STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook Pine Haven	210 Northwest 3rd Street Pine Island, MN 55963

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, and document review, the facility failed to prevent the loss of resident's personal clothing by not investigating the root cause of the missing items. Findings include: Facility grievances dated 3/25-8/25, indentified five grievances were filed related to missing clothing items. The resolution/follow up for all 5 was to reimburse the resident/family after the item was replaced. During an interview on 8/26/25 at 2:01p.m., the administrator stated social services does an inventory of all belongings and a check list is uploaded to the resident's chart. Clothing items are labeled by laundry. During an interview on 8/27/25 at 7:21 a.m., laundry aide (LA)-F stated any staff can take a report about a missing item. Once reported, staff will look for the item on the unit and she will look through the laundry room for the items. The facility has a no name cart that contains all unclaimed clothing items. LA-F stated upon admission, all resident items are cataloged and put in a green bag and sent down to laundry. The green bag tells laundry there are unlabeled items in the bag. All items in the bag are labeled with the resident's name and room number. Any new clothing items after admission go through the same process. LA-F stated the label maker is old. The pressing plate on the top of the label maker is no longer on the machine so the clothing labels don't always stay on. When labels fall off, they will use a marker to label the resident clothing. LA-F stated they told maintenance about the label maker a while ago however could not pinpoint exactly when. During interview on 8/27/25 at 8:34 a.m., nursing assistant (NA)-B stated clothing is sent to the laundry in a green bag marked with the resident's name and room number. Laundry staff will label the clothing and send it back to the resident's room. During an interview on 8/27/25 at 8:38 a.m., licensed practical nurse (LPN)-C stated all washable items are sent to the laundry in a green bag with the resident's name and room number on it. Once labeled the items are sent back up. If an item is reported missing, a missing items form is filled out and given to the social worker. All staff will look for the item on the unit and then in laundry. If an item cannot be found, then family can submit to have the item reimbursed. During an interview on 8/27/2025 at 10:08 a.m., the maintenance director (M)-A stated he was not aware the label maker in the laundry room was broken. If it was having issues and was reported, he would know about it. During an interview on 8/28/25 at 1:59 p.m., the administrator stated the current process for lost clothing is to search for the items. The families are given the option to order the item and provide a receipt or the facility will order a replacement item for them. The administrator stated they have noticed a pattern of missing clothing however have not identified a reason for the missing clothing items. The facility noticed an issue for residents in the rehab unit where families initially choose to do the laundry themselves so the clothing is not marked, however sometimes the families change their minds so the clothing is sent down to the facility laundry unlabled. The facility also identified the isolation carts contain a receptacle for laundry and garbage so staff may be placing clothing items in the wrong receptacle. The administrator stated she was unaware the label maker in the laundry was broken and that could be part of the problem. A policy titled Grievance Policy dated 3/2025 indicated, the facility will ensure prompt resolution to all grievances, keeping the resident and resident representative informed throughout the investigation and resolution process. The grievance official will work with facility staff utilizing the root cause analysis process for resolution of the grievance or concern.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a proper procedure was in place to identify a residents resuscitation wish was appropriately updated in the electronic medical record (EMR) in a timely manner based on a signed Physician Orders for Life Sustaining Treatment (POLST, a medical order indicating treatments a person would like to receive in case of serious illness and/or cardiac arrest) for 1 of 1 residents (R60) reviewed for advanced directives.Findings include:R60's was admitted to the facility on [DATE].R60's medical record electronic medical record (EMR) banner indicated R60 was on hospice however lacked code status on the banner.Further review of R60's medical record identified Hospice admission documents located under a tab labeled documents included hospice orders for code status of DNR/DNI signed on [DATE]. A Provider Orders for Life Sustaining Treatment (POLST) dated [DATE], was included in the hospice admission documents on page 16 of 22. During an observation and interview on [DATE] at 9:40 a.m., registered nurse (RN)-A stated the quickest and the first place to identify code status was to review the banner in the EMR or check in the paper chart binder. RN-A