STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview, and document review, the facility failed to ensure residents were treated with dignity and respect for 3 of 3 residents (R2, R3, R4) who required assistance with activities of daily living (ADLs) and reported concerns about a staff member. Findings include: R2 R2's Minimum Data Set (MDS) dated [DATE], indicated he had diagnoses including hemiplegia following cerebral infarction affecting the left side (left-sided paralysis after a stroke), depression, psychotic disorder, and diarrhea. The MDS identified R2 was always incontinent of bowel and bladder, had intact cognition, did not exhibit behaviors or indicators of psychosis, had range of motion impairment in one upper and one lower extremity, and required maximal assistance with transfers and bed mobility and was dependent on staff for bathing and toileting hygiene. R2's care plan for physical mobility included an intervention dated 6/14/24, BED MOBILITY ASSIST - Extensive assist x ONE. R2's care plan for communication included interventions dated 6/14/24, including ensure/provide a safe environment: call light in reach, adequate lighting, bed in lowest position, and wheels locked. Avoid isolation, anticipate and meet needs, and speak at an adult level, speaking clearly and slower than normal. R2's care plan for vulnerability included interventions dated 1/23/24 including encourage resident to report to staff if resident feels threatened or bothered by other residents and/or staff, observe for potential pain, discomfort, and/or mental anguish, and validate resident to convey empathy/understanding and bolster self-coping skills. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Vulnerable Adult Maltreatment Report number 357344 submitted to the State Agency (SA) by the facility dated 7/22/24, noted R2 reported concerns about rough handling by a staff member and was interviewed by the social services director (SSD). R2 reported that last night around 4:00 a.m. he spilled water on himself and the nurse thought it was urine and started changing his sheets without asking and he felt like he was going to fall out of bed. He stated the staff member sometimes hit his legs, told him to straighten out your legs damn it, and was mean to him often. The report noted the facility identified nursing assistant (NA)-B as the staff member and reviewed video footage of care provided by NA-B to R2 around 4:00 a.m. on 7/22/24 and there were no concerns noted. In an interview on 7/23/24 at 2:48 p.m., R2 stated a NA was pissed off and sick of changing diapers and the NA got on my ass. He noted a recent incident where my legs were the problem. I have one that is kind of curving and she wanted me to put my legs straight and said put your legs straight and then probably just one of them she hit. I had a stroke and it messed up a lot of things for me. In an interview on 7/25/24 at 9:33 a.m., R2 stated the aide treated him roughly about a week prior and noted she has a temper problem, it makes me feel violated. He further stated she doesn't treat me with respect and dignity, she doesn't like me. He stated I just wanted you to be aware this is going on, I'm not afraid of her, she's just mean. During interview, R2 noted the discussion to be talking about things that are painful. R3's MDS dated [DATE], indicated she had diagnoses that included aftercare following explanation of knee joint prosthesis (knee joint prosthesis surgery after amputation), pyogenic arthritis (acute arthritis due to infection), urinary tract infection in the last thirty days, anxiety, depression, and chronic pain syndrome. The MDS identified R3 was frequently incontinent of both bowel and bladder, had no memory impairment, did not exhibit behaviors, and was dependent on staff for toileting hygiene and transfers. R3's care plan identified bowel and bladder incontinence and included an intervention dated 5/10/24, of BRIEF USE: The resident uses (XXL brief) disposable briefs. Change q2H [every two hours] and prn [as needed]. R3's care plan identified a focus dated 4/2/24, of I have experienced events and/or circumstances which have been physically and/or emotionally harmful, which have adverse effects on my individual functioning and/or well-being. Interventions dated 4/2/24, included approach resident warmly and positively. R3's care plan identified a focus on vulnerability with interventions dated 3/29/24 of validate resident to convey empathy/understanding and bolster self-coping skills, remove resident from potentially abusive situations, encourage resident to report to staff if resident feels threatened or bothered by other residents and/or staff, and observe for potential pain, discomfort, and/or mental anguish. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Vulnerable Adult Maltreatment Report number 357364 submitted to the SA by the facility dated 7/23/24, noted R3 reported concerns about care provided by a staff member determined to be NA-B. During interview, R3 reported to facility staff that over the weekend during the night an aide had helped her onto the bed pan and she noticed after using the restroom that the bed pan wasn't properly placed and alerted the aide who entered the room and said what the fuck did you do. The aide then left the room, returned with a soaker pad [absorbent pad], placed it under her, and told R3 there, now you can sleep in it. In an interview on 7/23/24 at 2:58 p.m., R3 stated I can't walk and I need help and if I can't get someone to get here quick enough I end up peeing in the bed and I have some nastiness from one nurse [nursing assistant] in particular for that. R3 stated the staff member had said to her Girl, why you gotta do this again? after an episode of incontinence when the other night she put the bed pan under me and I peed and it wasn't in the right place so the pee went in the wrong place and she said 'I don't know why you do this to me' and started throwing things and grabbed a couple of soakers and put them under me instead of changing me. So, she was pretty nasty to me. R3 stated she would pee the bed every night because I would sleep right through it and I would wake up in the morning wet and she would harass me about that. R3 stated NA-B had had previously told her don't fuck with me tonight. In an interview on 7/25/24 at 8:36 a.m., R3 confirmed the staff member previously discussed with NA-B and indicated on one of the nights the weekend prior NA-B had provided care to her and she thought she was funny that night but I didn't think she was funny. R3 stated I don't feel like I was treated with dignity and respect, not at all and she needs an attitude adjustment. R4's MDS dated [DATE], indicated she was admitted to the facility on [DATE] with diagnoses including a wedge compression fracture of fourth lumbar vertebra (fractured lower back), arthritis, dementia, anxiety disorder, and tremor. The MDS identified R3 was frequently incontinent of both bowel and bladder, had no memory impairment, did not exhibit behaviors, and required moderate assistance from staff with toileting hygiene and maximal assistance with toilet transfers. R4's care plan for bowel incontinence included an intervention dated 7/15/24, of check resident every two hours and assist with toileting as needed. R4's care plan for bladder incontinence included an intervention dated 7/15/24, of INCONTINENT: Check (Q2H [every two hours]) and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN [as needed] after incontinence episodes. R4's care plan identified a psychosocial well-being problem with interventions dated 7/15/24, including Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears, increase communication between resident/family/caregivers about care and living environment. Explain all procedures and treatments, medications, results of lab tests, condition changes, rules, options, and monitor/document resident's feelings relative to isolation, unhappiness, anger, or loss. R4's care plan for vulnerability included interventions dated 7/16/24, including encourage resident to report to staff if resident feels threatened or bothered by other residents and/or staff, observe for potential pain, discomfort, and/or mental anguish, and validate resident to convey empathy/understanding and bolster self-coping skills. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Vulnerable Adult Maltreatment Report number 357365 submitted to the SA by the facility dated 7/23/24, noted R4 reported concerns about care provided by a staff member determined to be NA-B. During interview, R3 reported to the SSD that on the weekend during the night an aide entered her room to answer her call light and said what do you want now, [R4] R4 reported she had to use the restroom and noted she did not appreciate the aide's attitude. In an interview on 7/23/24 at 3:40 p.m., R4 stated there was an overnight NA who is ornery all the time, like she'll go 'Oh, off, [R4] what do you want' in a gruff voice. R4 stated one night I had to go to the bathroom several times in the night and she said 'aren't you every going to quit going to the bathroom' and I can't help it if I gotta go. She acts like it's a real problem. R2/R3/R4 In an interview on 7/25/24 at 8:59 a.m., trained medication aide (TMA)-A stated if she were a resident and an aide complained about cleaning her up or seemed frustrated, she would feel neglected, I would feel like my dignity and respect wasn't given to me. Residents have the right to be treated with dignity and respect . I would not feel right if my family or loved ones were treated that way. TMA-A indicated that if she were a resident and a staff member asked if she was ever going to stop going to the bathroom she would be shocked, like I have to go to the bathroom, like they are denying my dignity and my needs because I need to go and I'm a resident and I need help, that's what I'm here for. In an interview on 7/25/24 at 9:20 a.m., NA-C stated that if she was a resident and needed assistance with toileting and staff complained about cleaning her up or seemed frustrated I would feel very belittled, I would be here to get care and not receiving that would feel very bad. I expect residents to be treated with the most respect that we can give them and as much care as we can. In an interview on 7/25/24 at 10:37 a.m., NA-B stated she was aware of concerns expressed about the care she provided to R2, R3, and R4. NA-B denied these accusations or reports were true. NA-B stated yes, I'm aware residents say I'm rough with cares. NA-B stated R2 said he was going to fall out of the bed which is not true, I think she's [R3 is] pissed off because she had wet the bed, the bed pan tipped over, and I don't know what's wrong with her [R4]. I've just changed her, changed the soaker pad, but she want [sic] to say that I put it under her head but I didn't. NA-B stated of course residents have the right to be treated with respect and dignity. I never had a problem with them. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/25/24 at 12:10 p.m., the SSD stated all residents have the right to be treated with respect and dignity by all staff. SSD indicated she was aware of recent concerns voiced by R2, R3, and R4 regarding care from NA-B. She noted that on Monday R2 had expressed concern and on Tuesday R3 and R4 also came forward with concerns and the facility identified all three concerns to be regarding NA-B. SSD stated she interviewed R2 about the concerns he reported and NA-B's actions were not in line with my expectations of treating residents with respect and dignity. She stated it felt like [R2] felt she [NA-B] assumed it was urine which it wasn't, which like don't assume he had incontinence. And then just asking him before you can change the sheets and being gentle. If he feels like he's falling out of bed I would expect that someone would listen to that and . I would expect you to stop the activity and respect what he's saying and reposition so he's more comfortable. The SSD confirmed that if she was the resident she probably wouldn't feel like I was treated with respect and dignity in that situation. The SSD stated she had not interviewed R3, but was aware she expressed a concern about NA-B and the care that was provided during an incontinence episode. The SSD stated R4 reported there was a night where she put on her call light and the aide that answered it came in the door and said 'What do you want now, [NAME]?' which made [NAME] feel as if why did I put on my call light. The SSD confirmed this was not treating residents with dignity and respect, it was not in line with her expectations of staff treatment of residents, and if someone said that to me I wouldn't feel good, it makes people feel like they're a burden when we're here to help them. The SSD noted that if a staff member expressed frustration with providing cares or made comments such as why you gotta do this to me, I don't know why you do this to me, or when are you gonna quit to residents regarding the provision of cares, it did not demonstrate treating a resident with dignity and respect and it is a violation of their right to be treated with dignity and respect. In an interview on 7/25/24 at 3:32 p.m., the director of nursing (DON) confirmed residents have the right to be treated with respect and dignity. She confirmed that the reported about NA-B's treatment and communication obviously wasn't respecting the residents' respect and dignity. When asked how she would feel as a resident if an aide made comments complaining or expressing frustration with providing cares it would have to be in the context and did not identify such treatment as a violation of respect and dignity. Facility policy titled Resident Rights: Dignity dated 10/24/23, included 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 .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a) a dignified existence; b) be treated with respect, kindness, and dignity.

