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	10/23/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47497 Based on observation, interview, and record review, the facility failed to appropriately assess for broken/missing teeth and difficulty chewing for 1 of 1 (R24) resident. Findings include: R24's 8/27/24, admission Minimum Data Set (MDS) assessment identified her cognition was moderately impaired. R24's diagnosis list identified diagnosis of moderate protein calorie malnutrition, paranoid schizophrenia, dementia, and weakness. R24's oral assessment dated [DATE], indicated R24 had her own teeth and does not wear dentures, has chewing problems and R24 would be a regular diet with thin liquids with a care plan intervention to provide diet as ordered. R24's Nutritional assessment dated [DATE], identified R24 ate independently, was on a regular diet, had no difficulty chewing or swallowing, and would be given a supplement three times daily. The assessment summary identified the current diet order remains appropriate, resident appears to be tolerating diet texture and consistency, and current diet order/oral nutritional supplement order provides adequate calories/protein to meet estimate nutritional needs. The summary further identified R24 should continue current nutrition plan of care and care plan had been reviewed and updated. R24's 8/21/24, care plan item identified she was at risk for inadequate intake related to recent hospitalization due to dizziness, with interventions of eating independently, provide diet as ordered, and record weight per facility protocol/MD [medical doctor] orders. During an observation and interview on 10/22/24 at 12:40 p.m., R24 was seated at the edge of her bed with an overbed table in front of her with a meal tray on the table. Her plate had a whole potato with unopened packet of sour cream and butter on the side, R24 attempted to open the sour cream but was unable to. Included on the plate was an open-faced chicken sandwich with large bite size pieces of chicken mixed with gravy on top of a bun, green beans, and a mixed fruit cup on the side. R24 placed a bite of the chicken in her mouth, chewed it up and spit it back out on her spoon. She placed the chewed food to the side of her plate then took another bite, chewed the food and then again spit it out on the spoon and laid it to the side of her plate. R24 said she cannot chew the meat stating, this would be good if it was done right, the sauce is good, but I can't chew the meat. During the observation a nursing assistant (NA)-A looked into the room and said she was just checking to see if R24 was done eating, she then closed the door. (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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NAME OF PROVIDER OR SUPPLIER Edenbrook Rochester West		STREET ADDRESS, CITY, STATE, ZIP CODE 2215 Highway 52 North Rochester, MN 55901	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During and interview on 10/22/24 at 12:54 p.m., NA-A said she offered assistance to R24 when she dropped of her meal tray, she said R24 doesn't like people to help her, she identified she could have opened her sour cream prior to bringing the tray into her room but she did not think of that at the time. During an observation and interview on 10/23/24 at 8:53 a.m., R24 identified she has difficulty chewing, she opened her mouth to reveal no top teeth and several missing lower teeth. During an observation and interview on 10/23/24 at 12:33 p.m., R24, meal tray was on the overbed table in front of her, food items included whole boneless, chicken breast, mixed vegetables, and a dinner roll. R24 looks at her plate and stated same old same old, R24 points to the chicken breast and states I can't eat that, I don't have any top teeth. I need a blender so I can blend my food up so I can eat it. R24 said it was not anyone fault she can't eat the food, it's just her teeth. She asked surveyor if someone could give her a ride to the store to get a blender. During an interview on 10/23/24 at 3:24 p.m., registered dietitian (RD), identified she completes the nutritional assessment for residents at the facility. She determines the need for a mechanically altered diet by looking at the doctor orders and reviewing the nursing progress notes or from feedback at the interdisciplinary team meeting (IDT). RD identified she had completed a preference assessment with R24, and she had told her staff cut up her food. RD stated, I didn't really pursue it much more since that. RD identified they do not observe the resident eating as part of their assessment and agree R24 should have been evaluated by speech therapy if she had missing teeth and difficulty chewing. The RD identified she works for the facility 8 hours a week, of those hours she currently works 5 hours every other week on site and the rest of the hours are completed remotely. The facility provide Nutritional Assessment guidelines from the Food & Nutrition Services which identified the assessment process includes identifying and assessing the resident's nutritional status and risk factors, evaluating the assessment information, developing, and consistently implementing pertinent approaches, monitoring the effectiveness of interventions, and revising them as needed. The assessment should be completed with residents who are at risk for unplanned weight loss or compromised nutritional status. The guidelines identify the elements of the assessment which includes general appearance such as cognitive status, affect, oral health, and dentition.

