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	02/12/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a cable cord face plate was fixed and secured for 1 of 1 resident (R1) reviewed for a safe and homelike environment. Further, the facility failed to remove discarded cigarette butts from the ground at the back entrance of the facility. This had the potential to affect all 56 residents, staff and visitors.Findings include:R1's comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated R1 had no cognitive impairment. R1 was dependent on facility staff for bathing and toileting, required substantial assistance for dressing, and dependent on staff for position changes.During an interview on 2/9/26 at 6:00 p.m., R1 pointed towards the wall and indicated she was upset about the hole with two cable cords coming out; it appeared to need a cable plate cover. R1 stated she asked the facility staff to cover the hole a month ago but, they haven't.During observation and interview on 2/11/26 at 9:53 a.m., the hole in the wall remained with cords still exposed, this still bothered the resident. R1 stated again she wishes they would cover the cords with an outlet cover. During an interview on 2/11/26 at 11:00 a.m., director of nursing (DON) stated she was not aware of the hole in R1's wall with cable protruding. The DON stated this could be a safety issue and should be fixed.During an interview on 2/11/26 at 2:33 p.m., maintenance (M)-A stated he was aware the cable in R1's room was protruding out of the wall. On 1/6/26 at 12:44 p.m. a maintenance request was submitted to fix the cable in R1's room. He stated after the cable ends were replaced, the faceplate was not reattached. The maintenance report had been marked as completed on 1/7/26 at 7:18 a.m. M-A stated the maintenance report should not have been marked completed until the face plate had been replaced. He understood why the hole in the wall might bother R1. M-A stated it is important to replace lost or missing items so that residents have a homey feel to their surroundings.During an interview on 2/11/26 at 2:39 p.m., administrator stated when residents let facility staff know about a building concern, this should be fixed as soon as possible. The administrator stated he was not aware of the hole in the wall, and this could be fixed as soon as possible. The administrator stated it is important for residents to feel like this is their home.Cigarette ButtsDuring interview on 2/10/26 at 09:16 a.m., family member (FM)-A stated she does not like to enter the facility through the back door. FM-A stated the back entrance area was littered with dirty, old cigarette butts. FM-A stated she was disgusted by the facility for not removing the cigarette butts.During observation on 2/10/26 at 9:48 a.m., the facility's back entrance was littered with dozens of cigarette butts.During observation and interview on 2/10/26 at 10:58 a.m., the administrator confirmed the cigarette butts lined the facility wall at the facility's back entrance. Further, cigarette butts lined the driveway extending towards the designated smoking area. Additionally, cigarette butts were found in the garden planter next to the designated smoking area. The administrator acknowledged the discarded cigarette butts were unpleasing to the eye. A facility policy titled Preventative Maintenance dated 4/6/23, routine facility inspections promote safety.A facility policy titled Preventative Maintenance dated 4/6/23, maintenance includes part replacements that is performed specifically to prevent faults from occurring.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 2 of 2 (R30, R2) residents who utilized a urinary catheter (tube from bladder to a bag outside the body) and 4 of 4 (R17, R25, R49, R52) residents who required assistance in the dining room.Findings include: R30's quarterly Minimum Date Set (MDS) assessment, dated 12/30/25, indicated a moderate cognitive impairment. Diagnoses included heart failure and renal insufficiency and had an indwelling catheter.R30's care plan dated 9/29/25, indicated an actual/potential for alteration in elimination related to urinary retention. R30's interventions included catheter changes per provider schedule.R30's progress notes dated 11/29/25 at 10:01 p.m., indicated R30 had an indwelling catheter.On 2/10/26 at 8:28 a.m. R30 was observed sitting in the commons area watching television. The foley catheter bag and tubing was noted hanging on the lower part of the wheelchair uncovered. There was a dark colored cloth bag noted on the opposite side of the wheelchair, not being utilized. On 2/10/26 at 8:41 a.m., R30 was observed in the dining hall eating breakfast. R30's foley catheter tubing and bag was on the right lower side of the wheelchair, uncovered. There were 8 residents present in the dining room. On 2/10/26 at 8: 46 a.m. nurse assistant (NA)-D confirmed R30's catheter tubing and bag were exposed and uncovered. The urine was observable draining down the tubing and into the bag. NA-D confirmed the tubing and bag should be covered in a dignity bag to prevent others from seeing residents who have a catheter. NA-D confirmed there was a dignity bag on the opposite side of the wheelchair not being utilized. R2's significant change MDS assessment, dated 2/5/26 indicated a moderate cognitive impairment. Diagnoses included coronary artery disease and heart failure. R2 had an indwelling catheter which included an suprapubic catheter (a catheter surgically placed through a hole in the lower abdomen to the bladder). R2's care plan dated 11/28/25 indicated an actual/potential for alteration in elimination