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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** 49338 Based on observation, interview, and document review the facility failed to notify the physician of an injury after a fall for 1 of 3 residents (R5) who fell from the wheelchair and landed on a freshly healed below knee amputation causing bleeding and dehiscence to the healed site which resulted in surgery and facility failed to notify the physician of the inability to procure and administer an emergent medication for 1 of 3 residents (R1) which resulted in a visit to the emergency department to lower potassium level. Findings include: R5's Minimum Data Set (MDS) assessment dated [DATE], indicated R5 admitted to the facility on [DATE] from a hospital with diagnoses including encounter for orthopedic aftercare following surgical amputation, and acquired absence of right leg below knee. The MDS indicated R5 had a major surgical procedure during her prior inpatient hospital stay that required active care during her stay at the facility and had surgical wounds. A Incident Note progress note by licensed practical nurse (LPN)-C dated 7/9/24 at 5:49 p.m., indicated therapy yelled for help and we discovered res[ident] lying face down on her floor and her wheel chair was lying beside her she was trying to reach for something in her drawer she said, we asked her where she hurt and if she hit her head, she said no to head and her stump was hurting and it was also bleeding the bp [blood pressure] machine was not working so we got her up with Hoyer [type of mechanical lift] and then we took her vs [vital signs] 174/70 [blood pressure] p [pulse/heart rate] 75. An SBAR [Situation, Background, Assessment, and Recommendation] Rochester progress note by LPN-C dated 7/9/24 at 5:55 p.m., included an assessment/appearance section with note right hip abrasion and end of stump bleeding and a provider notified of SBAR (date/time) section with note 7-9. A progress note by LPN-C dated 7/18/24 at 3:00 p.m., indicated R5 had a right BKA and right now it has an open spot due to fall that we are dressing and she was unable to be fitted for a prosthetic until the wound healed. A physician visit note from MD-B dated 7/18/24, indicated R5 was seen in a clinic for physical medicine and rehabilitation follow-up. The note included unfortunately about a week ago she tells me she fell out of her wheelchair. She was not sure how she fell but she did land directly on her right residual limb and notice bleeding soon after . upon removal of her shrinker sock [compression sock over residual limb site] she had a gauze dressing and Steri-Strips still in place. The Steri-Strips had blood on them. Upon removal of the Steri-Strips there was a superficial dehiscence present with subcutaneous fat visible in the wound bed . unfortunately 1 week ago she slipped out of her wheelchair on her residual limb and has now suffered a superficial dehiscence of her residual limb . I called [MD-A's] service and discuss[ed] the case with them. They may want to see her back in the cast room for further evaluation given that her incision is now dehisced. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 7/19/24 at 11:15 a.m., indicated R5 went to a cast room clinic appointment and the clinic called the previous night and stated R5 would be directly admitted to the hospital following the appointment. In an interview on 7/29/24 at 9:12 a.m., MD-B stated he was a physical medicine and rehabilitation provider and had seen R5 on 7/19/24. He noted his team followed their patients before surgery, during inpatient hospitalization s, and outpatient the purpose of the visit on 7/19/24 was to see her and prescribe a prosthesis for her residual limb as she had been orthopedic surgery and MD-A on 7/5/24 who had cleared her to get a prosthetic fitted after seeing MD-B. He stated I was expecting her residual limb to be healed on the 18th and begin the prosthetic fitting process. He further stated her wound was dehisced, about two to three inches of the incision was open at this point which had not been the case when she had seen [MD-A] on July 5th. MD-B noted my medical recommendation would be if trauma occurs to a residual limb during the healing process and bleeding is seen I would recommend that the medical teams be alerted for further evaluation and that did not happen to my knowledge, I was not notified. MD-B noted he would expect either the surgical or physical medicine and rehabilitation team to be notified as they collaborate. He stated We are in close communication. I see no evidence that they [MD-A's team] were alerted, if they had been they would have evaluated her. And I was the one that alerted them and it was news to them. MD-B stated that because R5's incision site became an open wound he contacted MD-A's team who admitted her to the hospital for revision surgery to surgically close the incision. In an interview on 7/25/24 at 3:46 p.m., LPN-C stated she was working on 7/9/24 when R5 fell . She noted after the fall she applied pressure to the [R5's] stump because it was bleeding, she said it was hurting, we noticed there was blood on the floor from the stump. LPN-C stated she notified R5's attending primary provider at the facility, MD-C, of the fall by faxing the SBAR progress note. When asked what MD-C's response was, LPN-C stated she did not get a response. In an interview on 7/29/24 at 10:35 a.m., MD-C stated she had last seen R5 on 7/3/24 and was not notified of her fall on 7/9/24. MD-C stated there was an on-call twenty-four seven and we would have documented a fall on the 9th if they had call us. I don't see any documentation that they notified us. MD-C noted that if R5 had a fall with bleeding to her incision site and a complaint of pain we would have notified orthopedic [MD-A's team] at [hospital], and also would have done an x-ray and examined for possible infection as well. She confirmed she expected the facility to notify the orthopedic team but sometimes they notify the primary provider team and she would then have instructed them to notify the orthopedic team. She further specified she would have expected staff to give her primary care team a phone call with a description of the wound, R5's pain level, if she was on any PRNs [as needed medications], and her current vital signs and would expect to have been notified immediately. MD-C stated the facility has a 24 hours per day seven days per week on-call phone number they use to contact her team and for something really critical, including falls with injuries, she would expect a phone call even after hours and not just an SBAR report via fax. She noted that all SBAR reports are answered by 4:30 p.m. and expected staff to reach out again if they had not heard back by that time because a fax may not have gone through or there may have been an error. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/29/24 at 11:00 a.m., LPN-C stated providers should be notified of falls with injury and this was done via the SBAR report generated in the electronic health record that is then printed and faxed unless it is really serious and we just send them in [send the resident to the hospital via emergency medical services] and let them know. She stated that if she sent an SBAR notification to a provider and did not hear anything back I just assume nothing is needed. She stated she did not hear anything back from MD-C's team after notifying them via faxing the SBAR progress note about R5's fall and didn't expect to because the injuries were not serious. LPN-C did not indicate that R5's surgical or physical medicine and rehabilitation providers were notified. In an interview on 7/29/24 at 11:36 a.m., clinical manager (CM)-A stated he responded along with LPN-C to R5's fall on 7/9/24. CM-A stated R5's surgical team was not notified of the fall to his knowledge, and he would have expected the surgical team to be notified. CM-A confirmed R5's orders contained an order active at the time directing staff to notify the provider of bleeding and would expect notification of the surgical team for bleeding from a surgical site regardless of if there was an order. R1's Admission Record dated 7/24/24, identified diagnoses of type 1 diabetes, acute kidney failure (condition where one or both kidneys no longer work properly), chronic kidney disease, pancreas transplant, kidney transplant, immunodeficiency due to drugs, end stage renal disease, disorder of phosphorous metabolism and hyperkalemia (potassium levels in the blood are too high and can damage the heart and muscles). R1's Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact. R1's care plan dated 7/23/24, identified intervention to monitor/document/report as needed (PRN) any signs/symptoms (s/sx) of hypokalemia (low potassium) in residents receiving diuretic therapy: fatigue, muscle, weakness, diminished appetite, nausea and vomiting and dysrhythmias, monitor potassium levels. R1's progress notes dated 7/16/24 did not identify hyperkalemia, medical doctor (MD) communication, pharmacy communication, R1 going or returning from an appointment, or staff assessments of R1 while hyperkalemic. R1's progress note dated 7/17/24 at 3:00 p.m., identified a call from MD-D stating R1 had elevated potassium. Order for kayexalate 30 grams (g) and send to emergency room (ER) for additional tests and treatment. R1 left at 3:50 p.m. R1's progress note dated 7/18/24 at 5:44 a.m., identified R1 returned from ER at 1:00 a.m. with new order. During an interview on 7/24/24 at 11:53 a.m., R1 was sitting on the side of the bed with a side table in front of her with food on plate. R1 stated she did not have any symptoms when her potassium was high. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview 7/25/24 at 2:49 p.m., MD-D ordered two doses of lokelma 10g to be given 7/16/24 and to recheck basic metabolic panel (BMP) on 7/17/24 for R1's elevated potassium of 6.0. MD-D stated he called the facility to give the order and was told the facility only accepts faxed orders. MD-D called the facility around 5:00 p.m., to ensure R1 would receive lokelma as ordered on 7/16/24 and if the order was ok. MD-D stated BMP results came for 7/17/24 and the potassium results were higher 6.4 and that does not make sense because the potassium should be better. MD-D called the facility again and was informed R1 did not get the medication on 7/16/24. MD-D stated he would have sent R1 to the emergency roiagnom on [DATE] if the facility would have told him they would not have the medication to give R1. MD-D ordered kayexalate 30g and send to ER for treatment on 7/17/24. I am not going to take the risk and wait for you to get the medication, send the patient [R1] to the ER. During an interview on 7/25/24 at 9:37 a.m., health unit coordinator (HUC)-A reviewed the high potassium order and lab sheet. HUC-A discussed with director of nursing (DON) what times the lokelma should be given. HUC-A faxed the order to the pharmacy. During a phone interview on 7/29/24 at 3:10 p.m., licensed practical nurse (LPN)-E did not get information on the elevated lab for R1 on 7/16/24. LPN-E stated while doing the medication pass if a medication is unavailable she will mark '9' and leave a nurses note that the medication is not there. I remember talking to the DON on the 17th but not on the 16th about the critical lab. During a phone interview on 7/29/24at 8:35 a.m., LPN-D stated the medication had not come from pharmacy I had never heard of it [lokelma]. I did not call the DON because sometimes meds don't show up till the next day. LPN-D stated she was unaware of the importance of lokelma. During an interview on 7/25/24 at 2:04 p.m., DON verified that both lokelma doses needed to be given on 7/16/24 and BMP was scheduled to be checked on 7/17/24 in the morning. DON verified the order was not received until 1:30 p.m. and that it would come on the next run unless the pharmacy was notified it was needed right away. No one thought from the order that it needed to be called on right away. DON was under the impression that R1 would have had the lokelma either from direct delivery or the emergency kit. MD-D called DON and asked if R1 received lokelma, DON verified R1 did not receive the medication and informed MD-D they had kayexalate on hand. DON stated MD-D did not want to wait for the lokelma to come from pharmacy and ordered R1 to go to the emergency room . Facility policy titled Post Fall Policy dated 10/13/23, included Notification and communication: Notify the physician and a resident representative as applicable . update MD/NP [doctor of medicine/nurse practitioner] with evidence of acute changes after a fall. A facility policy regarding notification of changes was requested but not received.

