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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook Rochester West	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 0691 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure physician orders were in place to provide treatment and monitoring for an ostomy (ileostomy) (opening to allow waste to exit the body and be collected in a pouch) for 1 of 1 resident (R5) reviewed for ostomy care. The facilities failure resulted in harm for R5 who continued to exhibit symptoms of redness, severe pain, excoriation (abrasion, breakdown) and infection requiring two courses of antibiotics.Findings include:R5 was admitted to the facility on [DATE]R5's Minimum Data Set (MDS) assessment, dated 09/12/25, identified no cognitive impairment, had limited range of motion of both her upper and lower extremities and R5 required substantial to maximal assistance with personal hygiene. In addition, R5 had an ileostomy to manage her fecal excretion.R5's care plan dated 6/24/2025, had an alteration in elimination; interventions listed included, ileostomy care as ordered. R5's care plan lacked direction or interventions of how to care for the ileostomy .R5's admission orders included call MD (medical doctor) with any excessive bleeding, pus, foul smelling drainage, stoma that is recessing into the belly, bulging skin around the stoma, change in stoma color, chills, nausea/vomiting, increased pain in the belly or around the stoma, no gas or stool in 24 hours every shift for monitoring; Change ostomy flange and bag every 3 days and PRN; Empty ostomy pouch every shift or when 1/3 full. Cleanse area after emptying with warm water and gentle soap. Apply skin prep after cleansing every shift for monitoring; Ostomy cares: as needed bag size and change, skin prep: wafer size and change.R5's above mentioned orders were ended on 8/1/25. R5's orders lacked any additional updates or orders to care for the ostomy.R5's orders dated 9/9/25, was to vent ostomy bag and empty every 4 hours while awake.R5's provider assessment dated [DATE], noted a history of Crohn's disease with a surgical ileostomy. Provider assessment lacked specific appliance change instructions (i.e., bag type, bag size, skin protectants, skin barriers, and bag removal).R5's hospital stays dated 7/24/25 and 8/6/25, included provider assessments, lacked specific appliance change instructions (i.e., bag type, bag size, skin protectants, skin barriers, and bag removal).R5's provider evaluation dated 7/16/25, indicated R5's stoma was reddened, painful, and swollen with what appeared to cellulitis (a common bacterial skin infection of the deeper layers of skin and tissue, most often caused by group A streptococcus or Staphylococcus bacteria entering through a break in the skin). R5 was started on an antibiotic to treat the infection. No new ostomy orders were initiated.R5's provider evaluation dated 9/24/25, indicated R5's stoma was reddened, painful, and swollen with what appeared to be cellulitis. R5 was started on an antibiotic to treat the infection. R5's orders lacked additional ostomy cares. R5's nursing skin assessments indicated:-6/27/25 noted no new skin issues.-7/4/25 noted ileostomy area a little red-7/18/25 noted area around ileostomy is quite reddened-8/11/25 noted ileostomy changed 3 times today due to leaks lower right side of stoma, red in color and resident stated painful-9/1/25 noted area around stoma is reddened-9/10/25 noted area around stoma is quite reddened-9/15/25 noted skin irritation and erosion around stoma-10/7/25 noted redness around ileostomy-10/14/25 noted redness around ileostomy-10/21/25 noted redness around stoma-10/28/25 noted no assessment of ileostomy-11/4/25 noted area around stoma is quite reddened with opening approximately 3 cm (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 0691 Level of Harm - Actual harm Residents Affected - Few	(centimeters) circle-11/11/25 noted stoma area is reddened-11/18/25 noted redness around her ileostomyR5's progress note dated 10/15/25, indicated the stoma area was red and bleeding, R5 rated pain 8/10 (8/10 indicates severe pain on the pain rating scale) and required pain medication to get comfortable.During observation and interview on 11/18/25 at 3:19 p.m., R5 stated her ileostomy was leaking and needed to be changed. R5 stated the area around her ostomy is reddened and has a burning sensation almost all the time. R5 stated the condition of her ostomy causes her pain and she gets anxious because she feels the facility isn't doing enough to reduce her pain and discomfort. Registered nurse (RN)-B in the room stated R5 does not have orders for specific ostomy supplies or dressing changes. RN-B stated R5 requires frequent, almost daily dressing changes. RN-B stated staff use whatever supplies are in the room. RN-B stated R5 has not seen a dedicated wound/ostomy nurse; however, this would be beneficial, to know what appliance/supplies work best for the resident. RN-B washed the ostomy site with warm water and dried using a washcloth. She waited approximately two minutes before applying a light sprinkle of Adapt Stoma Powder; then applied the Steawoce Colostomy Bag.During an interview on 11/18/25 at 4:24 p.m., the director of nursing (DON) confirmed R5 does not have orders or an established ostomy care plan indicating specific supplies to use because the facility has been trialing new ostomy supplies since R5's readmission to the facility on 8/6/25. The facility planned to enter those orders once they found a set of supplies that worked. On 8/12/25, the facility received the June hospital recommendations from the hospital wound-ostomy nurse that included:-Coloplast Sensura Fecal #820306-Small convex oval ring #816983-Stomahesive powder #007639-Cavilon No Sting Barrier film #135096The DON stated the 8/12/25 orders were not documented because I think we tried the supplies, but they did not work. The DON confirmed there is no documentation the facility tried the recommended supplies, or the supplies did not work. Currently, the