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	06/15/2026

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 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. Based on interview and document review, the facility failed to provide timely notification for change in condition to the physician for 1 of 3 residents (R1) reviewed for change in condition.Findings include:R1's order summary dated 6/4/26, identified R1's primary diagnoses included pulmonary embolism, chronic obstructive pulmonary disease (COPD), atherosclerotic heart disease, and chronic respiratory failure with hypoxia.R1's admission Minimum Data Set (MDS) assessment, dated 6/5/26, indicated R1 had no cognitive impairment and required maximum assistance for toileting and transfers.R1's physician orders dated 6/3/26 included:-Monitor for signs and symptoms of pulmonary edema (PE) including chest pain or shortness of breath (SOB), notify the provider immediately if or any of the above, and document in the progress note every shift.R1's standing orders for skilled nursing facilities dated 2/16/23 instructed:-To initiate and titrate supplemental oxygen (O2) from 1-4 L/minute via NC (nasal cannula) PRN (as needed) for dyspnea, hypoxia, (O2 saturation (sat) lower than 90% or 88% for COPD) or acute angina to keep O2 saturations above 90%; immediately update provider with nursing assessment.R1's occupational therapy treatment encounter note dated 6/5/26, indicated R1 was only able to complete four exercises with yellow (light) TheraBand for 1 set of 10-15 repetitions each due to significant SOB. Therapeutic rest break was utilized to increase oxygen saturation (O2 sat) level, educated in pursed lip breathing techniques and breathing through each respiration; however, R1's O2 sat continued to decrease to 70%. The note further indicated R1 was not recommended to continue with therapy due to poor O2 sats and inability to tolerate sessions.R1 medical record, lacked evidence the provider was notified of R1's O2 sat, poor activity tolerance, or recommendation to discontinue therapy.R1's physical therapy treatment encounter note dated 6/5/26, included, R1 was fatigued, and his O2 sat decreased to 80% on 2L/min when sitting at the edge of the bed. The note further indicated a physical therapist (PT)-A increased O2 flow to 3L/min; however, R1's O2 sat remained in the 80's. After R1 was wheeled out of his room to the therapy room, his O2 sat increased to 89% on 3L/min. Additionally, the note also indicated R1's respiratory status was reported to the nurse, with instructions to notify the provider for review of R1's O2 orders.R1 medical record, lacked notification of the provider.Review of R1's blood pressure report indicated the following:6/4/26 at 10:59 p.m., blood pressure 95/56 mm/Hg (millimeters of mercury) on laying position on left arm6/5/26 at 11:42 a.m., blood pressure 94/55 mm/Hg on sitting position on left arm6/5/26 at 11:16 p.m., blood pressure 92/58 mm/Hg on sitting position on left armR1 medical record, lacked evidence the provider was notified regarding R1's low blood pressure results from 6/4/26 through 6/5/26.During an interview on 6/11/26 at 3:29 p.m., an occupational therapy (OT)-A stated during a therapy section on 6/5/26, R1' s O2 sat was in the 80s and 70s with 2L/min while sitting. OT-A explained she reported to a licensed practical nurse (LPN)-A and did not know whether it was escalated to the provider.During an interview on 6/15/26 at 12:43 p.m., PT-A stated on 6/5/26, R1 was sitting at the edge of the bed with O2 sat of 80% while receiving O2 at 2L/min. PT-A reported notifying LPN-A, who entered the room and rechecked R1's O2 sat, obtaining a reading of 84% on 2L/min. PT-A stated R1 was experiencing significant SOB but could not recall whether LPN-A implemented any interventions to address R1's respiratory distress. PT-A explained LPN-A left the (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and did not return. As a result, PT-A increased R1's O2 flow to 3L/min, after which R1's O2 sat increased to 89%. PT-A stated R1 declined participation in therapy activities due to SOB which was reported to LPN-A with request to reevaluate R1's O2 needs. PT-A further stated he did not know whether the change in condition was reported to the provider.During an interview on 6/15/26 at 11:54 a.m., LPN-A stated he provided care to R1 on 6/5/26. LPN-A explained OT-A reported R1's O2 sat levels were in 70s and 80s during therapy. LPN-A stated R1's O2 sat remained in the 80s while receiving O2 at 3L/min. LPN-A stated after rechecking R1's O2 sat using