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NAME OF PROVIDER OR SUPPLIER Edenbrook of Rochester		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19th Street Northwest 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 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** 49338 Based on observation, interview, and document review, the facility failed to ensure personal privacy and confidentiality was provided for 1 of 1 resident (R2) noted to have a facility video monitoring recording device with a view that included the interior of a resident room without resident knowledge or consent. Findings include: R2's Minimum Data Set (MDS) dated [DATE], indicated R2 admitted to the facility on [DATE] with diagnoses including hemiplegia following cerebral infarction affecting the left side (left-sided paralysis after a stroke), had intact cognition, and required maximal assistance with personal hygiene cares and transfers and was dependent on staff for toileting hygiene and bathing. Review of R2's electronic health record (EHR) failed to identify documentation of a consent form for video surveillance. During an interview on 7/25/24 at 11:28 a.m., the facility administrator presented recorded video footage from the facility's video monitoring system from the camera named North Medroom Camera. The administrator stated the cameras are a brand that are triggered when they sense something and begin to record when there is movement but do not run continuously. The administrator stated she was unsure of the length of time for which the recorded footage was stored before deletion. The administrator noted the facility had footage of all resident hallways from different cameras and they do not capture the inside of resident rooms. The facility administrator presented recorded clips dated 7/22/24, from between 4:00 a.m. and 4:10 a. m. of varying lengths. The administrator confirmed that in the clips the camera view included the interior of R2's room and R2 could be seen lying in bed from mid-torso up while receiving cares from nursing assistant (NA)-B with the door open. The administrator stated that in the 4:06 a.m. clip, NA-B was seen changing R2's gown. NA-B removed R2's gown while he was lying on his back in bed and after his gown was removed his unclothed body was visible from the mid-torso up. The administrator stated the facility need a consent from R2 for video monitoring in his room and confirmed the facility did not have a consent form from him for video monitoring in his room. During interview on 7/25/24 at 11:40 a.m., the administrator opened the live stream footage of the North Medroom Camera and confirmed the viewpoint was the same as in the footage from 7/22/24. The administrator stated the camera footage was of the North unit hallway and doorways to resident rooms on the hallway were visible but not the interiors of the rooms, but if R2's door was open the camera would have a view into his room. The administrator stated residents have a right to privacy and confidentiality, stated she was not previously aware of this issue, and confirmed the camera view did not protect R2's privacy and confidentiality. Review of live video feeds confirmed the interior of resident rooms were not visible on any other camera. The administrator noted she and the maintenance director had access to the camera footage and she believed he installed them last fall. She stated she would be moving the camera outside R2's room in the North unit hallway immediately so the interior of his room would not be visible. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 7/25/24 at 12:05 p.m., the camera's placement in the North unit hallway was noted to have been adjusted such that it no longer pointed towards R2's doorway. During an interview on 7/25/24 at 12:10 p.m., the social services director (SSD) stated residents have the right to privacy and confidentiality and she believed the facility would need consent to record a resident inside of their room. The SSD stated, If I found out I had been being recorded and part of my body in various states of dress was visible, I would feel upset. The SSD noted that as a female having the upper half of her body exposed would be very revealing and upsetting. The SSD stated being recorded without knowledge or consent could affect someone with a history of trauma, it could be triggering to not have the privacy and confidentiality. During an interview on 7/25/24 at 1:28 p.m., the environmental services director (ESD) stated he installed the facility's cameras and they had been installed over approximately the last year and a half. He stated the cameras were used for security purposed and monitored areas like the exterior of the facility, main hallways, parking lot, and common areas and there were 12 total cameras. He noted the cameras were for monitoring common areas and not resident rooms and as far as he understood the facility was not allowed to have cameras in resident rooms because it would be a violation of the Health Insurance Portability and Accountability Act. The ESD opened the live video feeds application and the North Medroom Camera was noted to be pointed at the North unit nurse station and the North unit medication room. He confirmed that R2's room was now outside the view of the camera and stated he wasn't aware that you could previously see in the room with that camera. The ESD noted when he originally installed the cameras, he utilized his phone to check the views of each and had never noticed you could see into the room. He confirmed access to the live and recorded video footage was limited to himself and the administrator who were able to access it via phone or laptop. He confirmed that video feeds were not displayed anywhere in the facility like on a monitor at a nurse station. During an interview on 7/25/24 at 3:01 p.m., R2 stated the SSD had just spoken with him and she told me something about they had a video tape of me with a shirt off. R2 stated if I was completely naked or doing something weird or a bunch of people were seeing it and laughing, I wouldn't like that at all. However, he stated he did not feel like has privacy had been invaded. R2 did not express further concerns. During an interview on 7/25/24 at 3:04 p.m., the SSD stated she had a talk with R2 about the camera and it went good. She stated I did tell him that one of the cameras had accidentally been turned and while we were investigating we noticed that it did catch part of him in his room and part of it with his shirt off. I told him it didn't catch anything below his midline, and he said that's alright. She noted she asked R2 how he felt about it and he said it was alright, did not seem concerned, and did not display signs of distress. The SSD noted she told R2 the camera was no longer pointing into his room and she thought the footage all automatically deleted after thirty days. In an interview on 7/25/24 at 3:06 p.m., the administrator stated all the facility cameras were on either a two week or thirty-day storage plan and the footage deleted after that time frame. The administrator stated she was not sure what the oldest stored footage from the North Medroom Camera was, but confirmed there were none from the month of June. She noted that the facility's cameras had been in the same positions since they were originally installed and noted the bed in R2's room used to be near the window in the room and would not have been visible on the North Medroom Camera at that time, but the bed was moved at some point into position to the left of the doorway upon entry and was then visible on the footage. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Video Surveillance dated 2/5/24, included The facility may employ video cameras, digital video recorders (DVR) and other surveillance technology on the facility property for the purposes of protecting the safety and property of the campus community, deterring crime, and assisting police in criminal investigations . Surveillance technology may be positioned in appropriate places within and around the company buildings. Surveillance technology does not allow for the viewing of any residents'/participant's or tenants' personal health or other private information nor does it allow for viewing inside private areas of restrooms, spas, showers, dressing rooms and resident or tenant rooms. Facility policy Resident Rights: Dignity dated 10/24/23, included The facility must protect and promote the rights of the residents . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . s.) privacy and confidentiality.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on observation, interview, and document review, the facility failed to ensure routine grooming and personal hygiene care (i.e. nail care) was provided for 1 of 1 resident (R2) reviewed for activities of daily living (ADLs) and who was dependent on staff for such care. Findings include: R2's Minimum Data Set (MDS) dated [DATE], indicated R2 admitted to the facility on [DATE] and had diagnoses including diabetes mellitus and hemiplegia following cerebral infarction affecting the left side (left-sided paralysis after a stroke). The MDS identified R2 had intact cognition, did not exhibit behaviors or reject cares, and required maximal assistance to complete personal hygiene cares. R2's facesheet included a diagnosis dated 1/22/24, of need for assistance with personal care. R2's care plan for ADLs dated 1/23/24, noted R2 had an ADL self-care performance deficit related to hemiplegia, hypertensive heart disease, and dysphagia (difficulty swallowing). Interventions included BATHING/SHOWERING: Check nail length and trim and clean on bath days as necessary. Report any changes to the nurse. R2's most recent Weekly Skin Check assessments dated 7/5/24 and 7/25/24, identified R2 had no new skin alternations, but lacked detail or evidence R2's nails had been reviewed with the completed skin check. R2's task charting dated 7/25/24, for the previous 14 days for bathing indicated R2's most recent bath was a bed bath performed on 7/23/24 at 9:59 p.m. Further charting indicated the activity did not occur on 7/20/24 and 7/18/24, and resident not available on 7/16/24 and 7/13/24. Review of R2's task charting lacked evidence nail care was offered or completed. During an observation on 7/23/24 at 2:48 p.m., R2 was lying in bed in his room and noted to have long fingernails with a brown substance underneath them. During observation and interview on 7/25/24 at 9:14 a.m., R2 had a dark brown substance under the ends of the nails and around the cuticles of fingernails on both hands with fingernails that extended multiple centimeters past the nail bed. R2 stated he got a bath a couple of nights ago and they said they were going to clip my fingernails but they never did it and that happens a lot. He further stated he would like for my fingernails to be cut and I prefer them to be short, god no I don't like them long. During an observation on 7/25/24 at 9:17 a.m., licensed practical nurse (LPN)-A confirmed R2's nails were long and stated R2's nails were long and they are soiled. LPN-A asked R2 if he wanted his nails cut and R2 stated I don't like them long, yes, I want them cut. During an interview on 7/25/24 at 2:41 p.m., LPN-A stated I went to school for cosmetology and was trained to do nails and did a little study on the growth of nails and it is not possible with how long his nails are that they grew in two days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/25/24 at 2:43 p.m., nursing assistant (NA)-A confirmed R2 needed assistance with hygiene. She stated usually the aides complete resident showers and are responsible for nail care, but aides could not complete nail care for people who were diabetic, nurses did that. NA-A stated she did not think there was charting for nail care in the electronic health record (EHR), she usually just told the nurse. In an interview on 7/25/24 at 2:51 p.m., LPN-B stated showers are a good time to perform nail care and she usually checked residents' nails every week. LPN-B noted the aides were typically responsible for nail care but if the resident had diabetes the nurse would take care of it. LPN-B confirmed R2 needed assistance to cut his nails because of his stroke and hemiparesis and noted he was very dependent on staff for all cares. She stated weekly skin checks are usually done on the same days as showers and when aides complete showers they let her know and she would then complete the skin check and perform nail care for diabetic residents at that time. In an interview on 7/25/24 at 3:32 p.m., the director of nursing (DON) stated nail care is done by the aides with baths and nail care is also sometimes offered as an activity by the activities department for residents without diabetes. The DON noted nail care was offered with bathing and nurses performed nail care for diabetic residents, the aides would report it to the nurses when giving baths if they noted nails were in need of care and the nurses would then address it. The DON confirmed R2's care plan instructed staff to check his nail length and trim and clean nails on bath days as necessary and R2 would need assistance to do so. She stated she would expect fingernails to be trimmed on a weekly basis in accordance with resident wishes and she expected care plans to be followed. The DON confirmed she did not see documentation of fingernail care being offered or completed in R2's EHR, stating she could not provide documentation of when his nails were last cut. Facility policy titled Activities of Daily Living (ADLs) dated 3/15/21, included A resident will be given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, The facility will provide care and services for the following activities of daily living: Hygiene - bathing, dressing, grooming, and oral care, ADLs will be provided per the resident's individualized plan of care, and ADL cares will be provided based on the resident preferences.