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that residents are free from significant medication errors.

34083

Based on observation, interview and document review the facility failed to ensure an insulin FlexPen was appropriately primed prior to insulin administration for 1 of 2 residents (R14) who received sliding scale (SS) insulin.

Findings include:

During an observation and interview on 10/22/24 at 4:32 p.m., registered nurse (RN)-A prepared to administer R14's SS insulin dose. R14's blood glucose (BG) reading checked on 10/22/24 at 4:26 p.m. was 264. The physician orders for SS Novolog Aspart insulin (FlexPen) identified the dose to be administered as 8 units. RN-A checked the pen against the MAR, removed the pen cap, dialed the pen to 2 units and depressed the plunger. She then obtained a package containing the needle for the pen, and additional supplies and preceded to R14's room. RN-A performed hand hygiene, applied gloves, wiped the end of the pen with an alcohol pad and attached the needle. She then dialed the pen to 8 units, and prepared to administer the insulin dose. RN-A was interrupted and she and the surveyor exited the room, where RN-A was asked about priming the pen without the needle attached. She responded was the way she had always done it and reported she was not aware the needle should be attached prior to priming the pen. RN-A responded she was glad to learn this, and stated she had received training which included medication administration, but she was not aware of the FlexPen package insert detailing the correct method of applying the needle, then priming with 2 units to remove the air before dialing the ordered insulin dose.

Review of the manufacture's steps for use of a FlexPen included:

1.) check the label to ensure the pen contains the ordered form of insulin

2.) Pull off the pen cap

3.) Pull off the outer needle cap. Keep it to remove the needle from the pen after injection, pull off the inner needle cap and dispose of it.

4.) Turn the dose selector to 2 units

5.) Hold the FlexPen with the needle pointing upwards. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.

6.) Keep the needle upwards and press the push-button all the way in. The dose selector should return to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If a drop still does not appear, you must use a new FlexPen.

7.) Turn the dose selector to select the number of units you need to inject.