a different finger, he obtained a reading of 90% on 3L/min. LPN-A reported R1 denies experiencing any respiratory distress and remained in the dining room. LPN-A confirmed he did not document the episode of decreased O2 sat and did not notify the provider of the change in condition. Additionally, LPN-A stated he did not notify the provider regarding PT's request for reevaluation of R1's oxygen needs.During an interview on 6/15/26 at 10:35 a.m., a nurse practitioner (NP)-A stated she was present in the facility on 6/4/26 and 6/5/26 but was not notify of R1's respiratory distress or any request to reevaluate the resident O2 needs. NP-A reviewed the provider call logs from 6/4/26 through 6/6/26 and found no evidence indicating a provider had been notified regarding R1's respiratory distress. NP-A stated staff were expected to complete an SBAR and notify the provider immediately when such a change in condition occurred.During an interview on 6/15/26 at 6:24 p.m., the director of nursing (DON) stated staff were expected to immediately report any change in condition or resident concerns to the provider. The DON explained she was unaware of R1 respiratory distress that occurred during therapy sessions, including PT's staff request for provider notification to reevaluate R1's oxygen needs. The DON confirmed this information was not reported to the provider. The DON stated, while the surveyor was onsite, she initiated education for all nursing staff regarding the requirement for appropriate and timely notifications to the provider of changes in resident condition and concerns.Facility Change in Condition Policy dated 11/13/24 identified the physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference in usual sign/symptoms and/or the signs/symptoms are unrelieved by measures already prescribed. The Policy identified specific information that required prompt notification included:Significant change or instability of vital signs;A significant change in the resident's physical/psychosocial/mental condition;A need to transfer the resident to a hospital/treatment center

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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** Based on interview and document review, the facility failed to monitor, assess, implement physician orders and notify the physician of worsening hypoxia for 1 of 3 residents (R1) reviewed for change in condition. This resulted in actual harm for R1 when as a result of the delay in care, R1 experienced respiratory distress without necessary and appropriate medical intervention for over two and a half hours before emergency medical staff arrived.Findings include:R1's admission note dated on 6/3/26 at 6:53 p.m. written by licensed practical nurse (LPN)-B included, [AGE] year-old male admitted to facility following a hospitalization for a fractured left femur which became infected. Resident came in a wheelchair and was accompanied by his daughter and granddaughter. Resident has history of COPD (chronic obstructive pulmonary disease)/Emphysema (chronic lung condition) and is on oxygen, 2L (liters) via NC (nasal cannula). Vitals completed. Resident states that his goal is to become stronger and return to the assisted living facility from which he came.R1's order summary dated 6/4/26, identified R1's primary diagnoses included pulmonary edema, COPD, heart disease, and chronic respiratory failure with hypoxia (condition characterized by the inability to effectively exchange oxygen and carbon dioxide).R1's admission Minimum Data Set (MDS) assessment, dated 6/5/26, indicated R1 had no cognitive impairment and required maximum assistance for toileting and transfers.R1's shortness of breath assessment dated [DATE] identified R1 with the following:-Shortness of breath or trouble breathing with exertion-Shortness of breath or trouble breathing when sitting at rest-Shortness of breath or trouble breathing when lying flatR1's physician orders dated 6/3/26 included:-Check oxygen saturation level every shift and as needed (PRN)-Monitor for signs and symptoms of pulmonary edema (PE), (is the abnormal accumulation of fluid in the lungs, particularly in the alveoli, which impairs gas exchange and can cause life-threatening breathing difficulties), including chest pain or shortness of breath (SOB), notify the provider immediately if or any of the above, and document in the progress note every shift.-Oxygen continuous oxygen via nasal canula (NC), 1L at rest/awake, 2L with exercise/activity every shift.