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49338

Based on interview and document review the facility failed to identify, comprehensively assess, monitor surgical wound changes for 1 of 1 resident (R5). This resulted in harm when the physician was not notified of R5's fall that caused R5's wound to dehisce which delayed healing because of required surgical intervention.

Findings include

R5's Minimum Data Set (MDS) assessment dated [DATE], indicated R5 admitted to the facility on [DATE] from a hospital with diagnoses including encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg below knee, and type 2 diabetes mellitus. The MDS indicated R5 had a major surgical procedure during her prior inpatient hospital stay that required active care during her stay at the facility and had surgical wounds.

R5's care plan included a focus dated 5/31/24, that included I have an alteration in skin integrity related to aftercare following surgical amputation of right lower extremity. Goals with revision date of 6/18/24 included I will be free of complication and minimized pain related to my skin alteration through the review date and My alteration in skin integrity will show signs of improvement in healing by the review date. Interventions dated 5/13/24 included administer my treatments as ordered, assess/monitor the alteration in my skin integrity and document status weekly, prevent trauma, and ensure I have proper fitting footwear.

R5's physician note dated 7/3/24, indicated she had a right below the knee amputation (BKA) on 5/22/24 with placement of a wound VAC (negative pressure wound therapy via vacuum assisted closure dressing) placed for postoperative healing. On 6/21/24 R5 was evaluated by orthopedic surgery with the incision in excellent condition per reports and care with the wound VAC was continued.

R5's physician order with start date of 7/2/24, instructed staff to complete a weekly skin check every Thursday on the day shift.

R5's physician visit note from doctor of medicine (MD)-A dated 7/5/24, indicated R5 was seen in the cast room clinic for orthopedic surgery follow-up. It noted R5 had a right transtibial amputation (BKA) on 5/22/24. Her wound VAC was discontinued, 23 centimeter (cm) incision was noted to be healed, the remining sutures were removed, Steri-Strips were applied and to be removed in two weeks, she was fitted with a compression sock, she had a future appointment with the amputee clinic scheduled on 7/18/24, and further follow-up with orthopedic surgery was to be as needed.

R5's Incident Note progress note by licensed practical nurse (LPN)-C dated 7/9/24 at 5:49 p.m., indicated therapy yelled for help and we discovered res[ident] lying face down on her floor and her wheel chair was lying beside her she was trying to reach for something in her drawer she said, we asked her where she hurt and if she hit her head, she said no to head and her stump was hurting and it was also bleeding the bp [blood pressure] machine was not working so we got her up with Hoyer [type of mechanical lift] and then we took her vs [vital signs] 174/70 [blood pressure] p [pulse/heart rate] 75. The corresponding Incident Report #1758, added the injury was located on front left lower leg and was described as a laceration. The report did not include further assessment of the laceration.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R5's record did not include a comprehensive assessment of the injury to the residual limb that was identified in the Incident Note and Incident report dated 7/9/24. An SBAR [Situation, Background, Assessment, and Recommendation-physician communication form] progress note by LPN-C dated 7/9/24 at 5:55 p.m., included right hip abrasion and end of stump bleeding but did not include further assessment of the wound. R5's progress note dated 7/10/24, indicated R5 refused her shower that evening, she had one on Saturday. It did not include assessment of R5's skin or identify the wound on R5's right residual limb. R5's FOCUS progress note dated 7/10/24, indicated the reason for review was 7/9 17:10 [5:10 p.m.] unwitnessed fall in room and the skin and wounds section noted surgical incision with routine healing. It did not identify the recent alteration in R5's right residual limb wound or include assessment of the wound. R5's Post Fall assessment dated [DATE], noted the presence of leg pain but did not identify or include assessment of the wound on R5's right residual limb. R5'sWeekly Skin Check dated 7/11/24, noted an other type skin alteration on the front right knee 8 cm long with old blood stain, marked no new skin alterations identified, and the summary included no skin issues noted except old blood stain from recent fall per resident. It did not include further assessment of the wound on R5's right residual limb. R5's Post Fall assessment dated [DATE], did not identify or include assessment of the wound on R5's right residual limb. R5's provider note dated 7/12/24, indicated R5 was seen by the primary care provider team at the facility and did not indicate R5 had a recent fall or had experienced injury and bleeding at the incision site of her right residual limb. The physical exam noted skin is warm and dry and right lower leg: no edema. The physician note did not identify the appearance of the incision. R5's Post Fall assessment dated [DATE], did not identify or include assessment of the wound on R5's right residual limb. R5's second Post Fall assessment dated [DATE], did not identify or include assessment of the wound on R5's right residual limb. R5's Weekly Skin Check dated 7/18/24, noted R5 had a surgical incision on the front of her right lower leg and the summary indicated on the right leg, the removed one when she fell out of wheel chair she landed on her stump and broke it open, she still has an open area that we are now dreeing [sic], also coccyx area has small open area. The measurements section of the skin alteration charting for the wound on R5's residual limb was blank. No further assessment of the wound was included. R5's progress note dated 7/18/24, indicated she had a rbka [right BKA], right now it has an open spot due to fall that we are dressing, the cant fir [sic, they can't fit] the prosthetic until the wound has healed. It did not include further assessment of the wound on R5's right residual limb. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R5's Treatment Administration Record (TAR) for dates the month of July 2024, included a treatment ordered 6/26/24 and discontinued 7/23/24 directing staff to monitor for signs or symptoms of bleeding/bruising. Notify provider of any changes every shift. The order was scheduled to be completed on day shift, evening shift, and overnight shifts and charted with a check mark indicating completion on all shifts from 7/9/24 through 7/18/24. R5's physician visit note from MD-B dated 7/18/24, indicated R5 was seen in a clinic for physical medicine and rehabilitation follow-up. The note included unfortunately about a week ago she tells me she fell out of her wheelchair. She was not sure how she fell but she did land directly on her right residual limb and notice bleeding soon after . upon removal of her shrinker sock [compression sock over residual limb site] she had a gauze dressing and Steri-Strips still in place. The Steri-Strips had blood on them. Upon removal of the Steri-Strips there was a superficial dehiscence present with subcutaneous fat visible in the wound bed . unfortunately 1 week ago she slipped out of her wheelchair on her residual limb and has now suffered a superficial dehiscence of her residual limb . I called [MD-A's] service and discuss[ed] the case with them. They may want to see her back in the cast room for further evaluation given that her incision is now dehisced. I will follow the patient closely along with orthopedics and once she was [sic, is] healed have her seen back in the amputee clinic for prosthetic prescription. R5's progress note dated 7/19/24, indicated Resident out to cast room for appointment, cast room had called facility last night and stated resident would be a direct admit following appointment. R5's hospital records included an orthopedic surgery physician note dated 7/19/24, which noted Her [R5's] recovery from her right transtibial amputation was uneventful until this past week when she reportedly fell in her nursing home and developed an area of dehiscence distally over her tibia. She had a follow up appointment with the PM&R [physical medicine and rehabilitation] team yesterday, at which point we were contacted given concern for this dehiscence. Today in the cast room, she was examined and the decision was made to admit her directly to the hospital for right transtibial revision amputation on 07/21/2024. R5's hospital Discharge Planning assessment dated [DATE], included Patient has been residing at [facility] working on rehabilitation. Patient experienced a fall after a PT [physical therapy] session in which she stated she 'saw a lot of blood.' Patient stated she inquired about the status of her leg but was re-assured many times by staff at [facility] that it was 'fine' and 'not to worry about it.' Patient returned for a follow-up outpatient visit and was informed her wound had dehisced and required surgical intervention . The patient stated her current admission could have been prevented had she not had a fall. R5's hospital physician consult note by infectious disease dated 7/21/24, included Patient was initiate on empiric vancomycin and cefepime [intravenous antibiotics] prior to surgery. Patient was [is] currently status post revision and closure of dehisced wound following trauma to right BKA incision. Intraoperative cultures are currently in process. Given the superficial wound as well as source control with debridement, it is reasonable to continue empiric antibiotics for an additional 5 days. Would recommend p.o. [oral] Augmentin and doxycycline to complete course. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R5's hospital physician progress note by the orthopedic surgery team dated 7/25/24, included [R5] underwent revision closure of the right leg wound on 7/21/24. The aftercare plan section included nonweightbearing right lower extremity until the wound has healed [and] the residual limb is ready for prosthetic fabrication (typically 6-7 weeks in this situation) . Wound care: incision VAC . Additionally, given the high risk of impaired wound healing, we will recommend extended negative pressure wound therapy to support the 9 cm x 7 mm [millimeter] x 5 mm wound during the first six postoperative weeks and perhaps longer depending on her clinical course . Orders have been placed for three cast room visits. Next vac change on Wednesday 7/31 . She will be seen again on Wednesday 8/7/24 to change the incisional VAC sponge (order placed). We anticipate retaining the sutures for a minimum of four weeks. R5's hospital physician consult note by MD-B dated 7/25/24, included We discussed the healing timeline after revision surgery. I will place an order for follow up in the amputee clinic in 6 weeks. The amputee service will continue to follow her in the hospital. In an interview on 7/25/24 at 3:20 p.m., hospital social worker (SW)-A stated R5 was still in the hospital and would discharge tomorrow, 7/26/24. In an interview on 7/29/24 at 9:12 a.m., MD-B stated he saw R5 at an appointment on 7/18/24 and the purpose of the appointment was to see her and prescribe a prosthesis for her residual limb. R5 had seen orthopedic surgery with MD-A on 7/5/24 and was cleared to get prosthetic fitting after her appointment with MD-B, and MD-B was expecting her residual limb to be healed on 7/18/24 and to begin the prosthetic fitting process. MD-B stated when he saw R5, he noted dried blood on her Steri-Strips and shrinker sock, removed them both and noted her wound was open and dehisced about two to three inches which hadn't been the case at the visit with MD-A on 7/5/24. MD-B stated R5 reported she fell about a week prior and landed on her residual limb and saw bleeding immediately that got on the floor but told him that her limb wasn't really looked at. MD-B stated based on the incision now being an open wound, he contacted orthopedic surgery and R1 was admitted the next day for revision surgery; since the wound was now open it needed to be surgically closed to avoid infection and to improve healing time of the wound. MD-A was not planning revision surgery when he saw her on July 5th as the incision had been completely closed. MD-B stated he was not aware prior to seeing R5 on 7/18/24 that she had fallen and injured her residual limb which had been bleeding and he did not see any evidence that MD-A was notified as he was the one who alerted MD-A. MD-B stated the medical recommendation would be if trauma occurs to a residual limb during the healing process and bleeding is seen the medical teams be alerted for further evaluation. Normally this far after surgery we would not expect bleeding from a residual limb, she was already six weeks past surgery. MD-B stated MD-A had to perform a revision surgery on R5's residual limb and it does delay the time healing, now we have to reset the clock to get her prosthesis and certainly there is going to be heightened emotional impact. MD-B thought R1 was understandably quite disappointed; R1 told him that. MD-B also noted that intraoperative cultures (soft tissue samples taken from the wound) returned positive for a bacterium and the orthopedic surgery team consulted with the infectious disease team who prescribed two antibiotics for treatment. (continued on next page)

