from wheelchair to bed and bedside commode, placement of a urinal and bedpan within reach, assistance with toileting, and incontinent care as needed.During an interview on 5/13/26 at 10:53 a.m., R2 stated staff were good, but the facility needed more staff. R2 used a bedside commode for toileting and required use of an EZ stand lift with assistance from two staff members. Staff sometimes left R2 sitting on the commode for up to an hour, causing soreness to his buttocks. R2 stated he had episodes of bowel incontinence because he could not wait long enough for staff to assist him with toileting. Call light response times were horrendous and estimated average wait times were approximately 30 minutes, with waits at times lasting up to an hour. The delays were ongoing and were not limited to a certain time of day. R2 further stated he took a water pill and was up multiple times overnight urinating and had to call staff because all three of his urinals were full.R2's call light log report was reviewed from 5/6/26 through (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/13/26 (7 days) and identified R2's call light remained active for longer than 15 minutes on 7 occasions. Review identified prolonged wait times occurring during daytime, evening, and overnight hours, with delays ranging from 17 minutes to 47 minutes. The longest documented wait times included 47 minutes on 5/10/26, 42 minutes on 5/8/26, and 31 minutes on 5/10/26. Additional prolonged wait times included 29 minutes, 23 minutes, 19 minutes, and 17 minutes.Thursday, 5/8/26:-11:02 a.m. to 11:21 a.m., for a total wait time of 19 minutes.-9:11 p.m. to 9:53 p.m., for a total wait time of 42 minutes.Saturday, 5/10/26:-5:40 p.m. to 6:11 p.m., for a total wait time of 31 minutes.-6:49 p.m. to 7:36 p.m., for a total wait time of 47 minutes.-9:01 p.m. to 9:30 p.m., for a total wait time of 29 minutes.Sunday, 5/11/26:-11:18 a.m. to 11:41 a.m., for a total wait time of 23 minutes.Monday, 5/12/26:-4:51 a.m. to 5:08 a.m., for a total wait time of 17 minutes. During an interview on 5/13/26 at 12:27 p.m., staffing coordinator (SC)-A stated the south hall had 17 residents, including four residents who required assistance of two staff members with a mechanical lift and an additional resident who required assistance of two staff members for transfers. The north hall had 9 residents, including four residents who required assistance of two staff members with a mechanical lift. Nursing assistants did not currently have radios, requiring staff to leave resident rooms to locate another staff member when two-person assistance was needed. SC-A stated delays in responding to resident needs were more difficult when a float aide was not scheduled. SC-A stated the facility was currently staffing at approximately 3.2 hours per patient day (PPD) and acknowledged staffing should be approximately 3.5 PPD based on resident acuity. Ideal staffing would include two nursing assistants, two nurses, and a float aide on day and evening shift and one nursing assistant and one nurse on night shift; however, if staffing strictly reflected resident acuity, three nursing assistants would be needed on day and evening shifts and two nursing assistants on night shift. SC-A further stated she was working with corporate to obtain approval for additional staffing.Review of the staffing schedules from 5/6/26 through 5/13/26 identified multiple shifts where no designated float nursing assistant (NA) was scheduled. The schedules identified:5/6/26: No designated float aide scheduled for evening shift.5/7/26: No designated float aide scheduled for evening shift.5/8/26: No designated float aide scheduled for day or evening shift.5/9/26: No designated float aide scheduled for evening shift.5/10/26: No designated float aide scheduled for evening shift.5/11/26: No designated float aide scheduled for day or evening shift.5/13/26: No designated float aide scheduled for evening shift. During an interview on 5/14/26 at 11:02 a.m., nursing assistant (NA)-A stated staff did their best to answer call lights timely; however, when only one nursing assistant was scheduled on the hall, delays occurred because several residents required assistance of two staff members due to use of mechanical lifts. NA-A stated staff frequently had to locate another aide from a different hall to assist with transfers and toileting, which could take additional time, particularly during morning care. Call lights were answered more timely when a float staff member was available.During an interview on 5/13/26 at 1:56 p.m., registered nurse (RN)-A stated resident call lights should generally be answered within 15 minutes and acknowledged response times during busy periods, such as mealtimes, may increase to approximately 20 minutes. Residents should not have to wait an hour for assistance. RN-A further stated when only two nursing assistants were scheduled in the building, response times could take longer, and the facility needed enough staff to meet resident needs timely.During an interview on 5/13/26 at 1:59 p.m., the director of nursing (DON) stated she recently became aware of prolonged call light response times and increased resident complaints regarding delays in assistance, however, had not completed recent call light audits. The facility currently had an increased number of residents requiring mechanical lifts, which required additional staff assistance for transfers and toileting. DON stated the facility needed a float nursing assistant on day and evening shift to assist staff in meeting resident needs timely. DON further stated the facility previously staffed at approximately 4.0 hours per patient day (PPD), was currently staffing at approximately 3.2 PPD, and she planned to advocate for increased staffing. The goal for call light response times should be approximately 10-15 minutes. The DON was unaware that R2 and R3 had experienced episodes of (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinence due to delayed response times.During an interview on 5/13/26 at 2:20 p.m., regional director of clinical services (RDCS)-A stated the facility goal was for staff to answer resident call lights within 15 minutes and acknowledged residents should never wait over an hour for assistance. RDCS-A further stated the facility needed to staff according to resident acuity.The facility assessment dated [DATE], identified the facility population included residents with complex medical conditions requiring extensive assistance with activities of daily living (ADLs), transfers, toileting, mobility, incontinence care, ostomy care, and mechanical lift assistance. The facility assessment further identified 26 residents required assistance of one to two staff members for transfers and toileting. The assessment identified bowel and bladder care included responding promptly to resident requests for assistance to the bathroom or toilet in order to maintain continence and promote resident dignity. The assessment further identified nursing staffing needs were to be based upon resident acuity and adjusted as needed to meet resident care needs.Facility policy Call Light Use and Response, revised 7/18/23, identified the purpose of the policy was to respond promptly to resident's call for assistance. The policy further identified facility personnel were to be aware of resident call lights and answer all call lights in a prompt, calm, courteous manner.Facility policy Sufficient Staffing, revised 10/19/23, identified the facility would have sufficient nursing staff with the appropriate competencies and skill sets to provide services necessary to assure resident safety and maintain each resident's highest practicable well-being considering the number, acuity, and diagnoses of the facility's resident population. The policy further identified nursing direct care staffing ratios would be recalculated based on census and level of care needs and staffing patterns would be reviewed daily by the scheduler, human resources (HR), administrator, and director of nursing (DON).