facility is using:-Steawoce Ostomy Bag, Model A42-E Lot 250506-Ostomy Barrier Rings, Atwlux 20 pieces, 2.0mm, X004NL5ROL-Medline Sure Prep Rapid dry spray-Adapt Stoma Powder, [NAME] 7906-Adapt Medical adhesive remover [NAME] 7733R5's weekly skin assessments were reviewed and the DON confirmed R5 had ongoing redness, pain, and swelling leading to two separate courses of antibiotics for cellulitis. The DON stated she was not sure if using ill-fitting appliances would cause the above complications, but it is important to follow ostomy recommendations to ensure a proper fit.During interview and observation on 11/20/25 at 7:48 a.m., registered nurse (RN)-A stated R5 does not have specific orders for ostomy supplies and dressing changes. RN-A stated when he changes the ostomy, he uses the supplies that are in the room. RN-A stated R5 requires frequent appliance changes due to leakage. RN-A washed the ostomy site with warm water and dried using a washcloth. He waited approximately two minutes before applying a light sprinkle of Adapt Stoma Powder; then applied the Steawoce Colostomy Bag.During interview 11/19/25 at 8:53 a.m., wound-ostomy care registered nurse (RN)-C stated R5 was seen while R5 was in the hospital 8/2025. Recommendations at the time were:-[NAME] 8531 one piece with putty ring-Stoma powderRN-C stated recommendations are based on assessment of the stoma, contour of the area around the stoma, and a skin assessment. It is important the recommended supplies are used to prevent skin breakdown. RN-C stated it is abnormal for ostomy supplies to require changing more than 3 times per week. Frequent changes, burning, pain, infections could be complications from ill-fitting ostomy supplies. During a follow up interview on 11/19/25 at 10:19 a.m., the DON stated the facility did not order the recommended ostomy supplies from the August hospitalization because they didn't think they would work. The facility continued to trial other supplies. The DON confirmed it was possible using the incorrect supplies could lead to complications R5 experienced. During interview on 11/19/25 at 10:26 a.m., the facility medical director (MD) stated he was familiar with R5's ileostomy due to a history of Crohn's disease. MD stated he was aware R5 had been treated twice for cellulitis and was the treating provider for the 9/2025 infection. MD stated he would expect to be notified if R5 was continuing to have complications related to her ostomy. MD confirmed R5 did not have orders for ostomy appliance changes (size and type of appliance and treatment procedure). He stated it is the (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	provider's responsibility to ensure treatment orders are written post-hospitalization and those orders should have been entered upon R5's return from the hospital August 2025. A facility policy titled Colostomy and Ileostomy Care dated 1/28/25, the purpose of ileostomy care is to prevent infection and skin irritation.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure direct-care nursing staff were appropriately trained and competent in the assessment and care of ostomies for 1 of 1 (R5) resident reviewed for ostomy care.Findings include:R5 was admitted to the facility on [DATE] R5's Minimum Data Set (MDS) assessment, dated 09/12/25, identified no cognitive impairment, had limited range of motion of both her upper and lower extremities and R5 required substantial to maximal assistance with personal hygiene. In addition, R5 had an ileostomy to manage her fecal excretion. R5's care plan dated 6/24/2025, had an alteration in elimination; interventions listed included, ileostomy care as ordered. R5's care plan lacked direction or interventions of how to care for the ileostomy. During an interview on 11/18/25 at 3:19 p.m., registered nurse (RN)-B stated R5 does not have orders for specific ostomy supplies or dressing changes. RN-B stated the R5 requires frequent, almost daily dressing changes. RN-B stated staff use whatever supplies are in the room. RN-B stated she might have completed some sort of ostomy training when she started. RN-B stated she isn't sure if ostomy care was an annual competency. During an interview on 11/19/25 at 10:19 a.m., RN-A stated R5 does not have orders for specific ostomy supplies or dressing changes. RN-A stated staff use whatever supplies R5 has in her room. RN-A stated, I think there was education, I don't remember any specific training. Further, I'm sure we've had some education, I don't know when exactly. During interview on 11/19/25 at 10:25 a.m., licensed practical nurse (LPN)-B stated, I don't know if there is any specific Relias (online training company) training for ostomy care. LPN-B is unsure if she had completed any recent training on ostomy care. During interview on 11/19/25 at 10:19 a.m., director of nursing (DON) stated the facility does not have specific ostomy training. DON confirmed staff have not had specific training about how to assess and care for R5's ostomy. The Facility assessment dated [DATE], the facility could provide specialized treatment and care for ostomies. However, the facility assessment does not include ostomy care in the standard list of in-services and required competencies for nursing staff. Nurse staff competency transcripts (training and education) were request but not received.