-Vital signs every shift for 72 hours and documented in the progress note-Lasix (furosemide) 40 mg tablet one time a day related to heart failure- Ventolin HFA Inhalation Aerosol Solution 108 (90 base) mcg/act (albuterol sulfate) 2 puff inhale orally two times a day for SOB rinse mouth with water after use and spit.-Ventolin HFA Inhalation Aerosol Solution 108 (90 base) mcg/act (albuterol sulfate) 2 puff inhale orally every 4 hours as needed for SOB rinse mouth with water after use and spit.R1's standing orders for skilled nursing facilities dated 2/16/23 instructed:-To initiate and titrate supplemental oxygen (O2) from 1-4 L/minute (min) via NC PRN for dyspnea, hypoxia (O2 saturation lower than 90% or 88% for COPD) or acute angina to keep O2 saturations above 90%; immediately update provider with nursing assessment.-Heart failure management included: Daily weights for patients with heart failure, call for weight gain 3 pounds or greater in 24 hours or 5 pounds in one week weight, assess lung sounds, peripheral edema, and respiratory effort daily unless directed otherwise.Review of R1's vital sign record identified the following:6/4/26 at 10:59 p.m., blood pressure 95/56 on laying position on left arm. Temperature was 98.4 Fahrenheit (F) on the forehead, heart rate (HR) 74 beats per minute (bpm), respirations (RR) 18 breaths/min, and O2 sat 98% via nasal cannula (NC).6/5/26 at 11:42 a.m., blood pressure 94/55 on sitting position on left arm. Temperature was 98.3 F on the forehead, HR 76 bpm, RR 16 breaths/min and O2 sat 90% via NC.6/5/26 at 11:16 p.m., blood pressure 92/58 on sitting position on left arm. Temperature was 97.7 F on the forehead, HR 85 bpm regular, RR 14 breaths/min, and O2 sat 91% via NC.R1 medical record lacked evidence whether the provider was notified about R1's low blood pressure from 6/4/26 through 6/5/26.A review of R1's record from 6/3/26 through 6/6/26 lacked documentation staff completed daily or as-needed lung sound assessments. R1's progress note dated 6/6/26 at 5:53 p.m., written by LPN-B included nurse started their day at 6am. There was no indication in report there were concerns with R1. NA-A went into R1's room to give him (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	a bed bath and found R1 had removed his oxygen tubing. NA-A alerted LPN-B. Oxygen was put on immediately and R1's oxygen level read 84%. During the bed bath, R1's granddaughter visited and said R1 had called her and said he could not breathe. R1 did not alert nurses or staff at any time to this concern. LPN-B was with another resident when overheard the granddaughter say to R1, I turned up your oxygen so you can breathe better. LPN-B went to R1's room and looked at the O2 meter which read 4 liters per minute. LPN-B said to the granddaughter, Please do not turn the dial up or down, we have orders from the physician as to where R1's oxygen levels need to be and how much we can administer. If his needs are outside the parameters of the order, we can proceed with contacting a provider. Continuous checks were done to watch R1's oxygen which declined to 74%. LPN-B increased oxygen to 3L then to 4L for 5 minutes and remained at 74%. LPN-B asked the resident if he wanted to be sent into the emergency room for evaluation and he said, No, there isn't anything that they can do there that you aren't already doing here. LPN-B called the on-call nurse to inform her of the situation and the interference of the granddaughter. LPN-B was instructed to ask R1 one more time if he wanted to be sent in. LPN-B asked the resident this and he looked at his granddaughter who was shaking her head yes, and then he said, Yeah, I guess so. LPN-B stated that she would print all the paperwork for the paramedics and then make the phone call for the transportation. LPN-B took a bed hold into the room for the resident to sign and explained to him what it was. The granddaughter said, That won't be necessary because he won't be coming back here. Two paramedics arrived and assessed the resident. During the assessment, the paramedic asked LPN-B if this resident's lips were blue like this since awakening and writer proceeded to state that this resident admitted here with blue/gray skin color and purple lips. The granddaughter said, Yes but they weren't that bad. LPN-B did this resident's admission, and he looked no different this morning than he did the day he admitted . Paramedics called for back up to assist. Firemen showed up and were directed to R1's room as well as an ambulance person who came at the tail end of the situation. After the resident had left, the ambulance employees who arrived in a separate car, came to the