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	01/13/2025

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 - Minimal harm or potential for 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** 38685 Based on observation, interview, and document review the facility failed to assess and monitor non-pressure related skin injuries (bruises) for changes until resolved for 1 of 3 residents (R1), reviewed for injury of unknown origin. Findings include: R1's admission screener dated 12/13/24, directed staff to complete a full body skin audit and identified R1's skin color was normal, warm, and dry. Further identified R1 had a left forehead hematoma as a consequence of a fall, bilateral upper extremity bruising and on abdomen and trunk. Skin assessment did not include bruising color, characteristics, measurements, and pain. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1's cognition was intact, diagnoses included diabetes with other open ulcer, obesity, and peripheral vascular disease. R1 was at risk for development of pressure ulcers. R1 had one venous/arterial ulcer and required a pressure relieving device for bed, nutrition, or hydration intervention to manage skin problems, pressure ulcer injury care, and application of nonsurgical dressings other than to feet. R1's record identified R1 was hospitalized from 12/23/24 to 1/3/25. R1's care plan revised 12/26/24, identified a focus, R1 was at risk for alteration in skin integrity related to pain, osteoarthritis, diabetes, increased body habitus (obese), heart disease, generalized weakness, decreased mobility, limited Range Of Motion (ROM) black box medications, antidepressants and venous ulcer on shin. Interventions dated 12/16/24 included but not limited to, provide R1 education to promote skin integrity, manage individual risk factors as applicable related to nutrition, friction, shearing, and continence; keep skin clean and dry; manage clinical conditions and contributing factors to decrease risk of skin breakdown-notify MD and/or Registered Dietician (RD) of any significant changes; provide diet, supplements, and vitamins; use a draw sheet and two people when pulled up in bed (to prevent shear), and use a pressure relieving cushion for wheelchair. An additional focus revised 12/23/24, identified R1 had an alteration in skin integrity related to venous sore due to increased edema. Interventions dated 12/19/24, included but not limited to assess/ monitor alteration in skin integrity and document status weekly. R1's progress note dated 1/3/25 at 10:16 p.m., identified R1 was readmitted from the hospital and had multiple bruises on the entire lower abdomen, left hand and wrist . (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. Building B. Wing	01/13/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	R1's readmission screener dated 1/3/25, identified R1 had bruising on left hand (palm) and bruising on lower abdomen and no interventions were in place for the skin alterations because they were not indicated. Skin assessment did not include bruising color, characteristics, measurements, and pain. R1's Weekly Skin check dated 1/3/25, identified bruising on left wrist and lower abdomen. Skin assessment lacked bruising color, characteristics, measurements, and pain. R1's order summary dated 1/4/25, included an order to administer aspirin 81 mg delayed release daily for coronary artery disease. R1's MD visit dated 1/8/25, identified during R1's hospitalization on [DATE], the visit note indicated R1 had experienced symptoms of a gastrointestinal bleed (GI) and directed to hold aspirin 81 mg in the setting of GI bleed. R1's January medication administration record (MAR), dated January 2025 identified R1 received aspirin 81 mg daily from 1/9/25 to 1/13/25, with no orders to hold. R1's Weekly Skin check dated 1/11/25, identified bruising on left face. Skin assessment lacked bruising color, characteristics, measurements, and pain. R1's record was reviewed between 12/13/24 through 1/13/25 and did not include a comprehensive skin assessment and monitoring of the bruises identified on 12/13/24, 1/3/25, and 1/11/25. Additionally R1's care plan did not include a focus that identified R1's risk and had actual bleeding/bruising with associated interventions to decrease the risk and protect R1's skin from further injury. During an observation and interview on 1/13/25, at 10:32 a.m., R1 was seated in her wheelchair in her room wearing a short sleeve blue shirt. R1 was noted to have dark purple bruises on her left arm. R1 stated she just got done with a shower and thought the bruising was from her fall back in December but couldn't really remember. During an interview on 1/13/25 at 11:41 a.m., nursing assistant (NA)-C stated she had given R1 a shower today and further stated she had never bathed R1 before. NA-C told her nurse when it was time to do the skin assessment. NA-C remembered R1 had bruises up and down her left arm and a bruise on her right inner thigh that was dark purple. NA-C stated she has nowhere to document bruises that the nurse would do that. NA-C was not sure where the bruising was from. During an interview on 1/13/25 at 2:02 p.m., licensed practical nurse (LPN)-A indicated she was the nurse for R1 and did her skin assessment because it was her bath day today. LPN-A stated R1 did have healing bruises on her arms. LPN-A thought that the arm bruising had been there prior to R1's hospitalization . Today R1 did have some dark purple bruising on her inner thighs, hopefully someone put that on her readmission assessment, I don't know what those are from. Upon resident admission/readmission a full body skin assessment