opened a cupboard above the nurse station, and was unable to locate resident paper charts closed the cupboard and sat at a computer, selected a random resident's profile and verified code status on the banner. RN-A stated, a code status could also be verified with the POLST. RN-A opened the document tab, typed CTRL tab and the letter F tab and typed the word POLST. The residents POLST was located, RN-A opened the document, and verified the residents code status. RN-A stated the hospital included code status during verbal report with all admissions. The admission paperwork was given to the admissions team or the nurse manager to verify and enter code status into the residents EMR. Once the code status was entered into the EMR the banner would reflect code status. If there was no code status on the banner and no POLST under the document tab the resident was considered full code and cardiopulmonary resuscitation (CPR) was started.During an interview on [DATE] at 10:01 a.m., nursing assistant (NA)-C stated if there was no code status noted for a resident I would contact a nurse immediately.During an interview on [DATE] at 10:10 a.m., registered nurse (RN)-C stated code status was verified in the resident's profile, first on the banner. If no code status was on the banner, a second document was used to verify status. RN-C navigated the computer and stated, go through documents, miscellaneous, scanned documents and search for the word POLST. If no POLST and no banner, and the resident was unresponsive as a nurse, when in doubt, CPR was started per Good Samaritan laws. During an observation and interview on [DATE] at 10:12 a.m., registered nurse (RN)-D stated a code status would be observed in the Kardex or in the care plan. RN-D was observed searching a resident's chart and stated the banner was supposed to be up to date and pointed to the banner. RN-D verified no paper charts were used on the unit and was unable to identify where to locate a POLST and referred the question to the nurse manager.During a subsequent interview on [DATE] 10:20 a.m., RN-A accessed R60's EMR and verified the record lacked code status under the heading advance directive and was unable to locate a POLST. RN-A stated the area titled special instructions on the banner indicated hospice and this indicated DNR/DNI. RN-A stated all hospice residents are DNR/DNI and if R60 was unresponsive CPR would not be started. During an observation and interview on [DATE] 10:45 a.m., RN-D accessed R60's EMR and stated code status was verified on the banner. RN-D verified R60's EMR lacked documentation of code status on the banner and lacked documentation of a POLST. RN-D stated R60 was on hospice and assumed the status was DNR/DNI because all hospice residents were DNR/DNI.During an interview on [DATE] at 3:35 p.m., licensed practical nurse (LPN)-B stated code status was found on the banner and if no code status was listed the POST could be verified under miscellaneous tab. If a resident was on hospice, that would indicate a code status of DNR/DNI but would call to verify the status. If no code status was (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	listed and was unsure CPR would be started. LPN-B stated in their twenty years of long- term care experience there has never been a resident on hospice that wasn't DNR/DNI, but there was no assumption that automatically meant all hospice were DNR/DNI. The facility educated staff to verify code status by banner or POLST.During an interview on [DATE] 3:51 p.m., licensed practical nurse (LPN)-A stated code status was verified on the banner with DNR or Full Code. If there was no code status on the banner and no POLST to verify, even if the resident was on hospice CPR would be started. LPN-A stated the nurse managers kept code status up to date and has never seen hospice special instructions used as code status. During an interview on [DATE] at 3:57 p.m., registered nurse (RN)-F indicated resident's code status was verified on the banner or by accessing the POLST scanned into the documents. If a resident had no code status, first confirm code status with hospice, but if a resident became unresponsive and the situation was emergent, when in doubt, assume full code. There was no assumption that residents on hospice are automatically considered DNR/DNI because some hospice residents were full code.During an interview on [DATE] 2:56 p.m., registered nurse (RN)-E stated if there was no code status in the computer, they would be full code by default. Generally, code status was completed on admission day. The repercussions of having the incorrect code status could be traumatic for the resident and family. There were no assumptions hospice implied the resident was automatically DNR/DNI. During an interview on [DATE] at 11:02 a.m., the director of nursing (DON) stated staff would verify code status on the resident's banner or the POLST located in the scanned documents. Code status was updated by whom ever views the POLST upon admission. If there was no code status located on the banner it was the expectation to assume the resident was full code. Staff were not to assume all residents on hospice were DNR/DNI.A policy for advance directive was requested and not received.