desk and asked who the nurse manager was that was on duty. LPN-B informed him of who it was and gave him the phone number to reach her. LPN-B asked if there was a concern and his response was, That is a very sick gentlemen right there and staff was not very helpful. Two hours had been spent working with R1. R1's progress note further noted, while at the hospital, R1 developed new onset of shortness of breath and lightheadedness. An ultrasound confirmed bilateral acute occlusive DVT (peroneal and posterior tibial veins) and CTA (computed tomography angiography) confirmed Pulmonary Embolism. Code status at facility was DNR/DNI (Do Not Resuscitate/Do Not Intubate). Resident was his own decision maker.R1's record lacked notification to a provider regarding the above situation.R1's record review lacked evidence of his vital signs earlier on the day of 6/6/26.R1's hospital admission summary dated [DATE], identified R1's primary admitting diagnoses included acute hypoxic respiratory failure, pulmonary edema/volume overload, and concern for septic shock.EMS arrived at approximately 9:39 a.m. on 6/6/26.R1's emergency medical services (EMS) report dated 6/6/26, included, ambulance unit number dispatched priority two to the facility listed for trouble breathing. Ambulance unit questioned dispatch priority and dispatch stated the facility nurse requested a downgrade due to minimal breathing issues. Unit remained priority two. Upon arrival the nurse spoke to EMS crew outside the resident's room and stated the resident is not having difficulty breathing and the resident has had the same type of breathing since his admission a few days ago. The nurse indicated the family requested medical. The nurse states that the family is a lot and is overreacting. Upon walking into the residents' room, the temperature was very warm. Resident breathing with retractions, pale, diaphoretic and has cyanosis (blue) around the lips. The nurse came into the room, she said she increased the oxygen to 3L/min and then walked out. EMS crew quickly provided a duoneb (a combination inhalation solution used to treat COPD) with increased oxygen flow. Vitals obtained and showed tachycardia (an elevated resting heart rate greater than 100 beats per minute), tachypnea (abnormally rapid, shallow breathing), and low O2. Resident O2 slowly improved with the duo neb (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	treatment. The report further indicated R1 called a family member at approximately 7:00 a.m. reporting difficulty breathing and expressing fear of dying in the facility. When resident's breathing slightly improved attempts were made to move the resident. EMS crews were not able to move the residents and asked staff to bring in a mechanical lift, in which they did although had not brought in the needed sling to do so. EMS crew called for the fire crew to assist in lifting the resident on to the stretcher secured and transported via priority. During an interview on 6/15/26 at 11:54 a.m., LPN-A stated he provided care to R1 on 6/4/26 and 6/5/26 but did not recall reporting R1s low BP to the provider. LPN-A explained that on 6/5/26, occupational therapist (OT)-A reported R1's O2 sat levels were in 70s and 80s during therapy. LPN-A stated R1's O2 sat remained in the 80s while receiving O2 at 3L/min. LPN-A stated after rechecking R1's O2 sat using a different finger, he obtained a reading of 90% on 3L/min. LPN-A reported R1 denies experiencing any respiratory distress and remained in the dining room. LPN-A confirmed he did not document the episode of decreased O2 sat and did not notify the provider of the change in condition. Additionally, LPN-A stated he did not notify the provider regarding PT's request for reevaluation of R1's oxygen needs.During an interview on 6/11/26 at 4:45 p.m., registered nurse (RN)-A stated she provided care to R1 during the evening shift of 6/5/26, when R1's BP was recorded at 92/58 mmHg. RN-A stated she did recheck R1's BP which was within his baseline; however, she confirmed she did not document or notify the provider of the initial low BP reading and subsequent findings. RN-A stated nurses were expected to document assessments and report significant changes in a resident's condition to the provider.During an interview on 6/10/26 at 2:31 p.m., a nursing assistant (NA)-A stated at approximately 7:00 a.m. on 6/6/26, she responded to R1's call light. Upon entering the room, she observed R1 lying in bed without his NC in place with his phone resting on his chest. NA-A reported she informed LPN-B, R1 was not wearing his O2. NA-A stated