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and document review the facility failed to ensure all staff working in the dietary department had training on use of equipment, safe temperatures to ensure food safety and sanitation processes. This had the potential to affect all 29 residents in the facility. Findings include:During the initial kitchen tour on 11/17/25 at 10:58 a.m., dietary aide (D)-C met surveyor inside main kitchen entrance; exited the kitchen, putting on hair net and returning to the kitchen. Returned to stove side, D-C lacked a beard cover. Dietary aide (D)-B offered to escort surveyor since the dietary manager was not in the building yet. At the conclusion of the initial tour, D-B could not state the normal temperature ranges for the facility refrigerators and freezers. Further, D-B could not state how to complete temperature checks for the new dishwasher. Additionally, D-B stated it was acceptable to serve uncovered food from the freezer to residents, food in the refrigerators doesn't need a labeled expiration date because they use it so fast, and it was acceptable to have staff beverages in the main kitchen refrigerators. During the follow up kitchen tour on 11/17/25 at 11:31 a.m. with dietary manager (DM), stated she was unsure what education the dietary aides and cooks were required to complete. DM stated she had been hired at the facility for two weeks and had not verified the educational backgrounds of the current staff. DM confirmed her credentials were certified food protection manager (CFPM) and food service manager (FSM). DM stated dietary staff should have education about proper food handling, requirements for covered containers, proper labeling, normal temperatures for refrigerators and freezers, and should know how to check the temperature of the dishwasher. During an interview on 11/17/25 at 11:42 a.m., D-C stated the dishwasher was purchased a couple weeks prior and staff had not been shown how to verify temperatures yet. D-C stated the facility also doesn't have the temperature strips but is sure they will get them once they teach us how to temp the dishwasher. During an interview on 11/17/25 at 11:51 a.m., administrator stated dietary staff complete food safety education at hire, annually, and when updates are needed. The administrator stated this education would include food safety, infection control, appropriate temperatures, food storage, and how to use and measure temperature on the new dishwasher. Requested dietary staff education and competencies but did not receive. Facility policy titled Food Safety Requirements Policy and Procedure dated 11/26/2017, dietary staff will be educated on safe food handling including, proper food handling to prevent foodborne illness, requirements for covered containers or secure wrapping, proper labeling and dating of items, storage temperatures for refrigerators and freezers, dietary equipment use.

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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. Based on observation and interview the facility failed to ensure infection control practices were maintained by wearing a hair net and beard cover while in the kitchen. Additionally, the facility failed to ensure a commercial dishwasher was adequately monitored (i.e., every shift). Last, the facility failed to ensure food stored in the refrigerators and freezers were labeled, dated and discarded properly. These deficient practices had the potential to affect all 29 residents, staff and visitors who received food from facility kitchen. During the initial kitchen tour on 11/17/25 at 10:58 a.m., dietary (D)-C greeted surveyor inside the kitchen; after introductions D-C exited the kitchen with surveyor and applied a hairnet, returning to stove side to finish cooking lunch vegetables. D-C stated he should have put his hairnet on before coming into the kitchen. D-C did not have a beard cover while at stove side. Dietary (D)-B assisted surveyor with kitchen tour since dietary manager was not at the facility. The kitchen had one commercial dishwasher, staff indicated this was new and had only been in the building for a few weeks. The commercial dishwasher lacked a temperature tracking sheet, with D-C and D-B stating they had not monitored dishwasher temperatures since the dishwasher was installed. The following items were observed in the fridge and freezer expired, undated food, and uncovered food:-Frozen omelets in opened undated bag with crystalizing ice on food product-Uncovered, prepped ice cream-Pudding dated 10/31-Cranberry Sauce dated 11/4-Undated, thawing chicken-Undated Mayonnaise-Undated Bag of lettuce (turning brown)-Undated Ham-Undated SausageDuring second kitchen walk through on 11/17/25 at 11:31 a.m., dietary manager (D)-A confirmed it is an expectation that everyone entering the kitchen applies a hairnet and beard cover if applicable. D-A confirmed the commercial dishwasher was new; was an expectation the temperature monitoring be completed every shift. Additionally, conferred with staff, no one had monitored new commercial dishwasher because none of them had been trained to perform temperature monitoring. During interview on 11/17/25 at 11:51 a.m., administrator stated all staff entering the kitchen should have a hairnet and beard cover. The administrator also confirmed the dishwasher was new and had been installed a couple weeks prior. The administrator confirmed staff should be following facility equipment monitoring procedures. The administrator stated the dietary staff are expected to follow the facility food safety policy to accurately date and dispose of food items. A facility policy titled Food Safety Requirements Policy and Procedure dated 11/26/17, facility staff will follow proper food handling practices to include hair and beard coverings, proper labeling and dating of food items, food covering, and equipment monitoring.