8.) Push the needle into the skin, press the dose button until you reel or hear a click and the dose indication lines up with 0. Hold for 6 seconds and remove it.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9.) Guide the needle back into the outer needle cap and when completely on unscrew the needle and dispose of in a sharps container. Interview on 10/22/24 at 4:45 p.m., director of nursing (DON) and the corporate nursing consultant who was also in attendance identified the facility had a policy on administration of medication which included insulin's, and staff had all been trained on medication administration. She reported her expectation for nursing staff to read and follow the policy, and/or manufacture's instructions for use of an insulin pen, in addition to any other medication. Review of the January 2022 Medication Administration Subcutaneous Insulin from the Nursing Care Center Pharmacy & Procedure Manual Contained photo instructions on administration of insulin with a pen. The policy clearly explained how to attach and detach the needle safely, prime the pen, administer the ordered insulin dose, and safely remove the needle following the administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51380 Based on observation, interview, and document review the facility failed to ensure food temperatures were monitored consistently prior to serving to prevent risk of food born illness. The facility further failed to maintain a clean refrigerator and freezer for food storage. This had the potential to affect all 28 residents residing at the facility. Findings include: During dining/kitchen tour on 10/21/24 at 2:30 p.m., with dietary manager (DM) identified resident refrigerator in the dining room adjacent to the kitchen was to have loose debris laying on the bottom , unknown sticky substance spilled on bottom and on the shelves. In addition, items were not labeled to identify what items belonged to what residents. Observation of the freezer located in the basement of the facility had loose frozen carrots on the bottom, looked like ice buildup on top shelf, and frost around the door. DM reported cleaning the refrigerator and the freezer are shared by nursing and dietary staff. DM revealed there was no cleaning log or schedule to ensure completion. DM further identified they are to be getting a new freezer in the basement and is why it is has not been cleaned. During the evening meal on 10/21/24 at 5:07 p.m., cook (C-A) who checked the temperature of all food on the steam table. The temperature of the puree pasta was 98.9 and the puree ground beef was 142.7. C-A recorded the temperatures on the Service Line Checklist form and continued set up the area in preparation for serving. C-A then started to dish up the meal after looking at the meal slips. C-A proceeded to dish up puree pasts and was about to place it on the plate when surveyor asked C-A what the holding temperature for the food on the steam table should be and [NAME] A replied 140. Surveyor asked about the temperature of the pasta being 98.9 and C-A paused and said he needed to heat it up. During an observation on 10/22/24 at 11:50 a.m., DM-B was dishing up the noon meal. DM dished up a plate of puree food included chicken, mashed potatoes, gravy, and vegetables. DM took temperature of the food on the steam table; puree chicken at 111 degrees and the mashed potatoes at 123 degrees. DM indicated the holding temperature should be 145 degrees and he then proceeded to place the plate in the microwave to warm it up. Service Line forms which contained the food temperatures reviewed for October 1, 2024 through noon meal of October 22, 2024 indicated: 10/4/24 One temperature documented for hot cereal and not other temperatures monitored. 10/7/24 All meals had documentation of temperature monitoring completed. 10/8/24 Breakfast was monitored, lunch main entree was monitored, but no other food temperatures were recorded. 10/9/24 All meals temperatures were documented. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/10/24 All meals temperatures were documented. 10/11/24 Breakfast and lunch had completed temperatures logged, however no other temperatures logged for dinner. 10/13/24 All meals had documented temperatures. 10/14/24 No temperatures for pureed foods at lunch and dinner. 10/15/24 All meals had documented temperatures. 10/16/24 All meals had documented temperatures. 10/17/24 Pureed food (broccoli) had temperature monitored for lunch and the alternate puree was monitored also for dinner. 10/18/24 Only pureed meat was monitored for temperature at lunch and no pureed food monitored at dinner. 10/19/24 All meals had temperatures monitored. 10/20/24 No temperatures were monitored for breakfast or lunch. No pureed food monitored for temperature for dinner 10/21/24 Lunch had no meat or starch pureed temperature monitored. 