should be documented with measurements and characteristics. LPN-A verified she did not measure any of R1's bruises or document characteristics. During an observation and interview on 1/13/25 at 2:33 p.m., R1 was lying in bed, LPN-B measured the following bruises: (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	01/13/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	-left upper triceps 10.8 centimeters (cm) x 9 cm, bruise is red in color with a light purple dusky color. -cluster of bruising on left forearm measured 17.3 cm x 3 cm, fading bruise almost the same color as the skin. -left lateral elbow measured 5.2 cm x 4 cm, dark purple bruise. -left hand thumb side measured 6 cm x 3.5 cm, wide dark purple bruise with some light fading in the margins. -right medial thigh bruising measured 9 cm x 12.5 cm, dark purple bruise with fading in the margins. -fading bruise on triceps/bicep area measured 17 cm x 11 cm. -Resolved skin tear on left triceps with slight skin discoloration measured 1.8 cm x 1.8 cm. During an interview on 1/13/25 at 1:52 p.m., LPN-C stated skin assessments were completed once a week on the residents bath day and documented in the weekly skin assessment. When staff find a bruise it would also be documented in risk management, a skin progress note, reported to the oncoming nurse and to the DON. Once the bruise is healed, we would discontinue it off the treatment administration record (TAR). During an interview on 1//13/25 at 1:58 p.m., LPN-C stated when a bruise was found on a resident, it was documented and investigated on how it got there. LPN-C further stated If if could not be determined how the bruise ws sustained then prevention measures were taken and documented. LPN-C indicated measurements of the bruise were not taken unless the bruise increases in size and that would be documented in a skin assessment. LPN-C stated there was no daily monitoring of bruises that he knows of. .During an interview on 1/13/25 at 2:14 p.m., LPN- B indicated he was a unit manager. LPN-B stated on admission/readmission nursing would complete a skin assessment. LPN-B further stated with bruises, nurses should document color, location, size, pain. I would expect measurements for it to be monitored daily until healed. LPN-B stated when a nurse first found a bruise a nursing order should be put in to the electronic health record to monitor for healing which would populate on the TAR alerting the nurse to check the bruise and document on healing. LPN-B stated he was more focused on getting skin assessments for pressure ulcers done and the assessing and monitoring for bruises kind of fell off the radar. LPN-B verified R1's bruises did not include measurements, characteristics, size, and pain. During an interview on 1/13/25 at 2:47 p.m., director of nursing (DON) stated with new admissions and readmissions nursing would do a skin assessment in the admission and readmission screener. DON further stated with bruises the facility did not measure but would monitor them until they healed and document in a weekly skin assessment. DON was unable to articulate the size a bruise would need to be before you would measure it. (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	01/13/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/13/25 at 2:48 p.m., regional nurse manager (RNM)-A stated the facility did not have a non-pressure skin care policy. Staff would utilize our pressure ulcer prevention policy. For an injury of unknown origin (bruises) staff would follow our abuse policy. Facility policy. Pressure Injury Prevention and Wound Care Management, revised 3/4/24, identified . purpose: to promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown .Policy: It is the policy of this facility that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care .5. Resident's skin will be monitored daily during cares by nursing assistant and skin check will be completed weekly by licensed nurse .7. 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. a. 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. b. Wounds/skin alterations may be grouped or clustered together into one measurement following these guidelines: Pressure injuries cannot be clustered. Wounds need to be close in proximity and in same anatomical location on the body. Wounds must have the same etiology. 8. Documentation of the wound characteristics will be completed in PCC using the PCC Skin and Wound Assessment. This assessment is started in the mobile application. If a device is not available or in need of service, the documentation will be completed in the resident's electronic medical record. Consent for photography will be obtained in the admission packet. 9. 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 .12. Wound and skin care interventions will be monitored and evaluated for effectiveness. Care plans will include specific and measurable goals and interventions. The care plan will be reviewed and revised at least quarterly, or with significant change in condition . Facility policy, Policy and Procedure Vulnerable Adult Abuse and Neglect prevention revised on 10/29/24, identified . 15. Injuries of Unknown Source: An injury should be classified as an injury of unknown source when all of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. (a) Examples of when an Injury of Unknown Source should be reported: i. Bruising, scratches, redness, or any other bodily injury that is suspicious in location and size. Some examples include A. bruising that looks like an object, e.g. fingers, equipment, etc. B. the location of the bruise is in an area not susceptible to bruising, e.g. breast, inner thigh, groin area, etc .