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	07/30/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 7/30/24 at 12:24 p.m., R5 stated she had to have a second surgery after she fell and hit her residual limb. She stated staff did not seem too concerned about it the bleeding even though R5 told the nurse it's bleeding quite bit. The nurse responded oh, it's not that bad even though R5 told the nurse there was blood on the floor, to which the nurse responded we'll just clean it up later. R5 stated to her knowledge it wasn't ever checked again. R5 exclaimed thank god I had an appointment at the [physical medicine and rehabilitation clinic] already, I saw [MD-B]. R5 indicated MD-B contacted her surgeon, MD-A, who decided she needed to have another surgery and had her admitted to the hospital. R5 stated I could already be in my prosthetic if this hadn't happened and I'm angry. R5 explained it had already been a long healing process and has impacted her a lot. It has been really hard and very emotional. The wound delayed her from getting her prosthesis by maybe four weeks. It's not something I planned on at [AGE] years old, you know, and now I'm in another [rehabilitation] facility. R5 was noted to be tearful and emotional throughout the interview. In an interview on 7/29/24 at 11:00 a.m., LPN-C stated she was working when R5 fell and responded to the situation along with clinical manager (CM)-A. LPN-C stated she remembered seeing a small amount of blood coming from R5's stump, she removed the compression sock and there was blood coming from in-between the Steri-Strips over the incision site. LPN-C stated she cleaned the area with some gauze and put gauze over the Steri-Strips and the bleeding stopped. LPN-C noted that at the time of the fall she assessed the wound dressing, noted the Steri-Strips were intact and that there was blood and would document that in the risk management Incident Report in the injuries section. LPN-C stated she worked the next day and did not recall seeing any further bleeding from the site, the care for the site was just putting the compression sock on and off and we weren't doing anything else with it, just monitoring it and checking it. In an interview on 7/29/24 at 11:36 a.m., CM-A stated R5 had a fall on 7/9/24 and he responded because staff said there was bleeding. CM-A stated he assessed the site and there was bleeding obviously, but cleaning it up and applying pressure resolved the bleeding. There were no visible signs of opening or dehiscence, it sill looked intact, but obviously it was not because it was bleeding, but it wasn't a gaping wound. CM-A stated he did not see the wound after that but should have put an order in for nurses to monitor the wound and change the dressing and check up on it. CM-A had instructed LPN-C of what to include in the incident report. CM-A noted for a fall with injury there is a need for continued intervention from nurses including daily assessment of the site of the injury, should be looked at probably every shift. Nursing would monitor for new or worsening concerns and reporting those concerns to the provider groups if necessary. CM-A stated the findings should be documented in resident record. CM-A noted R5's EHR contained four Post Fall Assessments, dated 7/10/24, 7/12/24, and two on 7/14/24, and confirmed the first assessment should have been completed eight hours after the fall. CM-A stated he expected R5's surgical team to have been notified of the fall with injury to residual limb and the surgical team was not notified to his knowledge. He confirmed the Weekly Skin Check dated 7/18/24 did not include comprehensive assessment of the wound. Facility policy titled Post Fall Policy dated 10/13/23, included Monitoring and Re-evaluation: Document on resident's condition at a minimum of every shift for 72 hours. Staff should document relevant post-fall clinical findings, such as vital signs, pain, swelling, bruising, and changes in function or cognitive status. o Staff will have increased awareness that the resident has recently fallen and report any changes in function, increased pain, and changes in cognition to the nurse for further evaluation . Update MD/NP with evidence of acute changes after a fall. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Facility policy titled Pressure Injury Prevention and Wound Care Management dated 3/4/24, included Skin impairments, including pressure injuries, non-pressure injury wounds, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the Wound Nurse, or designee, using the PCC Weekly Wound Assessment. Weekly documentation will include pertinent characteristics of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues, and a description of any drainage, eschar, necrosis, odor, tunneling, or undermining . Daily, the clinicians responsible for caring for the Resident will assess the status of the dressing if present, (intact, soiled, leaking), and evaluate for complications such as infection and/or uncontrolled pain .Nursing staff should update the attending physician immediately of wounds that have developed complications and/or not healing as anticipated.

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that residents are free from significant medication errors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49338

Based on observation, interview and record review, the facility failed to provide and administer medications and failed to have a system in place to identify, record, and report omitted medications as medication errors for 3 of 3 (R1, R2, R3) residents reviewed for medication errors.

Findings include:

R1's Admission Record dated 7/24/24, identified diagnoses of type 1 diabetes, acute kidney failure (condition where one or both kidneys no longer work properly), chronic kidney disease, pancreas transplant, kidney transplant, immunodeficiency due to drugs, end stage renal disease, disorder of phosphorous metabolism and hyperkalemia (potassium levels in the blood are too high and can damage the heart and muscles).

R1's Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact.

R1's care plan dated 7/23/24, identified intervention to monitor lab reports of electrolytes and report to physician. Notify if serum potassium over 5.5. Monitor/document/report as needed (PRN) the following signs/symptoms (s/sx): edema, weight gain of over two pounds in a day, neck vein distention, difficulty breathing, increased heart rate, elevated blood pressure, skin temperature, peripheral pulses, level of consciousness, monitor breath sounds for crackles.

R1's Vulnerable Adult Maltreatment Report dated 7/17/24, identified R1 had admitted to the emergency department from facility on 7/17/24 for critically elevated hyperkalemia of 6.3 and medication to lower potassium was not provided to R1 at facility.

R1's nephrology clinic record dated 7/16/24 and signed at 1:36 p.m., identified Medical Doctor (MD)-D contacted facility nurse and initiated lokelma 10 grams (g) orally in two doses and recheck the basic metabolic panel (BMP) 7/17/24. The lab for potassium included with the order identified 6.0!! (crit H) [critically high] with normal range identified as 3.6-5.2. On 7/11/24, potassium level was 4.7.