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate information was communicated to the receiving facility, and obtain provider orders prior to discharge for 1 of 1 residents (R37) reviewed for discharge. Finding includeR37's discharge minimum data set (MDS) assessment dated [DATE], indicated R37 was admitted [DATE] after a short-term hospital stay with plans to return home/community. No long- or short-term memory issues and no behaviors. R37 was independent with eating, set up for oral hygiene, partial assist for bathing and upper body dressing, substantial assist with toilet and personal hygiene, and lower body dressing. R37 was dependent on staff for applying and removing footwear and required partial assist with bed mobility and transfers. R37 was diabetic and received insulin. R37's diagnoses list included respiratory failure, diabetes, obstructive pulmonary disease, depression, sleep apnea, heart failure, kidney disease, long term use of insulin, dependence on oxygen. R37's medication administration (MAR) record at the time of discharge included the following types of medications cholesterol medications, antidepressants, multiple vitamin supplements, thyroid, blood thinners, pain medications, diuretics, stool softeners, respiratory inhalants, and antihistamines. In addition, R37 was receiving insulin on a scheduled basis including sliding scale insulin (insulin dosing based on blood sugar value). R37 also had wound care orders, oxygen orders, and used a CPAP (continuous positive air pressure machine-used to treat sleep apnea).Care conference notes dated 8/7/25 indicated R37, R37's family, director of nursing (DON), assistant director of nursing, therapy staff and social worker were in attendance. The notes indicated R37 planned to discharge back to previous assisted living apartment. The notes indicated R37 would like scripts for a hospital bed and bariatric shower chair. The notes also indicated a voicemail was left with the director of nursing at the assisted living to determine what R37 will need to return. Progress notes dated 8/13/25 indicated R37 was packing up belongings stating she was planning to leave Friday (8/15/25).Progress notes dated 8/20/25 indicated R37 discharged from the facility at 4:25 p.m. with 2 grandchildren. Scheduled insulin and a pain medication were administered. Insulin pen was given to a family member for R37. The notes indicated R37 stated she signed her papers etc. this morning. During interview on 11/19/25 at 2:24 p.m., the receiving assisted living director (ALD)-A stated she performed an in-person admission assessment with R37 a day or two prior to R37 admitted to their facility. After the assessment, ALD-A and R37 went to the facility social worker's office to discuss what was needed prior to discharge. When R37 re-admitted to the assisted living facility, R37 arrived with no provider orders for medications or treatments. ALD-A stated she had to scramble to get orders from R37's primary provider, which was difficult because the primary provider had not seen R37. ALD-A stated the facility also did not send R37's medications with her. When asked what specific orders were required, ALD-A stated they needed discharge orders for medications, therapy orders, orders for cpap, wheelchair, and an order for a hospital bed. R5's progress notes provided by the assisted living facility indicated as follows:-8/11/25 at 2:07 p.m. ALD-A spoke with facility social worker regarding R37's possible return. Social worker to contact receiving facility in coming days regarding expected discharge date to schedule a re-evaluation.-8/19/25 at 12:45 p.m. ALD-A noted R37 was expected to return during the week pending provider discharge orders and hospital bed.-8/20/25 at 8:27 p.m. ALD-A noted, R37 returned from rehabs stay. R37 returned to facility without medications, paperwork, and requested tasks completed. Requests included: discontinue sliding scale insulin, hospital bed, and doctor's orders.-8/21/25 12:42 p.m., phone call placed to [clinic name] provider line to obtain orders for resident due to prior facility neglectfully completing tasks.During an interview on 11/20/25 at 10:06 a.m., facility social worker (SW)-A stated if a resident is planning to discharge to an assisted living facility, the facility will determine level of independence required, need for re-evaluation, type of paperwork required, any therapies needed post discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing department sets up a discharge visit with the provider. SW-A stated she opens the recapitulation of stay documentation screen for individual departments to provider their documentation. The nursing department gathers discharge paperwork faxed or emailed over to the receiving facility. SW-A stated ALD-A did an in-person re-evaluation on 8/19/25 and determined R37 was appropriate for readmission. SW-A also stated R37 had a discharge provider visit on 8/19/25. SW-A stated the discharge information was faxed to the assisted living facility and R37 discharged on 8/20/25. During interview on 11/20/25 on 10:30 a.m., the director of nursing (DON) stated R37 was eager to discharge back to her previous assisted living facility. The director of nursing stated R37 wanted a hospital bed however there was an issue with insurance coverage and gave options for R37's daughter to obtain a hospital bed. The DON confirmed R37 mentioned on admission a prescription for a hospital bed was required however, R37 did not mention needing a prescription for a hospital bed when she discharged . The DON stated there was not an established discharge date set. The assisted living director of nursing did a re-evaluation assessment a day or two prior to R37's discharge and the facility nurse practitioner did see R37 on 8/19/25. Email communication between the facility and the assisted living facility indicated as follows: -8/19/25 at 11:36 a.m., SS-A to DON indicated ALD-A had authorized R37's return to the assisted living and requested a script for a bariatric hospital bed. -8/20/25 at 10:56 a.m., SS-A to ALD-A indicated This is all I have for now. Once we get the rest of the paperwork, I will get it over to you. Attached to the email was a history and physical from the nurse practitioner visit on 8/19/25 and provider order adjusting R37's insulin dosages, including sliding scale insulin. The attached history and physical dated 8/19/25 indicated R37 was seen for wound and diabetes follow-up. It also indicated [R37] notes that she will be discharging home with husband in a day or 2. Still waiting to hear back from the facility's staff to either confirm or deny her claim -8/20/25 at 5:31 p.m. ALD-A to SS-A and DON indicated R37 returned to the facility but did not have things that were discussed including paperwork/provider orders for any medications, wound care orders, order for hospital bed, and discontinuation of sliding scale insulin as the assisted living