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	01/13/2025

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review the facility failed to ensure a system to provide the correct physician ordered textured diet for 1 of 1 resident (R1) who was at risk for choking and history of aspiration pneumonia. This resulted in a immediate jeopardy for R1 and has the likelihood to effect current and future residents who required changes to textured diets to prevent choking/aspiration. The immediate Jeopardy (IJ) began on 1/3/25, when R1 returned from the hospital with new diet texture orders and received a regular textured diet through 1/9/25 related to facility system failure when dietary orders are changed. The administrator and director of nursing (DON) were notified of the IJ on 1/9/25 at 5:49 p.m. The IJ was removed on 1/10/25, but noncompliance remained at the lower scope and severity, level D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: International Dysphagia Diet Standard Initiative (IDDSI) Level 5 Minced and Moist Diet tool dated January 2019, identified foods that are soft and moist but with no liquid leaking/dripping from the food, biting is not required, minimal chewing is required, lumps of 4 millimeters (mm) in size, lumps can be mashed with tongue, foods can easily be mashed with just a little pressure from the fork, and should be able to scoop food onto the fork with no liquid dripping and no crumbles falling off the fork .may be used if you are not able to bite off pieces of food safely but have some basic chewing ability. Some people may be able to bite off a large piece of food but are not able to chew it down into little pieces that are safe to swallow. Minced & Moist foods only need a small amount of chewing and for the tongue to 'collect' the food into a ball and bring it to the back of the mouth for swallowing. It's important that Minced & Moist foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat. These foods are eaten using a spoon or a fork .examples of foods to avoid .tough or fibrous foods-steak and pineapple .crumbly bits-dry cake crumble . International Dysphagia Diet Standard Initiative (IDDSI) Level 7 Regular: meant for individuals who do not have issues chewing or swallowing. R1's care plan dated 12/16/24, identified a focus, R1 had the potential for altered nutritional status related to pain, osteoarthritis, diabetes, increased body habitus, heart disease, generalized weakness, decreased mobility, antidepressants and on Ozempic (injectable diabetic) medication. Interventions dated 12/16/24, identified R1 was to receive a level 7 regular liberalized renal diet. On 12/18/24, identified R1 required set up assist with eating. R1's admission minimum data set (MDS) dated [DATE], identified R1's cognition was intact, diagnoses were diabetes, chronic obstructive pulmonary disease (COPD), and dyspnea (shortness of breath). R1 was independent with eating and required a therapeutic diet. (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	01/13/2025

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's progress note dated 12/23/24 at 9:39 a.m., identified R1 was sent to the emergency department (ED) for altered mental status, abdominal breathing 30+ breaths per minute, possible aspiration as there was vomit beside her. R1 unable to speak clearly only mumbling. R1's emergency department (ED) note dated 12/23/24 at 10:21 p.m., identified R1 presented to the ED with shortness of breath from the nursing home, R1 had vomited and was noted to be aspirating on the vomit, was hypoxic and oxygen saturations were 80% (normal 90-100%) on 8 liters of oxygen. Antibiotics started because chest Xray shows right lower lobe pneumonia .will be admitted to the intensive care unit given her new BiPAP (a machine that helps remove carbon dioxide) status. R1's after visit summary (AVS) dated 12/23/24 to 1/3/25, identified R1 was hospitalized for acute hypoxemic(low level of oxygen in the blood)/hypercapnic (carbon dioxide buildup) respiratory failure presumed secondary too aspiration pneumonia (developed following presumed episode of emesis) and COPD exacerbation requiring BiPAP. She was also encephalopathic (a change in how your brain functions requiring medical intervention) on admission. R1 participated in a bedside dysphagia (difficulty in swallowing) evaluation on 12/26/24, to assess safety with oral intake/risks for aspiration. Factors contributing to aspiration risk include generalized weakness, respiratory status cognitive involvement and decreased activity intolerance. History of