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to notify the physician in a timely manner for 1 of 1 resident (R5) who frequently refused important medications from certain staff. Findings include:R5's comprehensive Minimum Data Set (MDS) assessment dated [DATE], identified intact cognition with no behaviors towards others. R5's diagnoses included atrial fibrillation (an abnormal heartbeat that caused quiver instead of normal heartbeat), heart failure, hypertension, diabetes mellitus, depression, left knee amputation and one, stage three pressure ulcer. R5's care plan dated 6/21/21, identified goals and interventions to maintain blood glucose levels, reduce risk related to a history of atrial fibrillation, stroke, and pulmonary embolism, maintain mood, and report changes to the provider. R5's provider orders, included evening medications of acetaminophen for pain three times per day, apixaban for atrial fibrillation (blood thinning medication to reduce stroke) two times per day, atorvastatin for cholesterol at bedtime, cefadroxil for left amputation infection two times per day, gabapentin for diabetes pain three times per day, insulin to regulate blood sugar in the morning and evening, melatonin at bedtime for insomnia, novolog insulin before meals, novolog insulin sliding scale (dose dependent on blood sugar levels and food consumed), roxicodone a narcotic for pain every four hours as needed, sennoside docusate sodium used for constipation associated with narcotics twice a day, torsemide related to chronic congestive heart failure twice a day.R5's medication administration record for July 2025, indicated all evening medications and treatments offered by one nurse were refused on 7/16, 7/19, 7/20, 7/21, 7/22, 7/25, and 7/28.R5's medication administration record for August 2025, indicated all evening medications and treatments offered by the same nurse were refused on 8/2, 8/4, 8/5, 8/8, 8/11, 8/12, 8/17, 8/18, and 8/22.R5 grievance form dated 6/26/25, included R5 and a nurse didn't get along well.During an interview on 8/25/25 at 12:58 p.m., R5 stated there was an incident with a nurse on Christmas and the social worker was aware. A grievance form was completed, and the result of the grievance was R5 was told the nurse had the right to work anywhere in the facility. R5 stated all cares and medications were refused while they were on the unit even when another nurse from another unit was assigned to care for R5. R5 felt it wasn't fair to the other nurse to come all the way over just to do extra work and R5 refused cares from the assigned nurse as well. During an interview on 8/27/25 at 2:52 p.m., registered nurse (RN)-E stated R5 completed a grievance form dated 6/26/25 and was aware of an incident occurred between the resident and an evening nurse on 12/25/24. Since the event R5 refused to receive any medications or treatments from the nurse while they were assigned to the unit. RN-E stated R5 refused weights and other treatments and thought the provider was aware medications were refused. During an interview on 8/28/25 at 10:24 a.m., the medical director stated the expectation was to be notified if a resident wasn't taking medication, especially if the resident didn't take a medication three days in a row and the implication of R5 not taking medication could lead to stroke or a hyper or hypoglycemic event. The medications R5 refused were vital medications.During an interview on 8/28/25 at 11:02 a.m., the director of nursing (DON) stated the staff were expected to notify the provider if a resident refused medications typically after three doses of the same medication and this was important because the provider assumed the resident received the ordered treatments.During a subsequent interview on 8/28/25 at 9:45 p.m., R5 confirmed during the month of August 2025 the nurse never came into R5's room, provided cares, medications or treatments while scheduled on their unit. A bed bath was scheduled for Wednesday evenings and if the nurse was on the unit, R5 did allow another male nurse to come from another unit to perform a skin check. Besides the skin check Wednesday evenings, no other cares were performed and any documentation noted by the nurse would have been done through communication with the nursing assistant. A policy for provider notification was requested and not provided.