is unable to accommodate. -8/20/25 at 7:22 p.m., from DON to ALD-A indicated the facility social worker sent all this out and I won't be back in the office until tomorrow. -8/21/25 at 7:28 a.m., from SS-A to DON and ALD-A indicated I had sent over what we had at the time, The rest of the paperwork did not get completed by medical provider until after 4 p.m., I was gone for the day by then. I have attached the paperwork that came in after 4:00 p.m. If there is anything else needed, a medical provider will need to be contacted for follow up. Both [DON] and I did ask [provider] many times yesterday to get us the paperwork before 4:00 p.m. Attached to the email was a history and physical dated 8/19/25 that indicated R37 was seen today for a skilled nursing facility discharge visit. Section #23 titled Disposition indicated Patient is discharging to her assisted living facility with husband and family support. DME (durable medical equipment) ordered- N/A During follow-up interview on 11/20/25 at 1:39 pm., the DON stated her only communication with ALD-A was the email response after business hours on 8/20/25. She did not ever speak to ALD-A. The DON stated discharge orders for R37 were faxed to the assisted living however the facility is unable to provide proof of the fax transmission and confirmed R37's medical record does not contain signed provider orders. The DON confirmed a DME order for the hospital bed was not written. A policy titled Discharging a Resident revised 11/11/20 indicated The resident's attending physician is required to write a discharge order to include medication disposition. It continues, The discharge summary contains necessary medical information that the facility must furnish at the time the resident leaves the facility, to the receiving provider assuming responsibility for the resident's care after discharge. Further, the policy indicated the summary will include but is not limited to, the following:A. a recapitulation of the resident's stay that includes. bu8t is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.B. A final summary of the resident's status to include items: .medications, special treatments and procedures.C. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and document review, the facility failed to comprehensively assess and initiate a plan of care for 1 of 1 (R5) resident who was reviewed for ostomy care.Findings include:R5's Minimum Data Set (MDS) assessment, dated 09/12/25, identified R5 had no cognitive impairment, and R5 had an ileostomy to manage her fecal excretion. R5's care plan dated 6/24/2025, identified R5 had an ileostomy and alteration in elimination; interventions listed included, ileostomy care as ordered. R5's care plan lacked direction or interventions of how to care for the ileostomy . During observation and interview on 11/18/25 at 3:19 p.m., R5 stated her ileostomy is leaking and needed to be changed. R5 stated the area around her ostomy is also reddened and has a burning sensation almost all the time. R5 stated the condition of her ostomy causes her pain and she gets anxious because she feels the facility isn't doing enough to reduce her pain and discomfort. Registered nurse (RN)-B stated the resident has had her ostomy appliance changed 3 times in the last 12 hours. RN-B began to change the ostomy appliance, stated she just used whatever supplies were in the resident's room. RN-B confirmed the resident did not have active orders specifically for ostomy supplies and did not have a care plan detailing how to care for her ostomy. During interview on 11/18/25 at 4:24 p.m., director of nursing (DON) stated R5 does not have current orders for specific ostomy supplies; further stating the resident does not have an active care plan specifically for her ostomy care. DON stated nursing staff was actively trialing new ostomy supplies and they would enter orders and initiate a complete care plan once they found supplies that worked. DON confirmed it is essential staff use the correct supplies; this would prevent irritation and breakdown of the ostomy. DON confirmed staff would normally look at the care plan to know what supplies were being used for each resident. DON confirmed she should have done an ostomy-specific care plan to ensure staff used the correct supplies. Further, the care plan should have outlined what is normal or abnormal for R5's ostomy. During interview on 11/19/25 at 10:26 a.m., medical director (MD)-A confirmed he was familiar with R5 and her diagnosis of needing an ileostomy due to Crohn's disease. MD-A confirmed he would expect nursing to notify him if the ileostomy had complications (i.e., redness, pain, swelling). MD-A confirmed R5 did not have current orders for ostomy appliance changes (i.e., bag type, bag size, skin protectants, skin barriers, and bag removal) and R5 did not have a care plan for her ostomy. A facility policy titled Colostomy and Ileostomy Care dated 1/28/25, the purpose of ileostomy care is to prevent infection and skin irritation.

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Edenbrook Rochester West	2215 Highway 52 North Rochester, MN 55901

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and document review the facility failed to provide professional standards of practice when staff completed treatments and later entered orders in the medical administration record without verification from a physician for 1 of 1 resident (R5) reviewed for ostomy cares.Finding include:R5's Minimum Data Set (MDS) assessment, dated 09/12/25, identified no cognitive impairment, had limited range of motion of both her upper and lower extremities and R5 required substantial to maximal assistance with personal hygiene. In addition, R5 had an ileostomy to manage her fecal excretion. R5's care plan dated 6/24/2025, had an alteration in elimination; interventions listed included, ileostomy care as ordered. R5's care plan lacked direction or interventions of how to care for the ileostomy . R5's treatment administration record (TAR) and medication administration record (MAR) lacked ostomy