odynophagia (painful swallowing) secondary to Warthin's tumors (benign tumor occurring in the salivary glands) noted in the electronic medical record. Discharge orders included: Dysphagia clinical evaluation results: R1 participated in oral trials of thin liquids, puree and solid consistencies resulting in no observable signs of aspiration/penetration. However prolonged mastication with very small bite of cracker. No oral retention/pocketing. Current diet: solids IDDSI level 5 minced and moist, recommended form of medications crushed with puree. Recommendations: Dysphagia treatment. Aspiration precautions: Recommended Aspiration Precautions: Watch closely for signs of aspiration, Sit upright with all oral intake and when completing oral cares, Eat small bites, take small sips, eat slowly, Empty mouth before adding more food or liquid, Good oral care 3-5 times a day. Compensation Techniques/Adaptive Equipment: Requires supervision/assistance. Positioning: Positioning Recommendations: Upright as possible for all oral intakes take small sips, eat slowly, empty mouth before adding more food or liquid, minimize talking during meals, avoid lying down for 15 minutes after meals, good oral care 3-5 times a day every shift. Follow-up Information: Recommend dysphagia therapist evaluate and treat. Frequency and duration to be determined by the evaluating therapist. R1's physician order summary dated 1/3/25, included an order for liberalized renal diet Level 5 minced and moist texture with level 0 thin (regular) consistency. Aspiration precautions: Watch closely for signs of aspiration, Sit upright with all oral intake and when completing oral cares, Eat small bites, take small sips, eat slowly, empty mouth before adding more food or liquid, Good oral care 3-5 times a day. Review of R1's medical record identified R1's care plan and Kardex (abbreviated care plan for direct care staff) was not updated to include Level 5 minced and moist diet nor any interventions identified on the hospital discharge summary including but not limited to: R1 required supervision/assistance, minimize talking during meals, and avoid laying down for 15 minutes after meal. R1's progress note dated 1/5/25 at 10:36 p.m., identified R1 needed constant reminders to use call light. R1 stayed in her room the entire shift and had supper in bed and was able to feed self with appropriate set up. Oxygen saturations were 89% on room air with head of bed elevated, denied shortness of breath and pain. (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	01/13/2025

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's physician visit dated 1/8/25 identified R1 followed a renal diet. Since admission to the facility average intake at meals ranging from 76-100%. Identified assessment plan for dysphagia to remain minced and moist renal diet and thin liquids. R1's Kardex dated 1/9/24 identified R1 required a level 7 regular renal diet. During an interview on 1/9/25 at 4:28 p.m., nursing assistant (NA)-A stated to ensure a resident received the right diet, staff would verify the food on the plate against the meal ticket and could also check the care plan as well. During an interview on 1/9/25 at 4:29 p.m. NA-B stated when staff have to serve food to a resident when they are eating in their room, we would verify the food ticket against what was served on the plate, if staff had questions they would ask the nurse. During an interview on 1/9/25 at 4:31 p.m. licensed practical nurse (LPN)-C stated when we deliver food to residents in their rooms, we would check the food ticket against what is plated. If there were any discrepancies we would ask the kitchen. During an interview on 1/9/25 at 4:33 p.m. registered nurse (RN)-A if there was a discrepancy with the food and the meal ticket, we could check the care plan and would notify my nurse manager. During an interview on 1/9/25 at 4:25 p.m., director of nursing (DON) verified R1's care plan was not updated with level 5 minced and moist diet and the care plan identified R1 was to receive a regular textured diet. DON explained NA's were trained to verify the food on resident's plates by the meal ticket and not the care plan. The facility had seven (7) days to update the care plan with diet changes. During an observation and interview on 1/9/25 at 12:53 p.m. R1 was seated in her wheelchair and had her tray table in front of her. R1 stated she would normally eat in the dining room but had gotten up late today so would be eating in her room. At 1:20 p.m., an unknown male nursing assistant delivered R1's meal tray and set it