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and document review, the facility failed to assess and develop non-pharmacological interventions to promote comfort for 2 of 5 residents (R12, R16) reviewed for pain management.Findings include:R12's admission Minimum Data Set (MDS) assessment, dated 6/9/25, indicated R12 had intact cognition. Further the assessment identified R12 frequently has pain which occasionally effects sleep, interferes with rehabilitation therapy and day-to day activities and rated pain at a 2 out of 10 on a pain scale and R12 receives pain medications.R12's face sheet, identified the following diagnoses: fractures of the third, fourth and fifth lumbar vertebrae (a break in the bones of the lower back), low back pain, spinal stenosis of cervical region(spinal canal in the neck narrows compressing the snail cord and nerves), fibromyalgia (condition characterized by widespread chronic pain), polyneuropathy (general term for nervous system disorder that is characterized by symptoms like numbness, and burning pain in distal parts of the arms and legs) and disease of the spinal cord.During an interview on 8/25/25 at 1:41 p.m., R12 stated she was in the facility due to a broken back. R12 stated she will ask for ice packs to help with pain as they are not offered to her, and she finds the ice packs help with the pain.R12's care plan, identified resident was on pain medication therapy related to lower lumbar fracture. The care plan indicated to review pain medication efficacy, assess whether pain intensity was acceptable to resident and monitor for side effects. The care plan lacked evidence of offering non-pharmacological interventions prior to administering as needed (PRN) medications, what non-pharmacological interventions have been tried, what has been effective and not effective and what non-pharmacological interventions should be used.R12's August MAR/TAR (medication administration record and treatment administration record) included the following order:-oxycodone (opioid pain medication) give 2.5 milligrams (milligrams) every 4 hours as needed for pain of 4-6 out of 10 with a start date of 7/10/25. The medication had been administered a total of 43 times in August. A pain scale was used on the administration of Oxycodone which showed pain scale ratings of 0-9 and effectiveness of medication was documented.-oxycodone give 5 mg every 4 hours as needed for pain of 7-10 out of 10 with a start date of 7/10/25. This medication had been administered a total of 14 times in August. A pain scale was used on the administration of Oxycodone which showed pain scale ratings of 0-9 and effectiveness of medication was documented.MAR/TAR lacked evidence of non-pharmacological interventions being offered prior to administration of as needed pain medication.R12's progress notes, dated 8/1/25 to 8/27/25 were reviewed. Progress notes lacked evidence of non-pharmacological interventions being offered to R12 for pain.R16R16's significant change MDS assessment, dated 8/5/25, indicated R16 had severely impaired cognition. Further the assessment identified R16 frequently has pain which occasionally effects sleep and day-to day activities and rated pain at a 2 out of 10 on a pain scale and receives pain medication.R16's face sheet, identified the following diagnoses: end stage renal disease, malnutrition, acute kidney failure, alcoholic cirrhosis of liver with ascites (chronic liver disease with leads to scarring of liver which led to fluid accumulation in the abdominal cavity), heart attack and chronic liver failure.On 8/25/25 at 1:57 p.m., R16 stated has chronic pain. R16 stated his back gets very sore along with his shoulders. R16 stated they do not offer ice packs or heating pads to help with the pain. R16 stated no non-pharmacological interventions are offered for pain management.R16's care plan, indicated, resident has the potential for acute pain r/t (related to) end of life which included offer non-pharmacological interventions for pain relief such as heat, cold, repositioning, rest, music, family/ friend time and relaxation.R16's August MAR/TAR included the following orders:-hydromorphone (opioid medication used to treat moderated to severe pain) oral liquid 1milligram/milliliter (mg/ml) give 2 ml by mouth every 1 hour as needed for pain for dyspnea, moderate pain with a start day of 7/21/25 and discontinue date of 8/14/25. This medication was administered 6 times from 8/7/25 to 8/13/25 which showed pain scale ratings of 2-5 and effectiveness of medication was documented.-hydromorphone 1mg/ml give 2 ml by mouth every 3 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours as needed for pain for dyspnea with pain great 4/10 with a start date of 8/14/25. This medication was administered 8 times from 8/14/25 to 8/25/25. The MAR has an area NP, which was located above the pain level scale on the MAR, which had an X marked in all the boxes on the MAR.MAR/TAR lacked evidence of non-pharmacological interventions being offered prior to administration of as needed pain medication.R16's progress notes, dated 8/1/25 to 8/27/25 lacked evidence of non-pharmacological interventions being offered to R16 for pain prior to administering PRN opioid pain medication. During an interview on 8/27/25 at 10:05 a.m., nursing assistant (NA)-B stated they were familiar with R16. NA-B stated R16 requests pain medication, but he doesn't always complain of pain. NA-B stated they would report pain to the nurse for the nurse to administer medications and follow up with the resident.During an interview on 8/27/25 at 1:08 p.m., LPN-A stated when a resident complains of pain, the nurse would have the resident rate their pain if able or do a non-verbal pain scale and then look at the MAR to see what medications would be available. LPN-A stated they would try non-pharmacological as certain resident have it on their MAR/TARs as they could have ice packs. LPN-A stated if they do a non-pharmacological, it