change orders, ostomy site assessments, ostomy supplies, dates and times of appliance changes, and staff completing ostomy appliance changes. During an interview and observation on 11/18/25 at 3:19 p.m., registered nurse (RN)-B stated R5 does not have orders for specific ostomy supplies or dressing changes. RN-B stated R5 requires frequent, almost daily dressing changes. RN-B stated staff use whatever supplies are in the room. When asked how RN-B charts the ostomy change, RN-B replied since there isn't an order, sometimes staff will do a progress note. When asked how she knows what to use without an order; RN-B stated since there isn't an order, they use whatever supplies are in the room. According to the American Nurses Association (ANA) an RN's scope of practice is to implement orders, not to create them. The authority to create orders rests with authorized prescribers like physicians and nurse practitioners. Further, RN's need a provider's order to provide medical treatment, such as ostomy site care. During an interview and observation on 11/18/25 at 4:24 p.m., director of nursing (DON) confirmed R5 had one order to care for her ostomy. DON confirmed this order was not sufficient to care for her ostomy. Without conferring with an authorized prescriber, the DON created and entered ostomy care and treatment orders. During a follow up interview on 11/19/25 at 10:19 a.m., DON confirmed she had created and entered ostomy care orders the previous evening. When asked how she knew what to order, DON stated she just entered generic ostomy-care orders. DON confirmed she did not get resident-specific orders from a provider until she saw the provider earlier that morning. During an interview on 11/19/25 at 10:26 a.m., medical director (MD) confirms a provider writes orders for resident care; to include ostomy care orders. MD confirms R5 did not have orders for ostomy care. MD stated he knew staff at the facility had been changing the ostomy dressing frequently due to leakage. MD stated this probably couldn't be confirmed due to the lack of orders; thus, lacking a place to chart the ostomy dressing changes. A document titled Registered Nurse Job Description dated 8/2/23, registered nurses will safeguard the health, safety, and welfare of all guests under their care by following applicable laws, regulations, and established nursing policies and procedures.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident had physician orders for the care and treatment for 1 of 1 (R5) resident reviewed for ostomy care.Findings include:R5's Minimum Data Set (MDS) assessment, dated 09/12/25, identified no cognitive impairment, had limited range of motion of both her upper and lower extremities and R5 required substantial to maximal assistance with personal hygiene. In addition, R5 had an ileostomy to manage her fecal excretion. R5's care plan dated 6/24/2025, had an alteration in elimination; interventions listed included, ileostomy care as ordered. R5's care plan lacked direction or interventions of how to care for the ileostomy.R5 was initially admitted on [DATE]. R5's admission orders included call MD (medical doctor) with any excessive bleeding, pus, foul smelling drainage, stoma that is recessing into the belly, bulging skin around the stoma, change in stoma color, chills, nausea/vomiting, increased pain in the belly or around the stoma, no gas or stool in 24 hours every shift for monitoring; Change ostomy flange and bag every 3 days and PRN; Empty ostomy pouch every shift or when 1/3 full. Cleanse area after emptying with warm water and gentle soap. Apply skin prep after cleansing every shift for monitoring; Ostomy cares: as needed bag size and change, skin prep: wafer size and change.R5's above mentioned orders were ended on 8/1/25. R5's orders lacked any additional updates or orders to care for the ostomy. During an interview on 11/18/25 at 3:19 p.m., registered nurse (RN)-B stated R5 does not have orders for specific ostomy supplies or dressing changes. RN-B stated R5 requires frequent, almost daily dressing changes. RN-B stated staff use whatever supplies are in the room. During an interview on 11/18/25 at 4:24 p.m., the director of nursing (DON) confirmed R5 did not have active orders or an established ostomy care plan. The facility planned to enter those orders once they found ostomy supplies that worked. During interview on 11/19/25 at 10:26 a.m., the facility medical director (MD) stated he was familiar with R5's ileostomy due to a history of Crohn's disease. MD also confirmed R5 did not have orders for ostomy appliance changes (size and type of appliance and treatment procedure). He stated it is the provider's responsibility to ensure treatment orders are written post-hospitalization and those orders should have been entered upon R5's return from the hospital August 2025. A facility policy titled Physician Services and dated 2/26/22, the resident's physician is responsible for prescribing new treatments and cares to ensure that the resident receives quality care and medical treatments.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were addressed or acted upon for 1 of 5 residents (R5) reviewed for unnecessary medications.Findings include:R5's Minimum Data Set (MDS) assessment, dated 09/12/25, identified R5 no cognitive impairment, had limited range of motion of both her upper and lower extremities and diagnosis included: metabolic encephalopathy (diffuse brain dysfunction), lewy body dementia (protein deposits in the brain leading to cognitive decline), parkinsonism (movement disorder), psychotic disturbances, major depressive disorder and moderate anxiety. R5's medication orders included:Cyanocobalamin 1000mg Oral Daily: Start date 8/4/25Diclofenac Sodium External Gel 1% Topical, apply to right chest arms four times per day: Start Date 8/4/25 Pharmacy recommendations included:8/30/25Cyanocobalamin 1000mg Oral Daily - CHANGE TO Cyanocobalamin 1000mcg Oral DailyDiclofenac Sodium External Gel 1% Topical, apply to right chest arms four times per day - CHANGE TO Diclofenac