up on R1's tray table. Male aide then left the room. R1 attempted to use the side of her fork to cut off a bite of the roast beef and stated, this meat is tough. R1 took one bite at a time taking several minutes to chew and swallow each bite. After R1 swallowed a bite of her pineapple upside down cobbler, R1 coughed two times. R1 stated she was supposed to have moist and minced roast beef but they were not moist or minced nor were the carrots. R1's meal ticket dated 1/9/25 located on her tray included, Noon, regular level 7 diet. Entree roast beef, beef gravy, mashed potatoes, carrots, and pineapple upside down cobbler. R1 stated my meal ticket doesn't say moist and minced. At 2:03 p.m., licensed practical nurse (LPN)-A entered R1's room looked at R1's meal ticket that identified the regular diet, and reported R1 had received the wrong diet then removed the tray. LPN-A stated that R1 usually ate in the dining room and would be observed for aspiration as there is staff in the dining room during meal time. During an interview on 1/9/25 at 2:08 p.m., LPN-A stated she was unsure how R1's meal ticket did not match the current MD order and deferred the question to the dietary staff as they handle the meal tickets. LPN-A reported until she was prompted to refer to the record she was not aware R1 required her medications crushed in apple sauce and not whole; LPN-A gave R1 her medications whole this morning based on R1's response when she was asked how she took her pills. (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	01/13/2025

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/9/25 at 2:44 p.m., health unit coordinator (HUC)-A stated with a new admit she would be responsible to put new orders into the EHR physician orders which would include including diet orders and a nurse managers would doublecheck the entry to ensure accuracy. The clinical managers would be responsible to notify the kitchen staff with new diet orders. During an interview on 1/9/25 at 2:50 p.m. LPN-B stated he was one of the nurse managers. LPN-B stated the HUC would normally put the orders into the EHR and one of the nurse managers would be responsible to doublecheck the orders. LPN-B stated he was unsure who would be responsible for notifying the kitchen staff of new diet orders. The facility used to use a diet communication paper form but have not used one for quite some time. During an interview on 1/9/25 at 2:18 p.m., cook (C)-A stated residents who have new diet orders that would go through my manager (culinary director-CD). Level 5 diet is moist and minced, residents on this diet may not have teeth or have difficulty swallowing. For the noon meal today to meet the level 5 minced diet, the roast beef would have to be put through the food processor, similar to mashed-chunky texture, mashed potatoes would be fine, the carrots would have to go through the food processor too. During an interview on 1/9/25 at 2:23 p.m., culinary director (CD)-A stated when a new diet was ordered, nursing would enter it into the electronic health record (EHR), would typically email her that there was a diet change order, and/or verbally communicate the order. CD-A would then put the information on a dietary communication form, keep the form in a folder on her desk, then would enter the diet information into the [NAME] Brothers system that allows the meal ticket to print out which was used to inform dietary and nursing staff at meal times what was supposed to be plated. CD-A explained she was the only person who had access to to change diets in the system. CD-A did not get an email from nursing about R1's diet change when she returned from the hospital and had herself just returned from vacation. CD-A verified the ticketing system currently identified R1 was to receive a regular textured diet. CD-A verified R1's dismissal summary identified R1 was to receive a level 5 diet minced and moist starting on 1/3/25, and this was not done. R1 would have received the wrong textured diet from 1/3/25 to 1/9/25 due the meal ticket being wrong. During an interview on 1/9/25 at 2:52 p.m., DON stated the kitchen should have access to the resident discharge summary to see what the residents diet order was. DON indicated whoever was doing the admission should have notified the kitchen of a new diet order. The risk of R1 receiving the wrong textured diet would be aspiration and choking risk. Further R1 should have received her pills crushed in applesauce and not whole. During a phone interview on 1/9/25 at 3:13 p.m., speech therapist (ST)-A stated he had not been asked