would be documented in a progress note. LPN-A stated they do not put orders in the electronic medical record, typically, unless it was a standing house order as the nurse managers put orders in which would include the non-pharmacological that should be done. LPN-A stated that R16 does have pain, received as needed pain medications and required a lot of staff assistance.During an interview on 8/27/25 at 1:59 p.m., registered nurse manager (RN)-B stated the expectation would be staff attempt a non-pharmacological intervention prior to administering PRN pain medication. RN-B reviewed R16's EMR and verified there was no documentation of non-pharmacological interventions being attempted prior to administration of PRN pain medications.During a follow up interview on 8/28/25 at 10:18 a.m., RN-B verified R12 has pain and had been receiving PRN pain medication. RN-B, verified there was no non-pharmacological interventions attempted prior to administration of PRN medications and should have been. RN-B stated they would be documented in the progress notes. RN-B stated they are working on adding non-pharmacological interventions on the residents MARs so staff will have to document interventions when administering PRN pain medication. RN-B verified NP on a resident MAR would indicate non-pharmacological interventions.During an interview on 8/28/25 at 10:35 a.m., director of nursing stated the expectation would be non-pharmacological interventions would be attempted and documented in the progress notes prior to administration of PRN pain medication.A facility policy on use of non-pharmacological interventions for pain was requested but not provided.

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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** Based on observation, interview, and record review the facility failed to ensure proper hand hygiene for 1 of 1 resident (R9) reviewed for contact precautions. In addition, the facility failed to ensure proper PPE usage for 2 of 2 (R20, R46) reviewed for enhanced barrier precautions. Findings include: R9's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R9 was cognitively intact with no behaviors. R9 had no upper or lower body range of motion impairment. R9 was independent with eating, oral hygiene, toileting, mobility, and all activities of daily living. R9 had an indwelling urinary catheter and was always continent of bowel. R9's diagnoses list included cancer, received chemotherapy treatments, chronic kidney disease, diabetes, and malignant lung cancer. R9's careplan indicated R9 was diagnosed with clostridium difficile infection (c-diff-a contagious bacterial infection of the small and large intestine). Interventions included contact-based precautions, educate the resident/family/caregivers the importance of hand washing and use of antibacterial soap and disposable towels. Wash hands immediately after ADL's, care tasks, and activities. R9 was also independent with transfers, eats independently, dresses independently, and toilets independently. R9 was a standby assist of one for showers. During observation and interview on 8/26/26 at 2:24 p.m., R9 was observed sitting on the bed. An enhanced barrier and contact precautions sign were noted outside room. Registered Nurse (RN)-C applied proper PPE prior to entering the room. After assisting R9, RN-C took off Personal Protective Equipment (PPE), had R9's meal tray in his right hand, and used hand sanitizer in left hand. RN-C handed the meal tray to another staff member. Without performing hand hygiene, RN-C then grabbed an empty water pitcher with his right hand, walked over to the sink placing the water pitcher on the counter. RN-C then washed his hands, picked up the water pitcher, and filled it with water. RN-C then took the pitcher to R9's room and placed it on the table outside the room while applying PPE and brought it to R9. Upon leaving R9's room, RN-C used hand sanitizer and took a red bag outside to the main garbage. RN-C performed hand washing upon returning from the main garbage. During interview RN-C confirmed R9 has C-diff and stated hand sanitizer is not effective against c-diff. Staff should be washing hands upon exiting the room. RN-C confirmed he should have washed his hands prior to touching the water pitcher and when exiting with the garbage. EBP R20 R20's comprehensive Minimum Data Set (MDS) assessment dated [DATE], indicated R20 was cognitively intact with no behaviors. R20 had no upper or lower extremity impairment. R20 required set up assist for eating, independent with oral hygiene, independent with toilet hygiene, dependent with bathing, independent with upper and lower body dressing, footwear, personal hygiene. R20 was independent going from sitting to standing, independent with transfers to and from bed/chair, independent with toilet transfers, supervision with tub transfer, supervision/touching assist with walking, and independent with wheelchair mobility, R20 required intermittent catheterization, and was always continent with urine and bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's diagnosis list included benign prostatic hyperplasia, obstructive uropathy, and urinary