Sodium External Gel 1% Topical, apply 2g to right chest arms four times per dayClobetasol Propionate External Solution0.05 %, apply to scalp topically one time a day every Wed, Fri, Sun for dry scalp, apply to scalp - Issue: was not reordered upon re-admission from hospital 8/4/25, please verify need and re-order9/22/25Cyanocobalamin 1000mg Oral Daily - CHANGE TO Cyanocobalamin 1000mcg Oral DailyDiclofenac Sodium External Gel 1% Topical, apply to right chest arms four times per day - CHANGE TO Diclofenac Sodium External Gel 1% Topical, apply 2g to right chest arms four times per dayClobetasol Propionate External Solution0.05 %, apply to scalp topically one time a day every Wed, Fri, Sun for dry scalp, apply to scalp - Issue: was not reordered upon re-admission from hospital 8/4/25, please verify need and re-order10/26/25Cyanocobalamin 1000mg Oral Daily - CHANGE TO Cyanocobalamin 1000mcg Oral DailyDiclofenac Sodium External Gel 1% Topical, apply to right chest arms four times per day - CHANGE TO Diclofenac Sodium External Gel 1% Topical, apply 2g to right chest arms four times per dayClobetasol Propionate External Solution0.05 %, apply to scalp topically one time a day every Wed, Fri, Sun for dry scalp, apply to scalp - Issue: was not reordered upon re-admission from hospital 8/4/25, please verify need and re-order R5's medication administration record showed:Cyanocobalamin 1000mg Oral Daily was administered daily 9/1/25 thru 11/19/25Diclofenac Sodium External Gel 1% Topical was administered 4 times per day 9/1/25 thru 11/20/25 Clobetasol Propionate External Solution0.05 %, remains unordered R5's medical record lacked evidence to support the pharmacy consultant (Pharm D) recommendations were addressed and corrected in a timely manner. A call to the pharmacy consultant on 11/20/2025 at 3:13 p.m., was not returned. During an interview on 11/20/2025 at 11:32 a.m., the director of nursing (DON) stated they do have a process to review pharmacy recommendations and confirmed sometimes takes a while for the providers to respond. DON stated she corrected R5's cyanocobalamin order this morning. DON stated ideally the recommendations should be addressed immediately but sometimes it takes a while for the providers to make the necessary changes. The DON stated the process breaks down getting the form back from the providers after she received the recommendations from the pharmacy. The DON reviewed R5's pharmacy reviews, noted the recommendations lacked documentation in the follow up section of the form. DON stated she knows the pharmacy recommendation process needs updating so recommendations aren't missed. Attempted to speak with medical director on 11/20/25 at 11:51 a.m., he was unavailable at this time. A policy titled Medication Regimen Review dated 7/24/24, providers will review the medication recommendations from the pharmacist, follow up as applicable, and return recommendation form to the DON or designee.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure respiratory equipment was properly maintained for 2 of 2 residents (R27 and R2) reviewed for respiratory care. Findings include: R27 R27's admission minimum data set (MDS) assessment dated [DATE] indicated R27 was cognitively intact with no behaviors, independent with ADL's and uses oxygen. R27's care plan included a respiratory care plan indicating saddle embolus and OSA [obstructive sleep apnea] with interventions that included oxygen per MD (medical doctor) order R27's provider orders included: oxygen 2 liters per nasal cannula at rest, 4 liters with activity. CPAP [a machine used to treat sleep apnea] pressure setting as settings stored. Change distilled water daily During observation on 11/17/25 at 12:23 p.m., an oxygen concentrator was observed in R27's room next to the bed. The plastic housing where the oxygen tubing connects to the machine was broken with sharp edges. A nasal cannula was attached to one end of a metal connector. The connector was hanging outside the machine approximately 8 centimeters. The other end of the connector was attached to a green tubing that was coming from inside the machine. During observation on 11/18/25 at 8:32 a.m., R27's oxygen concentrator remained broken with the connector hanging out of the machine and the green internal tubing visible. During observation on 11/18/25 at 1:42 p.m., oxygen tubing was rolled up on top of the concentrator. The metal connector continued to hang out of the machine with the internal green tubing visible. Plastic housing remains broken. During interview on 11/18/25 at 3:35 p.m., the customer service representative (CSR) for the oxygen supply company stated oxygen concentrators are serviced every 6 months and as needed. The CSR stated oxygen concentrators are assigned to specific residents and there was no documentation the facility requested a new concentrator for R27. The CSR stated the expectation is for the facility to report any issue with the concentrators and if there are broken parts, the machines should be replaced. During observation and interview on 11/18/25 at 4:02 p.m., R27 was sitting on the edge of the bed wearing oxygen tubing attached to the concentrator. R27's family member (FM)-A stated the concentrator has been broken since R27 admitted on [DATE]. During observation on 11/18/25 at 4:15 p.m., the oxygen supply room contained several cylinders of oxygen and two oxygen concentrators. One of the concentrators had a sign stating not working taped to it. During interview on 4/18/25 at 4:23 p.m., registered nurse (RN)-D stated R27's concentrator has been that way for a while however was not working the day the plastic housing broke. During observation on 11/19/25 at 1:00 p.m., the oxygen concentrator remained broken. During observation on 11/20/25 at 8:30 a.m., the concentrator remained broken. R2 R2's annual MDS assessment dated [DATE] indicated R2 had mild cognitive impairment with no behaviors, no upper or lower body impairment, independent with all activities of daily living, independent with transfers and ambulating short distances, supervision for ambulating for long distances. It also indicated R2 uses oxygen therapy. R2's provider orders included the following:-change oxygen tubing and humidifier bottles weekly. Date tubing every night shift every Sunday.