to evaluate R1 for swallowing. A person who received a regular diet who should have had a level 5 minced and moist diet would be at risk for aspiration and choking. For a level 5 minced and moist diet the food should be cut up small enough to fit through a fork tine, be well moistened with no excess fluid. Someone on a level 5 diet typically can not chew food particles or swallow well. During a interview on 1/9/25 at 4:34 p.m., nurse practitioner (NP)-A stated R1 had clear orders to receive a level 5 moist and minced textured diet. NP-A further stated if R1 had been receiving a regular diet since 1/3/25, the risk would be aspiration and pneumonia. NP-A indicated with this type of diet her pills should be crushed and not given whole. (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	01/13/2025

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 1/9/25 at 4:58 p.m., medical director (MD)-A stated R1's level 5 diet would require supervision with eating and the risk would be aspiration. MD-A stated signs and symptoms to watch for aspiration while eating would be a new cough, problems with breathing, choking, spitting up, fever and fatigue. Facility policy, Diet and Diet Orders, revised 12/11/23, identified Policy: All diets will be prescribed by the Attending Physician. The Dietitian will review diets for accuracy and therapeutic goals and recommend changes to the Physician as deemed appropriate. Purpose: The purpose of this policy is to provide consistency and accuracy in all diets provided to our residents and patients. Procedure: 1. All diets must be prescribed by the Attending physician and reviewed by the Dietitian. 2. Upon admission, the diet order is entered into the EMR, using the terminology on the attached Diet Conversion Chart. The diet ordered should match the terminology used by Dietary Services. 3. Diets are ordered or changed in writing and communicated to the Dietary department. 4. All diet orders should include diet type (e.g. regular or therapeutic), diet texture, and liquid consistency. 5. Specific requests such as high protein, low potassium, high fiber, etc. will be assessed by the Dietitian and adjusted on the resident tray card and listed in the care plan. 9. The facility will utilize a tray identification system to ensure diet accuracy in the service of the meals. 10. The Dietitian, Speech-Language Pathologist and Nursing department will document significant information relating to the resident's response to the diet offered in the resident's medical record, including the care plan. When diet orders are changed, the care plan and tray card will be updated to reflect the change in order. 11. Residents on therapeutic or mechanically altered diets will not receive foods or fluids outside the diet order unless approved by the Attending physician in conjunction with the Dietitian, nursing and/or therapy . Responsibilities: o Dietitian - Monitor compliance with policy by ensuring accuracy of diets and communicating changes or recommendations. Ensures that care plan is updated with diet changes. o Food Service Director/Dietary Manager - Ensures that food provided is consistent with diet order and that tray card accurately reflects resident/patient diet order and food preferences.- Nursing Department - Enters diet orders in EMR per Physicians order and in compliance with approved diet type and texture. In cooperation with the other departments, ensures appropriate diet and liquids are provided and reports any discrepancies The IJ was removed on 1/10/25, when it was verified through observation, interview and document review the facility completed the following: - Reviewed and revised policies and procedures related to serving resident meals and ensuring residents receive correct textured meals. - Educated to procedures as appropriate. -Educated all nursing staff to utilize diet communication form and give to kitchen staff and on updating the care plan for diet orders. - Educated dietary and all staff who serve resident food to recognize each specific diet type/textured meal. - Educated dietary staff related to the importance of ensuring the meal ticket is updated. (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	01/13/2025

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Educated all staff who serve resident food items on the importance of checking the diet slip, ensure the resident is getting the correct textured food, and then delivering the correct diet order to the resident. - Developed and implemented a plan to complete all training before each staff worked their next shift.