retention. R20's provider order dated 7/18/25 included, indwelling foley catheter 14 fr (French) change every 30 days and as needed for obstructive uropathy and urinary retention, and enhanced barrier precautions related to indwelling device. R20's care plan indicated R20 has a history of self-transferring and refusal of cares. R20 requires assist of 1 to stand/pivot transfer and assist of 1 with ambulation. R20 has diagnosis of benign prostatic hypertrophy, obstructive uropathy and urinary retention requiring an indwelling foley catheter. During interview on 8/25/25 at 1:43 p.m., R20 stated the indwelling catheter was put in place during his last hospitalization. R20 stated staff do wear isolation gowns most of the time but not all the time. During observation and interview on 8/27/25 at 11:50 a.m., licensed practical nurse (LPN)-C arrived to R20's room to switch R20 from the large urinary drainage bag to the leg bag. An isolation cart and orange enhanced barrier precautions (EBP) signage were noted outside R20's room. LPN-C sanitized her hands and applied gloves however did not put on an isolation gown. LPN-C assisted R20 to a standing position from the recliner and with pulling R20's pants down. LPN-C then removed her gloves and left the room to get more supplies. LPN-C entered again wearing new gloves and a yellow isolation gown. R20 was switched from the large drainage bag to the leg bag using proper infection control practices. After emptying the large drainage bag in the bathroom, LPN-C removed gloves and gown and washed hands. Without donning another gown or gloves, LPN-C placed a hand under R20's arm and assisted him to a standing position. While R20 was standing, LPN-C used both arms to reach behind R20's right side and assisted with pulling R20's pants up. LPN-C then placed both hands under R20's armpits and assisted him with transferring to his wheelchair. After R20 was seated in the wheelchair, LPN-C assisted R20 with putting on his sweater, attaching the foot pedals to the wheelchair, and putting R20's feet on the pedals. During an interview, LPN-C stated proper infection control practices for catheter care include washing/sanitizing hands prior to entering room, using an alcohol wipe to clean catheter, and wearing a gown. LPN-C confirmed a gown should have been put on prior to entering R20's room the first time. RN-C stated there is some training upon hire, however feels there could be more explanation why specific residents are placed on precautions During an interview on 8/27/25 at 11:14 a.m., the infection preventionist (IP) stated hand hygiene, gowns, and gloves are required prior to entering a resident's room who has c-diff. When exiting the room, staff must wash hands with soap and water. When staff are hired, they are educated. When residents are put on c-diff precautions, you notify employees that work with the resident what they are supposed to do. Not following proper procedures could risk spreading the infection to yourself, other residents, staff, and your family. During an interview on 8/28/25 at 11:01 a.m., the director of nursing (DON) stated it is expected staff would follow the directions on the signs posted outside of the resident's room. Staff are expected to wash their hands with soap and water for any resident diagnosed with c-diff. This is important to prevent the spread of infection to staff and other residents. R46's Minimum Data Set (MDS) assessment dated [DATE], indicated R46 had intact cognition, was diagnosed with diabetes mellitus and peripheral vascular disease, and required assistance with all care activities. The MDS indicated R46 had one arterial ulcer present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook Pine Haven	210 Northwest 3rd Street Pine Island, MN 55963

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R46's care plan dated10/9/23, indicated R46 required the assistance of one staff member for dressing and personal hygiene, and the assistance of one staff and a mechanical lift for toileting and transfers. R46's orders, indicated R46 was placed on enhanced barrier precautions (EBP) on 3/7/25. The orders also indicated cares for a right great toe and left knee dated 8/22/25. During an observation on 8/26/25 at 10:42 a.m., outside R46 room was a three-drawer plastic bin was to the right of the doorway and inside the bin were gowns. On top of the bin were two bottles of hand sanitizer and one box of gloves. On the wall to the right of the door was a single page sign , Enhanced Barrier Precautions, clean hands, before entering and when leaving the room. Providers and Staff must also: wear gloves and gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wounds Care: any skin opening requiring a dressing. R46 was in her room sitting in her wheelchair. Nursing Assistant (NA)-A was positioning the mechanical lift, wearing gloves, without a gown NA-A touched R46's upper body when fastening a transfer belt around R46 waist and under her arms. R46 asked NA-A about her name written on tape and placed on her scrubs while transferring R46 to the bathroom. NA-A was observed pulling the curtain open with one hand ungloved while the other hand remained