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	03/12/2025

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation interview and document review the facility failed to ensure their Facility Assessment (FA) included resident diagnoses of organ transplant recipients who currently resided in the facility. In addition, the facility assessment failed to identify education on specific care or practices necessary to meet identified care needs regarding organ transplant recipients which had the potential to affect 1 of 1 resident (R1) and all future organ transplant residents reviewed for quality of care. Findings include: The Edenbrook Rochester Requirements of Participation Facility Assessment, revision dated 9/18/24, was reviewed and lacked evidence identifying organ transplant recipients and specific care or practices related to organ rejection monitoring. In addition, the (FA) further lacked training/competencies and provision of care related to organ transplant recipient monitoring, and care services. Record review identified: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had a diagnosis of Liver transplant and end stage kidney disease. Attempted phone interview completed on 3/11/25 at 12:35 p.m., with the medical director office assistant (MDOA)-A who stated the medical director (MD)-A would be out of the office until 3/17/25. During an interview on 3/11/25 at 1:23 p.m., licensed practical nurse (LPN)-A identified he was the nurse responsible for R1's care. LPN-A stated he had never received any training related to organ transplant recipients and was unaware of the signs and symptoms for liver rejection monitoring. During an interview on 3/11/25 at 1:42 p.m., nurse manager (NM)-A identified she was the nurse manager for R1 and stated she did not remember receiving an education regarding organ transplant recipient care. NM-A stated they did not have any information on R1's liver transplant team and did not know how to get a hold of them. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 3:23 p.m., director of nursing DON) indicated their facility assessment did not identify organ transplant recipient provision of services care or monitoring. DON stated they did not have access to R1's liver transplant team for coordination of care as R1 came from another facility and that information was not in R1's medical records. During an interview on 3/11/25 at 3:28 p.m., regional nurse manager (RNM)-A stated the facility assessment does not identify organ transplant recipients or education regarding provision of care or services. During an interview on 3/11/25 at 3:49 p.m., nurse practitioner (NP)-A stated the facility does not have contact information regarding R1's liver transplant care coordinator. During an interview on 3/11/25, at 4:55 p.m. the Administrator confirmed the facility assessment had not identified organ transplant recipients, and did not indicate specific care or practices related to organ transplant recipient care. During an interview on 3/12/25 at 9:20 a.m., via phone registered nurse liver transplant care coordinator (RNLTCC)-A stated she had wondered what happened to R1 as she had not heard from him in quite some time. RNLTCC-A stated with liver transplant recipients it is very important to be monitoring for liver rejection signs and symptoms, ensure anti-rejection medications are given daily, and will need routine monitoring of labs and ultrasounds of the liver. A policy for facility assessment was requested, but not provided.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on document review and interview, the facility's Quality Assurance Performance Improvement (QAPI) committee failed to identify, investigate, analyze, and respond to medication errors by developing and implementing action plans for process improvement. This had the potential to affect all 50 residents who resided in the facility. Findings include: Review of the facility Quality Assessment Performance Improvement Committee Agenda Minutes in conjunction with Medication Error reports from December 2024 to February 2025. The QA minutes were not all dated nor identify which members of the committee were present. The Medication Error reports were identified in QA however, the reports did not consistently include a causal analysis/investigation, nor measures developed and implemented to prevent reoccurrence. The Quality Assessment Performance Improvement Committee Agenda/Minutes were reviewed and did not identify the date or time of the meeting, nor did it identify who the members were of the committee who attended. Further the QA minutes consistently did not address specific action plans to decrease the medication error rates. January minutes: The facility's Quality Assessment Performance Improvement Committee Agenda Minutes, form did not identify the date of the meeting nor quality members who were in attendance. The form identified Medication Errors as a topic to review and analyze. A goal for medication errors was not identified. In the section Current trends vs Historical Trends, Goals, included 1 medication error in December 2024, down from 6 medication errors in November 2024 due to tracking medication not available from house stock or pharmacy. Process followed to notify provider and placing medication on hold when not available or getting medication delivered stat. The data collected for analysis included: The undated Agenda minutes identified for December 2024 the facility had one medication error: R17's medication was not available from the pharmacy due to it being a special-order medication, family provided the medication and did not include measures to prevent reoccurrence. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	February minutes: The facility's Quality Assessment Performance Improvement Committee Agenda Minutes, form did not identify the date of the meeting nor quality members who were in attendance. The form identified Medication Errors as a topic to review and analyze. A goal for medication errors was not identified. In the section Current trends vs Historical Trends, Goals, included 5 medication errors in January 2025, up from one medication error in December 2024, due to tracking medication not available from house stock or pharmacy. Process followed to notify provider and placing medication on hold when not available or getting medication delivered stat. Two transcription errors, one entered as twice a day was ordered daily, one entered as self-administered instead of staff to administer, one medication not delivered from the pharmacy as new regulation state dialysis needs to supply, one over the counter eye drop not delivered due to a weather delay of ordered supplies, one resident was a readmit. one medication not delivered until night run and one medication were not sent at all. The section Historical Actions taken/New Action Plans/Steps, was left blank and did not identify who was responsible for the action step, did not specify what component of medication errors was being monitored daily at stand-up, nor specific activities associated with decreasing medication errors associated with types of medication errors that were identified in the report. The data collected for analysis included: Review of January 2025 Medication Error reports identified a total of five medication errors from 5 residents: 1. R4's Medication Error report dated 1/16/25 at 10:48 a.m., identified R4 received prophylactic Tamiflu 75 milligrams (mg) once daily for two weeks. Resident was receiving Tamiflu 75 MG BID (twice a day) for last eight days. Provider was updated and will discontinue Tamiflu as R4 has received adequate doses of prophylactic Tamiflu.R4 has not no adverse reactions from medication being given BID. Reviewed by IDT team. R4 had no adverse reaction. Medication was discontinued, provider stated he had sufficient medication for prophylaxis. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the error nor any education for retraining. The report is unclear as to how many extra doses R4 received. 2. R16's Medication Error report dated 1/20/25 at 11:47 a.m., identified R16 missed Sevelamer Carbonate (medication to reduce phosphorus levels in dialysis patients) on 1/17/25 at 8:00 a.m., 1/18/25 at 8:00 a.m., 12:00 p.m., and 5:00 p.m. doses. Omnicare contacted they stated that they do not supply this medication, stating that dialysis is responsible. Dialysis notified of missed medication by assigned nurse on 1/18/25. This resident did not receive his 8:00 a.m., or 11:00 a.m., dose of Sevelamer Carbonate today before dialysis. The facility has no more on cards and this medication is not kept in the Omnicell. Writer called Omnicare to ask them about this and they said that this medication is not covered under insurance for R16 and they also said that it must be ordered through Dialysis. Writer then called Dialysis who stated that this does not create a problem that R16 did not get it today as it only means that the phosphorus will excrete via his bowel movements versus urination. Fax sent to Mayo Clinic Nursing Home office as well. Reviewed by IDT. Omnicare pharmacy stated they no longer supply this medication due to it being a non-covered med and that dialysis is responsible for it. Dialysis team notified. Dialysis ordered medication for resident to pick up from Mayo pharmacy. R16 was able to pick up medication and facility has it in stock to be administered. The report did not include measures to prevent reoccurrence for other dialysis patients. The report did not identify who made the errors nor any education for retraining. This would be six missed doses which reflects six medication errors. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. R15's Medication Error report dated 1/20/25 at 11:47 a.m., identified R15's over the counter (OTC) medication Muro eye drops (an eye drop used to treat corneal edema) TID (three times a day) administration missed from 1/14/25 - 1/20/25. Reviewed by IDT. Medication has been ordered. Supply has been delayed due to weather in the states that supply warehouses are located. Attempted to locate medication at a local pharmacy, none of them carry this medication. Awaiting supply. 1/23/2025 Medication placed on hold and supply ordered via Amazon. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the error nor any education for retraining. This would be twenty-one missed doses which reflects twenty-one medication errors. 4. R14's Medication Error report dated 1/20/25 at 11:52 a.m., identified R14 missed Advair (inhaled medication to prevent flare-ups or worsening of chronic obstructive pulmonary disease) AM and PM on 1/17/25 to 1/19/25 indicating 6 missed doses. In addition, R14 missed Erythromycin Ophthalmic ointment (ointment used to treat eye infections) on 1/17/25. R14 was readmitted to the facility 1/17/2025. Erythromycin Ophthalmic ointment was a new medication and was delivered on the night run. Advair was not delivered. Reviewed by IDT. R14 readmitted to the facility on [DATE]. Erythromycin Ophthalmic ointment was a new medication and was delivered on the night run. Medication start date should have been the following day. Advair was not delivered. Pharmacy was contacted on 1/18/25 at 8:00 a.m., they stated Advair would be delivered on the run tonight. Pharmacy did not deliver Advair until 1/19/2025 at 9:33 pm. R14 had no adverse effects from missing doses. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the errors nor any education for retraining. This would be seven missed doses which reflects seven medication errors. 5. R3's Medication Error report dated 1/27/25 at 8:00 a.m., identified R3's Heparin (blood thinner) order appears on MAR as completed as transcribed as self-med. No medication was administered by staff. Does not identify how many missed doses. Reviewed by IDT. R3 had no adverse reaction from missing doses. Order was corrected in the computer. Review of R3's MAR dated January 2025, identified R3 had nine omitted doses of heparin from 1/24/25 to 1/27/25 resulting in 9 medication errors. The report did not include a causal analysis/investigation nor include measures to prevent reoccurrence. The reports did not identify who made the error nor any education for retraining. The report did not identify who made the errors nor any education for retraining. This would be nine missed doses which reflects nine medication errors. After reviewing the facility's data analysis from the medication error reports for January 2025, the medication error rate would be 44 medication errors and not 5 medication errors with a difference of 39 medication errors that were not brought forward to quality assurance. Review of Medication errors dated February 2025, the facility identified 12 medication errors however review of medication error reports identified 42 medication errors, a difference of 30 medication errors that were not accounted for. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/11/25 at 2:42 p.m., director of nursing stated the facility department heads meet monthly for QAPI meetings. DON indicated at each monthly meeting they will discuss medication errors from the previous month. DON verified the QAPI notes from February 2025 identified six medication errors and the error rate was up 5 medication errors from the previous month. DON verified there was no new action plan in place to prevent future medication errors. DON further verified February 2025 medication errors increased to twelve, up seven from the previous month. DON stated they had not been tracking each omitted medication as one error rather identified if a resident who had several omitted doses as one error. DON indicated they had not completed an analysis of the February medication errors as they had not had their QAPI meeting for March yet, so no action plan was put in place to prevent future medication errors. During an interview on 3/11/25 at 3:49 p.m., nurse practitioner (NP)-A stated one omitted medication would be counted as one medication error and facility should be identifying this, should be analyzing for trends in medication errors to put prevention plans in place to prevent future medication errors. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy, QAPI Policy and Procedure, updated 5/5/24, identified It is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life and residents' choice and is based on the scope and complexity of services defined by the Facility Assessment. The objective of this requirement is the completion and implementation of the QAPI plan to identify the high risk, problem prone and high volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristic and needs of the residents . PROCEDURE: 1. The facility will develop, implement, and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. 2. The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as: a. Tracking and measure performance; b. Establishing goals and thresholds for performance measurement; c. Identifying and prioritizing quality deficiencies; d. Systematically analyzing underlying causes of systemic quality deficiencies; e. Developing and implementing corrective action or performance improvement activities; and f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. 3. The facility maintains documentation and can demonstrate evidence that the program meets CMS requirements. 4. The facility presents evidence in the form of documentation to substantiate the ongoing implementation and QAPI program compliance with regulations to the State Survey Agency, Federal Surveyor or CMS if requested. 