related to memory care deficit, heart failure, and reflux uropathy with a goal resident would have no complications related to the suprapubic catheter.During an observation on 2/10/26 at 9:24 a.m., R2 rolled himself down the hallway to his room. His catheter bag and tubing was hanging on the bottom of the wheelchair, uncovered. There were several residents, staff members and visitors in the hallway, able to visualize R2's catheter tubing and bag, and the urine draining through the tube.During an interview on 2/10/26 at 9:33 a.m., NA-C confirmed R2's catheter bag and tubing were exposed. NA-C stated all catheter bags and tubing should be in a cloth dignity bag so nobody around the resident could see the catheter, tubing and urine draining. NA-C confirmed getting R2 and R30 ready and out to breakfast. NA-C stated they were not able to locate a dignity bag prior to transporting them to breakfast. During an observation on 2/11/26 at 8:16 a.m., NA-C was observed sitting with R17, R25, R49 at one table. NA-C was assisting R17 and R52 to eat. R25 had her food in front of her but did not eat. Staff brought R49 to the same table and brought his food out. R49 was observed not feeding self. At 8:19 a.m., NA-C stood up and gave R17 and R52 a bite to eat while standing. NA-C then went to R49 and gave him a bite to eat while standing. NA-C then moved to R25 and gave her a bite to eat, while standing. NA-C continued to go around the table to each one of the residents, gave them a bite to eat, all the time standing by each of the residents side and this continued the rest of the meal. There was no communication with the residents while NA-C assisted the residents to eat. During an interview on 2/10/26 at 1:11 p.m., NA-C stated there were four residents that sat in the dining room who needed assistance with eating. The residents sat together at the same table. NA-C stated normally staff would sit down next to the one or two residents they were assisting to eat so conversation could occur, the resident could look at you eye level and the resident could make choices related to what they ate. NA-C stated she was the only one in the dining room for lunch. The four residents at the table had gotten their food. NA-C indicated not wanting to let the food to get cold. NA-C said she stood up and started to feed each resident a bite of food before going to the next resident and then starting over. NA-C stated she felt it would be more of (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a dignity issue and a respect issue if NA-C would have just fed one resident at a time.During an interview on 2/12/26 at 9:27 a.m. nurse manager (NM)-B stated anytime a catheter bag or tubing was exposed, and urine could be seen draining. This would be a dignity and respect issue for the residents. NM-B stated, the staff should also be sitting when they are assisting with meals. It is ok to assist one or two residents, but they need to be at eye level and talk with the residents as they eat.During an interview on 2/12/26 at 11:18 a.m., the director of nursing stated residents with a catheter should either have a dignity bag to cover the catheter bag and tubing or a new catheter bag with a white out space that hides the urine in the bag. Staff should also sit at the dining table when they are assisting a resident with the meal and not stand up or go around the table feeding all the residents at the table at the same time.Facility policy Resident Rights: Dignity last revised 10/24/23, indicated the facility would treat each resident with respect and dignity and care for each resident in a manner and environment that promoted maintenance or enhancement of his or her quality of life.Facility policy Foley Catheter Management last revised 1/28/25, indicated all catheter bags would be covered at all times.Facility policy Dining and Food services last revised 2/12/25, indicated when staff fed a resident, staff should remember to sit down next to the resident and feed one resident at a time. Do not stand while a resident is fed.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow-up from resident council complaints and grievances after a determination was made by the facility. This had the potential to affect all residents in the facility. Findings include:During a resident council meeting on 2/10/26 at 12:59 p.m., five different residents vocalized concerns related to food. They indicated it has been mentioned at each of the meetings. The residents indicated they have not heard back from the facility staff or an rationale as to why no response.During an interview on 2/10/26 at 4:51 p.m., the life enrichment director ([NAME]) stated food was a big grievance mentioned at resident council meetings. There were a few other items brought up recently but could not remember what they were. After the meeting, the grievances would be taken to the appropriate department to handle from that point. [NAME] indicated they would follow up with the departments prior to the next resident council meetings and if there was anything to bring forward they would be brought to resident council at that time. [NAME] indicated they have notes about everything talked about in resident council but have not inputted the information in the new form yet.On 2/10/26 at 4:51 p.m., a copy of the [NAME]'s resident council notes was requested although not received.Facility Resident Council Meeting Minutes for 10/25 through 1/26 were reviewed, the following grievances were reported:- on 12/17/25, grievances related to can foods used to often and artificial sweeteners used was filed.No other grievances were filled out from resident council meetings.The minutes lacked documented responses and rationales of the concerns resident council brought forward.During an interview on 2/10/26 at 5:11 p.m., the administrator stated the resident council staff spokesperson, who was [NAME], would bring all grievances to the appropriate departments to handle. The facility would deal with grievances on a more personal level, instead of taking them back to the resident council.During a follow up interview on 2/10/26 at 5: 22 p.m., the administrator stated the [NAME]'s notes had been reviewed and lacked any proof follow-through with the resident council members had occurred related to grievances and complaints filed in resident council.