gloved and held a bag of trash that contained a brief (undergarment) and white paper like contents. NA-A performed hand hygiene with sanitizer with her free hand and walked across the hall, opened a door with that same hand and threw the trash into a bin, removed the one glove and threw that into the bin. NA-A shouted out to the nurse, going to get some briefs. R46 remained in the bathroom with the mechanical lift. During an observation on 8/26/25 at 10:50 a.m., R46's call light alerted, and the nurse manager responded. The nurse manager was observed performing hand hygiene, donning a gown and gloves, then responded to R46's call light. NA-A returned with a package of brief and handed the package to the nurse manager and left the area. During an interview on 8/26/25 at 1:18 p.m., R46 confirmed NA-A did not wear a gown while she transferred into the bathroom and could be confident because NA-A wore a handmade name tag located on the chest of her blue scrubs and the nametag was discussed during the transfer. R46 stated staff never wore gowns before and wasn't sure why they started now. During an interview on 8/26/25 at 1:20 p.m. NA-A stated, to be honest with you, you saw me run in and out, transferred her to the toilet, and didn't put on a gown. NA-A confirmed infection control training was provided and EBP was included in that training. NA-A stated the facility never educated or explained which residents needed gowns, but then confirmed the directions for EBP were on the signage outside R46's door. NA-A stated that gown and gloves should be worn with all transfers with all residents on EBP. NA-A stated R46's had a covered wound, wasn't sure why it was important to wear EBP, and that maybe it was to protect herself. During an interview at 8/26/25 at 4:00 p.m., infection control preventionist (ICP) stated the expectation was when a resident was in their room and on EBP all staff wore gloves and gown while in close contact with the resident. Staff were expected to practice EBP precautions during transfers with residents in their rooms and especially when transferred to the bathroom. During an interview on 8/28/25 at 11:01 a.m., the director of nursing (DON) stated staff were to follow the directions on the Enhanced Barrier Precaution sign. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A contact precautions policy was requested but not received. The facility Infection Prevention and Control Manual Transmission-Based Precautions policy dated 2024, indicated staff were to wear personal protective equipment while high-contact resident care was performed. Gown and glove with dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 5 sampled residents (R23) was offered and/or provided updated vaccinations for pneumococcal disease, in accordance with Centers for Disease Control (CDC).Findings include: Review of the current, 10/26/24, Centers for Disease Control (CDC): Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV 21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV 21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV 21) at any age and a PPSV23 at or after the age of [AGE] years old. R23's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R23 was [AGE] years old. It also indicated R23's pneumococcal vaccination status was not up to date and the pneumococcal vaccine was not offered. R23's immunization record indicated R23 received the pneumococcal-conjugate vaccine-13 (PCV13) on 11/2015 and pneumococcal polysaccharide vaccine 23-valent (PPSV23) on 8/8/2001. It did not indicate record of R23 receiving the PCV-20 vaccine. R23's vaccine consent form dated 10/27/23 indicated R23 consented to receiving the COVID-19 and influenza vaccine however did not offer the pneumococcal vaccine. During interview on 8/27/25 at 1:57 p.m., the infection preventionist (IP) indicated the facility does offer the PCV-20 vaccination via immunization clinics offered during the summer and fall. New admissions are offered vaccinations upon admission in an individual basis. The last immunization clinic was 10/24 however R23 had COVID19 during that time and did not participate in the clinic. The IP stated he was under the impression R23's pneumococcal vaccination status was considered complete because R23 had received the PCV-13 and PPSV-23 vaccinations and confirmed there is no record of shared decision making and/or offering of PCV-20 vaccine to R23. During an interview on 8/28/25 at 11:01 a.m., the director of nursing (DON) stated it is expected the facility would follow CDC guidelines and offer vaccinations upon admission and during appropriate season. A 2024 policy titled Infection Prevention and Control Manual Pneumococcal Vaccine Program indicated It is the policy of this facility that residents will be offered immunization(s) against pneumococcal disease in accordance with Advisory Committee on Immunization Practices (ACIP recommendations. Pneumococcal disease is a serious illness that can cause sickness and even death. It continues, Recommendation for shared clinical decision making. Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 if they have received PCV13 at any age and PPSV at or after the age of [AGE] years old