-check oxygen saturation weekly on room air every night shift every Sunday for monitoring.-respiratory assessment every Wednesday day shift and Saturday evening shift-oxygen at 2 lpm (liters per minute) via nasal cannula to keep saturations at or above 90% for respiratory distress. Check SPO2 (measurement of oxygen saturation in blood) every shift for oxygen and as needed R2's care plan included congestive heart failure and asthma. Interventions included administer oxygen as ordered, elevate head of bed to ease shortness of breath, evaluate lung sounds and vital signs as needed, obtain oxygen saturation. During observation and interview on 11/19/25 at 12:59 p.m., R2 was observed lying in bed wearing nasal cannula. An oxygen concentrator was observed on the floor near R2's bed running at 2 lpm. R2's oxygen tubing was connected to a bottle containing clear fluid. The bottle was connected to the concentrator via tubing. The plastic casing of the concentrator was broken at the area the bottle was (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attached. A bright pink object was observed protruding from the concentrator and was holding the bottle in place. Upon closer inspection, the bright pink object had a rough texture and a similar object white in color was below the pink object, also protruding from inside the concentrator. R2 was asked if she knew what the bright pink object was and stated the objects were emery (nail filing) boards. R2 stated she placed them in the opening of the machine to keep the water bottle in place. When asked if the facility staff were aware the files were in there, R2 stated they must know because they change the tubing and do the water. R2 could not recall how long the files have been in there and reiterated the nurses come in and fill the humidifier bottle. During the observation and interview, licensed practical nurse (LPN)-A entered the room delivering R2's lunch. LPN-A was asked about R2's concentrator. LPN-A indicated they were not aware the concentrator casing was broken and did not know what the bright pink object protruding out of the machine was. LPN-A left the room. The emery boards remained in place. During observation and interview on 11/19/25 at 1:07 p.m., registered nurse (RN)-A stated R2 preferred to stay in her room. RN-A stated the humidifier bottle on R2's oxygen concentrator is filled every night or when it gets close to being empty. RN-A was brought to R2's room and observed R2's oxygen concentrator. RN-A stated, all that is broken is plastic, so it is functioning. RN-A stated the oxygen supply company was made aware of the broken concentrator however was unsure when. RN-A visualized the emery boards and stated R2 used them as a [NAME] to keep the water bottle in place. RN-A then left the room. The emery boards remained in place. During observation on 11/20/25 at 8:32 a.m., R2 was lying in bed awake speaking to a staff member. R2's oxygen concentrator continued to have the broken casing and emery boards holding the humidifier bottle in place. During observation and interview on 11/20/25 at 8:50 a.m., the director of nursing (DON) was brought to R2's room. The DON visualized the broken oxygen concentrator and asked R2 what the two objects were. R2 informed the DON she placed the emery boards in the machine to keep the oxygen bottle in place. The DON informed R2 a new concentrator would be obtained. The DON was taken to R27's room and observed the plastic housing on the concentrator broken. The DON stated she was not aware R27's concentrator was also broken. The DON stated if equipment is broken, she would expect staff to obtain a replacement concentrator and lock-out the broken concentrator so others cannot use it. She would expect to be informed if there is an issue with the oxygen concentrators. A contract dated 11/1/24 between the oxygen supply company (company) and the facility titled Medical Oxygen, DME [durable medical equipment] products and Services Agreement indicated, Equipment Maintenance and Use. [Company name] assumes full responsibility for proper maintenance and repair of all oxygen equipment rented to facility and [facility name] assumes responsibility for appropriate use and care of equipment while rented to [facility name]. A policy titled Oxygen Administration and storage revised 6/15/25 did not provide direction in the event of broken equipment.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review, the facility failed to ensure the nurse staffing data sheet was posted in a place readily accessible to residents, families, and visitors. This had the potential to affect all 29 residents in the facility. Findings include: During observation on 11/17/25 at 11:28 p.m., no staff posting was observed in the facility. During observation on 11/18/25 at 12:28 p.m., no staff posting was observed in the facility. During interview on 11/19/25 at 1:48 p.m., the administrator stated the staff posting was usually posted on the wall near the kitchen, however had been replaced by directional signage for visitors. The facility did not find a different location for the staff posting. A policy titled Staff Posting revised 10/19/23 indicated the facility shall post daily, for each shift, the actual hours and total number of hours worked by licensed and unlicensed nursing staff who are directly responsible for resident care on each shift in the facility. At the beginning of each shift, the facility will verify that the hours are posted in a clear and readable format: the name of the facility, current date, facility census for nursing home residents, facility specific shifts for the 24-hour period, total number of licensed nursing staff worked per shift, total number of unlicensed nursing staff worked per shift, actual time worked for the specific categories of nursing staff, including split shifts.