R1's medication administration record (MAR) for July 2024, identified sodium zirconium cyclosilicate (lokelma) 10g be mixed into 3 tablespoons of water and drink suspension immediately, do not leave any medicine in glass. Drink it all. Medication was scheduled to be given at 3:00 p.m. and 8:00 p.m. on 7/16/24.

R1's MAR at 3:00 p.m. on 7/16/24 identified staff initials with a '9' which indicated other/see progress note. R1's MAR at 8:00 p.m. on 7/16/24 identified staff initials with an '18' which indicated med not available from pharmacy. There was no indication the pharmacy was contacted.

R1's pharmacy shipment summary dated 7/16/24, identified R1's medication lokelma 10g powder packet was delivered to facility at 10:33 p.m. on 7/16/24 and signed for by facility staff. However, no indication R1 had received either of the doses of lokelma.

(continued on next page)

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Edenbrook of Rochester	1875 19th Street Northwest Rochester, MN 55901

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In review of R1's record it was not evident the physician was notified of the missed doses, plan to administer the doses, nor monitoring for any side effects of the missed medication. R1's progress note dated 7/17/24 at 3:00 p.m., identified R1 had elevated potassium, an order for kayexalate 30g, and send to emergency department (ED) for additional tests and treatment. R1 left via ambulance at 3:50 p.m. R1's ED note dated 7/18/24 at 12:41 a.m., identified BMP drawn 7/17/24 at 4:35 p.m., with the potassium level increased to 6.4 from 6.0 on 7/16/24. R1 was treated at the ED with one dose of lokelma and returned to the facility with new order for lokelma 10g two times a day for seven days and potassium lab drawn in two days. Review of the facility's medication error reports did not identify the facility had recognized the missed doses as a medication error with appropriate follow-up to the error completed per policy. R1's progress note dated 7/18/24 at 5:44 a.m., identified R1 returned from ED at 1:00 a.m., via taxi. During an interview on 7/24/24 at 11:53 a.m., R1 stated she had no symptoms when potassium was high on 7/16/24 and 7/17/24. During an interview on 7/25/24 at 9:37a.m., health unit coordinator (HUC)-A stated she received the lokelma orders and processed the order with direction from director of nursing (DON) on times the medication should be given. HUC-A faxed the order to pharmacy. During an interview on 7/29/24 at 12:06 p.m., case manager (CM)-A stated he overheard DON received an order from the provider for lokelma due to elevated potassium. CM-A stated he told LPN-E about the order but did not tell LPN-E the critical importance of the medication. CM-A stated only clinical managers and DON would confirm orders. CM-A verified the order in the MAR did not state that it is to lower potassium. During a phone interview on 7/29/24 at 3:10 p.m., LPN-E stated she did not get lab information and was unaware that R1 had a critical lab value. LPN-E did not have access to Omnicell so did not check if the lokelma was available and signed the medication as other/see progress note in the MAR. LPN-E did not recall hearing about the critical lab until 7/17/24 when MD-D had called DON. During a phone interview on 7/29/24 at 8:35 a.m., LPN-D stated she was supposed to give the 8:00 p.m. dose of lokelma. LPN-D stated she had never heard of lokelma before and was unaware what the medication was for, why it was ordered, and the importance of the medication. LPN-D marked 18 on the MAR because the medication had not come from the pharmacy at 8:00 p.m. when it was scheduled to be given. LPN-D did not notify the DON, clinic, or the pharmacy that the medication was not available. During an interview on 7/25/24 at 8:38 a.m., licensed practical nurse (LPN)-A stated the floor nurses do not have access to labs and do not usually put orders in the computer. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 7/24/24 at 1:05 p.m., consultant pharmacist (CP)-A stated for a facility to get medications quicker than the normal run times the facility must include STAT on the order sent to the pharmacy. CP-A verified STAT was not written on the order sent to the pharmacy. CP-A stated lokelma was not a medication available from the Omnicell (medication dispenser at facility). During a phone interview on 7/25/24 at 2:49 p.m., MD-D stated the lokelma was an emergent and time sensitive order. MD-D stated facility should have let the clinic know that they would not have the lokelma on 7/16/24, and MD-D would have sent R1 to the ED for treatment on 7/16/24, had he known the facility was not going to administer the doses. MD-D called the facility after the potassium result had increased to 6.3 when drawn on the morning of 7/17/24. MD-D had hoped to avoid an ED visit by having the facility administer the lokelma. During a phone interview on 7/25/24 at 4:20 p.m., MD-E stated the facility could have sourced the lokelma from another pharmacy or communicated back to the ordering provider the medication was not available and MD-D could have elevated R1 to the ED. MD-E stated serious ramifications and a significant error could occur with R1 not receiving lokelma and potassium increased with known medical diagnoses. During an interview on 7/25/24 at 2:04 p.m., DON stated both lokelma doses on 7/16/24 needed to be administered that day and that is how the order was put in the computer. DON stated the order would come on the next run unless STAT was on the order or staff called pharmacy. DON stated no one thought from the order that it needed to be called on right away. DON was under the impression R1 would receive the lokelma doses from direct delivery or the Omnicell. DON stated she was unaware that R1 did not receive lokelma on 7/16/24 until MD-D called her on 7/17/24. MD-D ordered kayexalate and to be sent to the ED for treatment on 7/17/24. During an interview on 7/29/24 at 12:10 p.m., administrator verified that when she read the order it did not appear critical, or STAT. Administrator acknowledged the order was for two doses lokelma with BMP checked in the morning. Reviewed pharmacy order that facility signed received on 7/16/24. R2's Minimum Data Set (MDS) dated [DATE], indicated he diagnoses including hemiplegia following cerebral infarction affecting the left side (left-sided paralysis after a stroke), depression, psychotic disorder, and diarrhea. The MDS identified R2 was always incontinent of bowel and bladder, had intact cognition, did not exhibit behaviors or indicators of psychosis, had range of motion impairment in one upper and one lower extremity, and required maximal assistance with transfers and bed mobility and was dependent on staff for bathing and toileting hygiene. R2's care plan dated 6/14/24, denitrified R2 had dehydration or potential fluid deficit related to cerebral vascular accident (CVA), c.diff infection, diarrhea, elevated BUN. Intervention to administer medications as ordered. R2's July 2024 MAR included an order for saccharomyces boulardii 250 milligrams (mg) twice a day (BID) for diarrhea. July 1-July 11, 2024, both a.m. and p.m. medication administrations were marked '18'-med not available from pharmacy. July 12, 14, and 15th, 2024, were blank for a.m., July 12, 13, 14, p.m. and 13 a.m. were marked '6'-hospitalized . Medication discontinued on 7/15/24. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's record did not identify physician notification the medication had not been available nor administered, a plan to administer the medication, nor monitoring for symptoms as a result of the medication not being administered. Review of the facility's medication error reports did not identify the facility had recognized the missed doses as a medication error with appropriate follow-up to the error completed per policy. During an interview on 7/30/24 at 3:30 p.m., CM-A verified R2 did not receive scheduled medication for diarrhea from July 1-15, 2024. CM-A stated the facility has had trouble obtaining saccharomyces boulardii for R2. CM-A stated he has talked with nurse practitioner (NP)-A about the order, and pharmacy with no results. CM-A stated he did not document his requests to NP-A or calls to the pharmacy for the medication. R3's MDS dated [DATE], indicated she admitted to the facility on [DATE] with diagnoses including aftercare following explanation of knee joint prosthesis (knee joint prosthesis surgery after amputation), pyogenic arthritis (acute arthritis due to infection), urinary tract infection in the last thirty days, anxiety, depression, and chronic pain syndrome. The MDS identified R3 was frequently incontinent of both bowel and bladder, had no memory impairment, did not exhibit behaviors, and was dependent on staff for toileting hygiene and transfers. R3's care plan dated 4/5/24, identified chronic pain with a goal of pain controlled at an acceptable level of 5/10. Interventions included to administer pain medication, anticipate need for pain relief and respond immediately to any complaint of pain. R3's MAR for July 2024 identified pregabalin 75mg BID for pain ordered 7/5/25 and discontinued 7/8/24. R3 did not receive medication on 7/5/24 p.m. shift or 7/6/24 a.m. shift due to medication not at facility. During an interview on 7/30/24 at 3:30 p.m., CM-A verified R3 did not receive pregabalin on 7/5/24 and 7/6/24. CM-A stated pregabalin was not available in the Omnicell or emergency kit and facility would have to wait until pharmacy delivered the medications. CM-A would expect the floor nurse to call the pharmacy to make sure a supply would be sent STAT because it is important to have pain medication. The Pharmacy Information page dated 4/23, identified three order by times and delivery windows: Order by 11:00 a.m. receive between 1:00 p.m. and 7:00 p.m. Order by 3:00 p.m. receive between 6:00 p.m. and 12:00 a.m. Order by 6:00 p.m. receive between 8:00 p.m. and 2:00 a.m. Review of the facility's medication error reports did not identify the facility had recognized the missed doses as a medication error with appropriate follow-up to the error completed per policy. Emergency Medication Procedure: if medication is needed prior to the next scheduled tote deliver and is not in the starter/emergency/back-up supply, follow the regular process to submit the order, then call to request the medications STAT. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pharmacy policy Receipt of Interim/STAT/Emergency Deliveries revised 1/1/22, identified facility should immediately notify pharmacy when facility receives from a physician/prescriber a medication order that may require an interim/stat/emergency delivery. If any item ordered is not received and the reason for missing item is not evident, facility should contact pharmacy and document any delivery discrepancies. The facility Medication Error and Drug Interactions Policy and Procedure revised 2/12/24, identified residents will be free of any significant medication errors. All medication errors and drug reactions will be reported promptly to the Director of Nursing, the attending physician, and will be documented according to established procedures. All medication error/incident reports relating to medication errors and drug reactions will be reviewed by the Quality Assurance committee at their next regularly scheduled meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview and document review, the facility failed to maintain a complete, accurately documented, and readily accessible medical record in accordance with accepted professional standards and practices for 2 of 3 residents (R1, R2) reviewed for medical record accuracy. Findings include: R1's Admission Record dated 7/24/24, identified diagnoses of type 1 diabetes, acute kidney failure (condition where one or both kidneys no longer work properly), chronic kidney disease, pancreas transplant, kidney transplant, immunodeficiency due to drugs, end stage renal disease, disorder of phosphorous metabolism and hyperkalemia (potassium levels in the blood are too high and can damage the heart and muscles). R1's Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact. R1's care plan dated 7/23/24, identified intervention to monitor lab reports of electrolytes and report to physician. Notify if serum potassium over 5.5. Monitor/document/report as needed (PRN) the following signs/symptoms (s/sx): edema, weight gain of over two pounds in a day, neck vein distention, difficulty breathing, increased heart rate, elevated blood pressure, skin temperature, peripheral pulses, level of consciousness, monitor breath sounds for crackles. R1's nephrology clinic record dated 7/16/24 and signed at 1:36 p.m., identified Medical Doctor (MD)-D contacted facility nurse and initiated lokelma 10 grams (g) orally in two doses and recheck the basic metabolic panel (BMP) 7/17/24. The lab for potassium included with the order identified 6.0!! (crit H) [critically high] with normal range identified as 3.6-5.2. R1's facility electronic health record did not note the critical value. R1's medication administration record (MAR) for July 2024, identified sodium zirconium cyclosilicate (lokelma) 10g be mixed into 3 tablespoons of water and drink suspension immediately, do not leave any medicine in glass. Drink it all. Medication was scheduled to be given at 3:00 p.m. and 8:00 p.m. on 7/16/24. R1's MAR at 3:00 p.m. on 7/16/24 identified staff initials with a '9' which indicated other/see progress note. R1's MAR at 8:00 p.m. on 7/16/24 identified staff initials with an '18' which indicated med not available from pharmacy. R1's pharmacy shipment summary dated 7/16/24, identified R1's medication lokelma 10g powder packet was delivered to facility at 10:33 p.m. on 7/16/24 and signed for by facility staff. R1's progress note dated 7/17/24 at 3:00 p.m., identified R1 had elevated potassium, an order for kayexalate 30g, and send to emergency department (ED) for additional tests and treatment. R1 left via ambulance at 3:50 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's ED note dated 7/18/24 at 12:41 a.m., identified BMP drawn 7/17/24 at 4:35 p.m., with the potassium level increased to 6.4 from 6.0 on 7/16/24. R1 was treated at the ED with one dose of lokelma and returned to the facility with new order for lokelma 10g two times a day for seven days and potassium lab drawn in two days. During an interview on 7/25/24 at 8:38 a.m., licensed practical nurse (LPN)-A stated the floor nurses do not have access to labs and do not usually put orders in the computer. During a phone interview on 7/29/24 at 8:35 a.m., LPN-D stated she was supposed to give the 8:00 p.m. dose of lokelma. LPN-D stated she had never heard of lokelma before and was unaware what the medication was for, why it was ordered, and the importance of the medication. During a phone interview on 7/29/24 at 3:10 p.m., LPN-E stated she does not get lab information and was unaware that R1 had a critical lab value. LPN-E did not have access to Omnicell so did not check if the lokelma was available and signed the medication as other/see progress note in the MAR. LPN-E did not recall hearing about the critical lab until 7/17/24 when MD-D had called DON. During an interview on 7/29/24 at 12:06 p.m., CM-A stated he overheard DON received an order from the provider for lokelma due to elevated potassium. CM-A stated he told LPN-E about the order but did not tell LPN-E the critical importance of the medication. CM-A stated only clinical managers and DON would confirm orders. CM-A verified the order in the MAR does not state that it is to lower potassium. During an interview on 7/29/24 at 12:10 p.m., administrator verified that when she read the order it did not appear critical, or STAT. Administrator acknowledged the order was for two doses lokelma with BMP checked in the morning. Reviewed pharmacy order that facility signed received on 7/16/24. R2 R2's facesheet indicated R2 was admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus with foot ulcer, peripheral vascular disease (a condition causing reduced blood flow to the limbs), and non-pressure chronic ulcer of other part of left foot. R2's Wound Evaluation & Management Summary physician visit note uploaded to R2's electronic health record (EHR) dated 7/26/24, included a recommendation of transfer to the hospital for exacerbation of necrosis (tissue death) and pain in left third and fourth toes despite taking oral antibiotics, transfer to hospital for wet gangrenous (infected tissue with compromised blood flow) left third and fourth toes, and need for evaluation. A faxed document uploaded into R2's EHR titled Medical Necessity Certification Statement for Ambulance Transport dated 7/26/24 identified R2 required transportation via ambulance from the facility to the hospital for an emergency department evaluation. The census record in R2's EHR, noted he was on hospital unpaid leave status with effective date of 7/26/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Rochester	1875 19th Street Northwest 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's order administration notes linked to medication and treatment order administration records dated 7/26/24 to 7/28/24, included admit, hospitalized , res[ident] is in the hospital, and res[ident] in the hospital. The last progress note was dated 7/21/24 and included Resident came to facility after having a cerebral infarction affecting his left non dominant side, along with a severe diabetic ulcer on the left 4th toe which he was recently seen for at the Mayo Clinic. Daily dressings are completed on this foot. Resident ate his entire lunch today and 90% of his supper tonight. Resident's brother came and talked his brother into getting up and going outside with him for a while' they spent 30 minutes outside but then resident wanted to return to his room to lay down. No progress notes from 7/22/24 to 7/30/24 were noted in review of R2's record and no progress notes identified when, where, why, or how R2 was transferred from the facility on 7/26/24. In an interview on 7/30/24 at 3:56 p.m., the director of nursing (DON) stated R2 was seen by a provider on 7/26/24 and his foot wounds were draining so they said to send him to the hospital. The DON stated she would expect nurses to make a progress note if transferring someone to the hospital shortly after the resident left, and by the end of the shift at the very least. The DON stated she would also expect the progress note to indicate what notifications were made about the transfer and confirmed she did not see evidence of that in R2's record. The DON stated the progress notes do not indicate why he is in the hospital or what happened to him and confirmed the last progress note was from 7/21/24. Facility policy titled Acute Care Transfer dated 9/15/21, included: Purpose: To establish criteria to determine the appropriateness to transfer the resident to the hospital or emergency room for evaluation and/or treatment to either stabilize a condition or to determine if admission to the hospital is required . Documentation in the medical record will include: a.) Identification and assessment information regarding change in condition b.) Resident condition at time of transfer c.) Notification of physician and orders obtained d.) Notification of Durable Power of Attorney/Responsible Party e.) Acute care facility accepting resident f.) Other pertinent information.