R1 reported not feeling well and the information was reported to LPN-B, who came into the room to put back R1's NC and confirmed the O2 flow rate was 2L/min. NA-A stated R1 was weak and was unable to stand to get dressed. R1 requested to lie back down in bed which they did and left the room.During an interview on 6/11/26 at 11:21 a.m., a family member (FM)-A stated R1 called her at approximately 7:00 a.m., on 6/6/26 reporting difficulty breathing. FM-A stated when she arrived at the facility at approximately 8:30 a.m., R1 was crying and receiving O2 via NC. FM-A reported she increased R1's O2 flow rate to 2L/min because R1 had been on 2L/min the previous day when she left. FM-A stated LPN-B overheard the O2 adjustment, entered the room, decreased the O2 flow back and then left the room. FM-A reported when she noticed R1's lips and face turning blue and observed he was unable to speak; she went to the nursing station at approximately 8:45 a.m. and found LPN-B sitting there. FM-A stated she requested R1 be sent to the hospital. FM-B stated, approximately 5 min later, LPN-B entered the room, checked R1 O2 sat and found it to be in the 70's. FM-A reported LPN-B increased R1's O2 flow rate to 3L/min; however, R1 condition did not improve. FM-B stated she again requested R1 be sent to the hospital and LPN-B replied that there was nothing the hospital could do that they could have not done, and left the room without rechecking R1's O2 sat. FM-B stated, LPN-B returned to the room and asked R1 if he wanted to go to the hospital. FM-A reported R1 agreed, and LPN-B then left the room. During an interview on 6/15/26 at 4:30 p.m., LPN-B stated R1 experienced SOB during her shift on 6/6/26, with O2 sat of 84% on 2L/min during a bed bath. LPN-B stated she believed she could not titrate R1's O2 to 4L without a provider order, despite having standing order to utilize. LPN-B reported leaving the room to allow the nursing assistant to complete the bed bath and proceeded to administer medications to other residents in the dining room. LPN-B stated she later returned to R1's room after overhearing the family member (FM)-A increase R1's O2 flow rate in an attempt to help R1 breath more comfortably. LPN-B reported she did not check R1's O2 sat level before titrating O2 back to 2L/min per the order and educated FM-A not to interfere with R1's care. LPN-B stated when she rechecked R1's O2 sat, it was 74% on 2L/min. She increased O2 flow rate to 3L/min; however, the O2 sat remained at 74%. LPN-B stated R1 initially refused to go the hospital, but FM-A encouraged him to go. LPN-B stated she subsequently left the room to care for other residents. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	She later learned from FM-A that R1 had agreed to go to hospital. LPN-B further stated she did not reassess R1's O2 sat levels, did not obtain a full set of vital signs, and did not notify the provider. LPN-B stated she did not have time to write an SBAR (Situation, Background, Assessment, and Recommendation) communication. LPN-B confirmed she should have notified the provider regarding R1's condition.R1's medical record lacked documentation whether R1 was reassessed, or the provider was notified of the initial low BP or follow-up assessment findings.During an interview on 6/11/26 at 1:34 p.m., EMS-A stated when she entered R1's room on 6/6/26 at approximately 9:39 a.m., it was apparent R1 was experiencing severe SOB. EMS-A stated this was inconsistent with the information provided by LPN-B, who reported R1 was fine and had no change in condition. EMS-A stated LPN-B left the room saying I have other things to do. EMS-A stated FM-A reported R1 has been in respiratory distress since approximately 7:00 a.m. EMS-A stated upon assessment, R1's O2 sat was in 60s with 3L/min, respirations were 25, and heart rate was 125.During an interview on 6/15/26 at 10:35 a.m., a nurse practitioner (NP)-A reported she could not confirm whether the facility contacted the on-call provider on 6/6/26 regarding R1's change in condition. NP-A stated she reviewed the provider call logs from 6/4/26 through 6/6/26 and found no evidence the provider was notified regarding R1's respiratory distress. NP-A explained when a resident experienced respiratory distress, staff were expected to obtain complete vital signs, perform lungs and skin assessments, evaluate the need for a face mask and get the provider involved. NP-A further stated staff were expected to complete an SBAR and notify the provider immediately.During an interview on 6/15/26 at 6:24 p.m., the director of nursing (DON) stated staff were expected to immediately report any resident experiencing respiratory distress to the provider, including their assessment findings and interventions. The DON stated the assessment should include obtaining full vital signs, auscultating lung sounds, assessing for changes in skin color, administering nebulizer treatment or inhaler when clinically appropriate, and documenting the findings and interventions in the progress note. The DON stated R1 was readmitted to the hospital on [DATE] with hypoxia and respiratory failure. The DON confirmed education was initiated for nursing staff on 6/11/26 after the survey entrance conference regarding change in condition, oxygen therapy, standing orders and provider notification requirements.The Facility Oxygen Administration and storage Policy dated 8/1/15 revised on 6/15/23 directed staff to provide emergency administration of oxygen when it is necessary for the care of the residents. The nurse will then call the physician as soon as reasonable to obtain a physician's order. As a guideline, a beginning flow rate of 2L/minute and adjust according to oxygen saturation levels which should be kept above 90% unless otherwise ordered by a physician. The physician should be notified of any concerns identified with oxygen titration needs so the physician may determine a need to change the order to best meet the resident's oxygen needs.Facility Change in Condition Policy dated 8/1/15, revised on 11/13/24 identified the physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference in usual sign/symptoms and/or the signs/symptoms are unrelieved by measures already prescribed. The Policy identified specific information that required prompt notification included:Significant change or instability of vital signs;A significant change in the resident's physical/psychosocial/mental condition;A need to transfer the resident to a hospital/treatment center

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide necessary respiratory care consistent with professional standards of practice, physician orders, standing orders, the resident's care plan, goals and preferences for 1 of 3 residents (R1) reviewed for change in condition.Findings include:R1's hospital admission summary dated [DATE], identified R1's primary admitting diagnoses included acute hypoxic respiratory failure and concern for septic shock.R1's order summary dated 6/4/26, identified R1's primary diagnoses included pulmonary embolism, chronic obstructive pulmonary disease (COPD), atherosclerotic heart disease, and chronic respiratory failure with hypoxia. R1's admission Minimum Data Set (MDS) assessment, dated 6/5/26, indicated R1 had no cognitive impairment and required maximum assistance for toileting and transfers.R1's physician orders dated 6/3/26 included:-Check oxygen saturation level every shift and as needed (PRN)-Monitor for signs and symptoms of pulmonary edema (PE) including chest pain or shortness of breath (SOB), notify the provider immediately if or any of the above, and document in the progress note every shift.-Oxygen continuous oxygen via nasal canula (NC), 1L at rest/awake, 2L with exercise/activity every shift.-Vital signs every shift for 72 hours and documented in the progress note- Ventolin HFA Inhalation Aerosol Solution 108 (90 base) mcg/act (albuterol sulfate) 2 puff inhale orally two times a day for SOB rinse mouth with water after use and spit.-Ventolin HFA Inhalation Aerosol Solution 108 (90 base) mcg/act (albuterol sulfate) 2 puff inhale orally every 4 hours as needed for SOB rinse mouth with water after use and spit.R1's standing orders for skilled nursing facilities dated 2/16/23 instructed: -to initiate and titrate supplemental oxygen (O2) from 1-4 L/minute (min) via NC PRN for dyspnea, hypoxia (O2 saturation lower than 90% or 88% for COPD) or acute angina to keep O2 saturations above 90%; immediately update provider with nursing assessment.R1's progress note dated 6/6/26 at 5:53 p.m., indicated R1's O2 sat was 84% on 2L/min during a bed bath. The note further indicated R1's O2 sat decreased to 74% on 3L/min. R1 refused transfer to the hospital, and staff left the room to check on another resident.R1's medical record lacked provider notification.During an interview on 6/11/26 at 11:21 a.m., a family member (FM)-A stated R1 called her at approximately 7:00 a.m., on 6/6/26 reporting difficulty breathing. FM-A stated when she arrived at the facility at approximately 8:30 a.m., R1 was crying and receiving O2 via NC at 1L/min. FM-A reported she increased R1's O2 flow because R1 had been on 