STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Rochester	1875 19th Street Northwest Rochester, MN 55901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review, the facility failed to protect a resident's right to privacy during a routine skin observation/assessment, making a resident feel their personal privacy was violated for 1 of 1 resident (R2) reviewed for resident rights. Findings include: R2's Minimum Data Set (MDS) discharge assessment, dated 6/27/24, indicated R2 was admitted on [DATE] and had an unplanned discharge to home on 6/27/24. No other MDS information was identified. A Nursing Home Incident Report Summary submitted to the State Agency (SA) on 6/27/24 at 11:04 a.m., indicated R2 reported that while working with physical therapy, licensed practical nurse (LPN)-A entered the room and completed a skin check of her back and buttocks. Further indicated LPN-A did not ask for her permission and exposed R2's bare skin in the presence of the male physical therapist (PT). This caused R2 to be embarrassed to be exposed in front of him. R2's care plan dated 6/26/24, included R2 had a potential psychosocial well-being problem related to recent hospitalization admission to a skilled nursing facility (SNF), depression, anxiety, panic disorder, personality disorder, medical condition, and loss of independence. During interview on 7/9/24 at 11:05 a.m., R2 indicated this was her first stay in a SNF and it was not a good experience. R2 further explained she was admitted on [DATE] and a male PT was working with her in her room when all of a sudden this wild woman came in and whipped my pants down and told me she had to look at my butt. R2 described the experience as being scared and in shock that the woman pulled my pants down in front of that man. R2 indicated shortly after the incident she moved to a different facility. During interview 7/9/24 at 11:39 a.m., the physical therapist indicated he was aware of the allegation and explained he was in R2's room during the time LPN-A did R2's skin observation. Further indicated he was in the process of R2's physical therapy assessment and LPN-A came into R2's room to do the admission skin check. PT was in front of R2 holding the walker and R2 was standing with the walker. LPN-A quickly pulled the back of R2's shorts down to check her back and buttocks and then left the room. The PT assessment continued. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/10/24 at 12:23 p.m., LPN-A indicated R2 was admitted on [DATE] at approximately 2:00 pm. R2 was working with PT in her room when she entered the room and announced she was going to take a quick peek at her [R2's] bottom as long as she was standing. Further indicated she pulled R2's pants not far down in the back and R2 did not say anything. The facility Resident Rights: Dignity policy last revised 10/24/23, identified the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. Further states that basic rights to all residents of the facility include the resident right to privacy and confidentiality and be treated with respect, kindness, and dignity.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review the facility failed to safely discharge 1 of 1 resident (R4), who was discharged from the facility without a source or a plan to obtain supplemental oxygen. Findings include: R4's admission Minimal Data Set (MDS) dated [DATE], indicated R4 was cognitively intact with diagnoses including heart failure, end stage renal disease, diabetes, obstructive sleep apnea, and morbid obesity. The MDS indicated R4 received intermittent oxygen therapy and a bi-level positive airway pressure (Bi-PAP uses mild air pressure to keep breathing airways open while you sleep). R4's Discharge Summary/Recap of Stay dated 7/1/24, indicated R4 was discharged to a hotel on 7/1/24 at 1500 (3 p.m.). R4 was oriented to person, place, and time. Equipment needed at time of discharge was blank although Bi-PAP and Oxygen were listed as options. R4's physician order dated 12/8/23, indicated Bi-level PAP with 2 liters of oxygen supplementation to Bi-level PAP. Indicated duration of use would be lifetime for obstructive sleep apnea. R4's care plan last revised on 6/28/24, indicated altered respiratory status/difficulty breathing related to pulmonary hypertension, obstructive sleep apnea, and shortness of breath when lying flat. Included interventions of CPAP/Bi-Pap settings per MD orders and oxygen per MD order. R4's facility social service progress note dated 7/1/24 at 15:18 (3:18 p.m.), indicated R4 decided to discharge to the hotel that day to avoid paying privately to remain in the facility. Further indicates discharge papers were reviewed and signed by R4. In-home therapy orders were provided to R4 to her preferred home care agency once she moves back to her home state. The progress note lacks any mention of oxygen durable medical equipment (DME) referral. R4's facility progress note title Discharge Summary dated 7/1/24 at 1640 (4:40 p.m.), by the DON indicates R4 was discharged to the hotel with personal belongings and Bi-Pap machine. Discharge instructions given to resident. During an interview on 7/9/24 at 3:00 p.m., R4 indicated she had severe sleep apnea and heart problems. The cardiologist had encouraged her to wear her Bi-Pap at night and any time she lays down. Further explained that she also had oxygen that was to be used with the Bi-Pap. R4 indicated she was discharged to a hotel on 7/1/24 but did not have any oxygen. Further stated, the facility was still trying to figure that out [how to get oxygen to her]. Did not have the oxygen to use the first night but called a number she had found on her discharge papers to the clinic and called them the next day. Indicated the clinic staff helped her get oxygen on 7/2/24. Denied any further contact or assistance by the facility. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/24 at 11:08 a.m., the director of nursing (DON) indicated R4 required supplemental oxygen connected to her Bi-Pap and was using her oxygen and Bi-pap at discharge. Verified R4 was discharged to a hotel on 7/1/24 with all medications and Bi-Pap supplies but was not able to secure oxygen delivery for R4 at the hotel. The DON indicated she called their oxygen supplier but, because R4's permanent mailing address was out of the state of Minnesota, it was out of their region and would not supply the oxygen. Further indicated the social worker usually secures all services, medical equipment, and referrals in preparation for discharge. Indicated the social worker was not available for interview. During an interview on 7/9/24 at 2:20 p.m., the administrator indicated that once a discharge date has been identified, the expectation is the social worker will get orders from providers and make referrals for home care services and DME equipment needs. Review of facility policy titled Admission, Readmission, Bed Hold, and Transfer/Discharge last revised 10/12/2021, indicated the facility must provide and document sufficient preparation and orientation to residents, in a form and manner that the resident can understand, to ensure safe and orderly transfer or discharge from the facility.