5. The Quality Assessment and Assurance Committee consists at a minimum of: a. The director of nursing services; b. The Medical Director or his/her designee; c. At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and d. The infection Preventionist - effective November 28, 2019 . 4. Our QAPI plan includes the policies and procedures used to i. Identify and use data to monitor our performance ii. Establish goals and thresholds for our performance measurement iii. Utilize resident, staff and family input iv. Identify and prioritize problems and opportunities for improvement v. Systematically analyze underlying causes of systemic problems and adverse events vi. Develop corrective action or performance improvement activities . Guidelines for Performance Improvement Projects (PIPs). Identified PIPs will be the center of the QAPI program. Identified areas of improvement will stay as focal issues until desired outcomes have been achieved. If the measures of interventions implemented are not delivering results, the details will need to be adjusted either at the quarterly, preferably monthly, meeting or sooner as appropriate. Once achieved they will be maintained and discussed routinely, however new focal points or PIPs will be introduced. Performance improvement activities must track medical errors and adverse resident events, analyze causes, and implement preventative actions and mechanisms that include feedback and learning throughout the facility. Responsibility and Accountability The administrator has responsibility and is accountable to the governing body and our corporation for ensuring that QAPI is implemented throughout our organization. QAPI activities and discussion will be a standing item on our regular governing body meeting agendas. The administrator will, report on and solicit input on all QAPI activities on a regular basis. The administrator is responsible for assuring that all QAPI activities and required documentation is provided to our corporation . Conducting Performance Improvement Projects (PIPs) Our organization will conduct Performance Improvement Projects that are designed to take a systematic approach to revise and improve care or services in areas that we identify as needing attention. We will conduct PIPS that will lead to changes and guide corrective actions in our systems, which cross multiple departments, and have impact on the quality of life and quality of care for residents living in our community. We will conduct PIPs that will improve care and service delivery, increase efficiencies, lead to improved staff and resident outcomes, and lead to greater staff, resident, and family satisfaction. An important aspect of our PIPs is a plan to determine the effectiveness of our performance improvement activities and whether the improvement is sustained. Method to Identify Potential Topics for PIPs The QAA committee will review data and input on a quarterly, preferably monthly, basis to look for potential topics for PIPs. We will monitor and analyze data, and review feedback and input from residents, staff, families, volunteers, providers, and stakeholders. We will look at issues, concerns, and areas that need improvement as well as areas that will improve the quality of life and quality of care and services for the residents living and staying in our community. Factors we will consider: high-risk, high-volume, or problem-prone areas that affect health outcomes, quality of care and services, and areas that affect staff. In addition, we will consider: o Existing

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP)-(an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented for management of an indwelling catheter to reduce the risk of infection to others for 1 of 1 resident (R1) reviewed for quality of care. Findings include: R1's face sheet identified diagnoses of obstructive and reflux uropathy and need of assistance with personal cares. R1's order summary dated 6/19/24, identified R1 had an order to provide catheter care every shift, ensure catheter is anchored via Velcro or tape. R1's care plan revised 8/2/24, identified a focus of actual/potential for alteration in elimination related to obstructive and reflux uropathy .goal identified will have no signs and symptoms of infection after completion of treatment through next review. Intervention dated 6/20/24 identified to change Foley catheter as ordered and monitor/document/report signs and symptoms of UTI: abdominal pain, weakness, functional decline, nausea, vomiting, dark cloudy urine, blood in urine and pus in urine. Did not identify EBP precautions. An additional focus revised 2/18/25 identified a focus related to renal failure due to end stage renal disease and had fistula created, waiting for fistula to mature, no start date for dialysis, does not want dialysis initiated. Intervention dated 7/2/24 identified to use enhanced barrier precautions. Care plan does not identify what cares identify the need for EBP nor does the foley catheter identify the need for EBP. During an observation and interview