2L/min the previous day when she left. FM-A stated LPN-B overheard the O2 adjustment, entered the room, decreased the O2 flow back to 1L/min and then left the room. FM-A reported when she noticed R1's lips and face turning blue and observed he was unable to speak; she went to the nursing station at approximately 8:45 a.m. and found LPN-B sitting there. FM-A stated she requested R1 be sent to the hospital. FM-B stated, approximately 5 min later, LPN-B entered the room, checked R1 O2 sat and found it to be in the 70%. FM-A reported LPN-B increased R1's O2 flow rate to 3L/min; however, R1's condition did not improve. FM-B stated she again requested R1 be sent to the hospital and LPN-B replied, there was nothing the hospital would do that they could have not done, and left the room without rechecking R1's O2 sat. FM-B stated approximately 10 min later, LPN-B returned to the room and asked R1 if he wanted to go to the hospital. FM-A reported R1 agreed, and LPN-B then left the room.During an interview on 6/15/26 at 4:30 p.m., LPN-B stated R1 experienced SOB during her shift on 6/6/26, with O2 sat of 84% on 2L/min during a bed bath. LPN-B stated she believed she could not titrate R1's O2 to 4L without a provider order, despite having standing order to utilize. LPN-B reported leaving the room to allow the nursing assistant to complete the bed bath and proceeded to administer medications to other residents in the dining room. LPN-B stated she later returned to R1's room after overhearing the family member (FM)-A increase R1's O2 flow rate in an attempt to help R1 breath more comfortably. LPN-B reported she did not check R1's O2 sat level before titrating O2 back to 2L/min per the order and educated FM-A not to interfere with R1's care. LPN-B stated when she rechecked R1's O2 sat, 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	06/15/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was 74% on 2L/min. She increased O2 flow rate to 3L/min; however, the O2 sat remained at 74%. LPN-B stated R1 initially refused to go the hospital, a decision that she stated was encouraged by FM-A. LPN-B stated she subsequently left the room to care for other residents. She later learned from FM-A that R1 had agreed to go to hospital. LPN-B reported she did not delegate any staff member to remain with R1 while she prepared the hospital transfer paperwork. LPN-A further stated she did not reassess R1's O2 sat levels, did not obtain a full set of vital signs, and did not notify the provider. LPN-B stated she did not have time to write an SBAR (Situation, Background, Assessment, and Recommendation) communication. LPN-B confirmed she should have notified the provider regarding R1's condition.During an interview on 6/15/26 at 10:35 a.m., a nurse practitioner (NP)-A stated she reviewed the provider call logs from 6/4/26 through 6/6/26 and found no evidence the provider was notified regarding R1's respiratory distress. NP-A explained when a resident experienced respiratory distress, staff were expected to obtain complete vital signs, perform lung and skin assessments, evaluate the need for a face mask and get the provider involved. NP-A further stated staff were expected to complete an SBAR and notify the provider immediately.During an interview on 6/15/26 at 6:24 p.m., the director of nursing (DON) stated staff were expected to immediately report any resident experiencing respiratory distress to the provider, including their assessment findings and interventions. The DON stated the assessment should include obtaining full vital signs, listening to lung sounds, assessing changes in skin color, administering nebulizer treatment or inhaler when clinically appropriate, and documenting the findings and interventions in the progress note. The DON stated R1 was readmitted to the hospital on [DATE] with hypoxia and respiratory failure. The DON confirmed reeducation was initiated for nursing staff on 6/11/26, after the survey started.The Facility Oxygen Administration and storage Policy dated on 6/15/23 directed staff to provide emergency administration of oxygen when it is necessary for the care of the residents. The nurse will then call the physician as soon as reasonable to obtain a physician's order. As a guideline, a beginning flow rate of 2L/minute and adjust according to oxygen saturation levels which should be kept above 90% unless otherwise ordered by a physician. The physician should be notified of any concerns identified with oxygen titration needs so the physician may determine a need to change the order to best meet the resident's oxygen needs.