10/22/24 Breakfast temperature was monitored, and lunch was not. And six days no temperatures taken of food prior to serving. During an interview on 10/22/24 at 12:10 p.m., DM-B confirmed he had not checked the temperature of the food prior to dishing up for service. During an interview on 10/23/24 at 2:15 p.m., Regional Dietary Manager (RDM-C) indicated the expectation was for the cook to monitor food temperatures prior to serving the meal to ensure safe serving temperatures. During an interview on 10/23/24 at 3:21 p.m., dietician indicated their role was to oversee sanitation audits, review temperature logs, and assess residents for dietary needs. The dietician reported the cleanliness of the resident refrigerator has been a concern and she has been monitoring this. She confirmed food not held at appropriate holding temperature could be a risk to residents for food born illness. She identified her expectations would be food temperatures were monitored prior to being served to assure the proper temperature was maintained. Interview on 10/23/24 at 4:45 p.m., director of nursing indicated she would expect kitchen staff monitor the food temperatures to assure appropriate safe serving temperatures to prevent food born illnesses.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49893 Based on observation, interview, and record review the facility failed to ensure utilization of proper personal protective equipment (PPE) with cares for 1 of 2 residents (R8) evaluated for enhanced barrier precautions (EBP). Findings include: R8's quarterly Minimum Data Set, dated dated dated [DATE] indicated R8 was cognitively intact with no behaviors, limited range of motion to both upper and lower extremities, frequent incontinence of bowel and bladder, G-tube (tube surgically placed in stomach), and tube feeding (liquid nutrition provided via g-tube) R8's face sheet indicated diagnoses of Parkinson's disease, severe protein-calorie malnutrition, nutritional anemia, and gastrostomy status. R8's orders indicated check tube placement before initiation of formula, medication administration, and flushing tube every 8 hours, flush tube with 20-30 ml of water before and after medications, check and record residuals, Compleat (brand of liquid nutrition) intermittent gravity 2.5 cans/day. 1/2 can at 9 am, 1 can at 2 pm, and 1 can at 9 pm. Water flushes of 90 ml before and after feeding. It also indicated enhanced barrier precautions d/t tube feeding. R8's careplan indicated risk for inadequate intake related to Parkinson's disease and need for supplemental enteral nutrition, incontinence of urine/bowel, assist with daily hygiene, grooming, dressing, oral cares and eating as needed. Bed mobility assist of 1-2, EZ stand lift (brand of lift used to assist residents to a standing position) for transfers and need for physical assist with transfers related to physical limitations. It also indicated feeding tube related to need for nutritional support. During observation and interview on 10/23/24 at 8:10 a.m., NA-A was wearing gloves and a hospital gown while providing cares for R8. NA-A assisted resident to a sitting position on the edge of bed. NA-A positioned the EZ stand in front of resident. NA-A assisted R8 to standing position and transferred the resident to the wheelchair. NA-A removed the resident's gown, provided underarm care, and assisted R8 with donning undergarments and shirt. NA-A then removed linens off bed and placed them on the floor and straightened remaining linens. NA-A picked up linens off the floor and placed them in an empty bag. NA-A removed hospital gown by pulling it over their head placing it in dirty laundry bag, removed gloves and washed hands. NA-A put on new gloves, gathered garbage and linens, and placed them in soiled utility room. During interview, NA-A stated residents are placed on EBP if they have devices such as catheters and g-tubes. NA-A stated staff would wear blue plastic gowns and gloves for incontinence cares and other close contact with residents. NA-A confirmed wearing a hospital gown and should have worn a disposable blue gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/23/24 at 9:28 a.m., the infection preventionist (IP) stated EBP are implemented for residents with catheters, g-tubes, central lines, and some wounds to prevent the spread of multidrug resistance organisms (MDROs). PPE is required for resident cares and transfers. The IP stated signs are placed on the residents' doors identifying the level of precautions, the type of PPE to be warn, and the resident interactions require PPE. The IP stated the expectation is for staff to read the signs on a resident's door and apply the appropriate PPE prior to entering the residents' room. The IP confirmed NA-A should have worn a blue disposable gown to provide cares to R8. During interview on 10/23/24 at 11:40 a.m., the director of nursing (DON) stated staff are expected to wear the proper PPE for residents on transmission-based precautions to prevent the spread of MDRO's. The DON confirmed NA-A should have worn a disposable blue plastic gown when providing cares to R8. A policy titled Enhanced Barrier Precautions dated 8/8/24, indicated EBP is implemented for the prevention of transmission of MDRO's. EBP is initiated for residents with chronic wounds and/or indwelling medical devices such as central lines, urinary catheters, feeding tubes and tracheostomies/ventilator tubes. PPE (gowns and gloves) are to be donned for high-contact resident care activities such as dressing, bathing, transferring, hygiene, changing linens, and changing briefs/assisting with toileting. It is also required for indwelling device care and wound care. A policy titled Personal Protective Equipment dated 3/17/23 indicated the facility promotes appropriate use of PPE to prevent the transmission of pathogens to residents, visitors, and other staff. Gowns are worn to protect arms, exposed body areas, and clothing from contamination with blood, body fluids, and other potentially infectious material. Dispose of gowns into the appropriate waste receptacle.