on 3/11/25 at 1:16 p.m., upon entrance to R1's room a paper sign was hung on the wall to the right side of R2's door. Two, STOP signs noted at the top on either side. Signage read: ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. The sign also had color pictures of hand cleanser, gloves, and gown. During an interview on 3/11/25 at 1:23 p.m., licensed practical nurse (LPN)-A verified R1's catheter was lying on the floor and should not be related to infection control concerns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/12/25 at 10:10 a.m., R1 was lying in bed and his catheter bag was hooked to the bed control cord and the bottom of the catheter bag was lying on the floor. At 2:17 p.m., NA-A verified the catheter bag was lying on the floor and should not be. NA-A stated he would have to find a catheter bag covering to put it in. At 10:19 a.m., LPN-A verified the catheter bag was lying on the floor, walked into R1's room with washing his hands and picked up the catheter bag without applying EBP per the room signage and hooked the catheter to the bed. LPN-A then picked up R1's breakfast tray and walked out of the room without washing his hands, walked down the hall, set the breakfast tray on the cart in between the east and west hallways, then proceeded to walk down the hall. LPN-A stated R1 should be on EBP precautions due to his Foley catheter and fistula and stated he should have used them in addition to washing his hands before and after entering/leaving the room. During an interview on 3/12/25 at 10:26 a.m., director of nursing DON stated staff should be using EBP's when touching R1's catheter bag. All residents with EBP have a sign clearly posted outside their room and staff should be looking for that and following our policy for EBP to help prevent the spread of infection. DON further stated staff should be washing hands prior to entrance of a room, after leaving a resident's room and between glove changes. DON stated not following EBP would be an infection control issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy, enhance Barrier Precautions, dated 3/6/24, identified it is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with chronic wounds requiring a dressing, indwelling medical devices or residents with infection or colonization with an MDRO 1. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Enhanced Barrier Precautions will not only focus on residents with infection or colonization with MDRO's but will also address residents at risk for developing or becoming colonized. Enhanced Barrier Precautions are precautions that are between Standard Precautions and Contact Precautions. Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities. Novel or Targeted MDROs include: Pan-resistant organisms Carbapenem's-producing carbapenem-resistant Enterobacter [NAME], carbapenems-producing carbapenem-resistant Pseudomonas spp., carbapenems-producing carbapenem-resistant Acinetobacter baumannii, and Candida auris1Additional MDROs that are epidemiologically important include: Methicillin-resistant Staphylococcus aureus (MRSA), ESBL-producing Enterobacterales, Vancomycin-resistant Enterococci (VRE),Multidrug-resistant Pseudomonas aeruginosa, Drug-resistant Streptococcus pneumoniae. The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-Contact Resident Care Activities include1: Policy & Procedure: Enhanced Barrier Precautions: Dressing, Bathing/showering, Transferring, providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care: any skin opening requiring a dressing1. Standard Precautions should be applied to all residents at all times. 2. Transmission-based precautions should be applied to all residents when standard precautions alone do not prevent pathogen transmission. 3. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A. EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. b. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid(R)) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. c. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. d. EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. 4. Post clear signage on the door/wall outside resident room a. Type of precautions i. Contact Link: Contact Precaution sign ii. Droplet Link: Droplet Precaution sign iii. Airborne Link: Airborne Precaution sign iv. Enhanced Barrier Precautions Link: EBP Sign 5. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: 1. Dressing 2. Bathing/showering 3. Transferring 4. Providing hygiene 5. Changing linens 6. Changing briefs or assisting with toileting 7. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator 8. Wound care: any skin opening requiring a dressing 1 ii. In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. Outside the resident's room, EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. iii. Residents are not restricted to their rooms or limited from participation in group activities. Because EBP do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until

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	03/12/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Requested a handwashing policy and was not received.