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure accuracy of the Minimum Data Set (MDS) for 1 of 1 resident (R11) reviewed for accuracy of assessments. Findings include:R11's quarterly MDS dated [DATE], indicated R11 was cognitively intact. Diagnoses included hypertension and Parkinson's disease. R11 received Invasive Mechanical Ventilator (must have a tube or other item placed in the airway and connected to a ventilator machine to assist breathing).R11's care plan dated 2/28/25, indicated R11 used a continuous positive airway pressure (CPAP) machine at night. The CPAP machine has a mask that fits over the mouth to assist in keeping the airway open when sleeping.During an interview on 2/10/26 at 2:26 p.m., the MDS coordinator (MDSC) reviewed R11's MDS report from 11/19/25 and confirmed an invasive mechanical ventilator was marked in error and should be for a CPAP which was noninvasive mechanical ventilation.During an interview on 1/29/26 at 2:33 p.m., the director of nursing (DON) stated MDS accuracy was important as it is part of their payment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to ensure professional standards of practice were followed for accurate charting of dialysis assessments including vital signs and weights for 1 of 1 resident (R52) reviewed for dialysis assessment.Findings include:R52's comprehensive Minimum Data Set (MDS) assessment, dated 10/8/25, indicated R52 had moderate cognitive impairment and was dependent on facility staff for all dressing, hygiene, and mobility needs. R52's medical diagnosis included end stage renal (kidney) disease, requiring dialysis (process of filtering and removing excess waste and fluids from the body) three times per week. Side effects of dialysis include low blood pressure, mineral imbalances, and increased risk of infections.R52's care plan dated 9/30/25 indicated R52 required dialysis due to end stage renal disease. R52's interventions for dialysis included daily weight prior to going to dialysis and again upon return to facility. R52 had a dialysis routine to go to dialysis every Monday/Wednesday/Friday at 11:45 a.m. and return to the facility approximately 3.5 hours later, monitor vital signs as ordered, and notify provider of significant abnormalities.R52's active orders included weights and vitals signs before dialysis every Monday/Wednesday/Friday and weights and vital signs upon return from dialysis every Monday/Wednesday/Friday. R52's dialysis schedule included:11:30 a.m. - Transport to dialysis center11:45 a.m. - Start dialysis3:15 p.m. - Dialysis complete3:30 p.m. - 3:45 p.m. - Return to facilityDuring observation and interview on 2/11/26 at 11:26 a.m., R52 was being prepared to leave the facility for dialysis, nurse manager (NM)-A stated a set of vital signs (VS) and weight is completed before dialysis and again upon return to facility after dialysis. This process is done to ensure the resident is stable before leaving for dialysis and remains stable upon return from dialysis. Collecting vitals signs and weights after dialysis is especially important because dialysis can cause low blood pressure. Residents with low blood pressures can experience weakness, dizziness, and unsteadiness which can be dangerous if not identified quickly. NM-A stated each resident has a dialysis communication sheet to document all the information. The dialysis communication sheet for R52 dated 2/11/26 at 10:50 a.m. showed a blood pressure of 104/69 and no weight. This blood pressure was later documented in R52's chart at 3:17 p.m.; not reflecting the blood pressure was taken at 10:50 a.m.R52's Treatment Administration Record (TAR) reviewed from 12/12/25 through 2/9/26 for pre and post vital signs and weights indicated:16 pre-dialysis blood pressure were documented later in the day13 pre-dialysis weights were documented at a different time than when taken18 post-dialysis blood pressure were reported later than obtained.12 post-dialysis weights were documented later in the dayDuring observation on 2/11/26 at 3:34 p.m., R52 returned from the dialysis facility. R52 was placed in the main living room upon returning. No assessment had been completed upon return. During observation and interview on 2/11/26 at 4:08 p.m., registered nurse (RN)-A stated any resident returning from dialysis should be assessed immediately upon return to make sure they are stable after dialysis, since dialysis can cause them to have low blood pressure. RN-A confirmed she had not completed R52's vital signs and weights since she returned from dialysis. After asking RN-A to review the charted documentation for R52's vital signs, RN-A stated the blood pressure taken prior to dialysis was charted at 3:17 p.m. RN-A stated sometimes they will chart the vital signs at the end of the shift instead of at the time of completion. RN-A stated it is probably better to chart at time of completion though.During an interview on 2/11/26 at 4:17 p.m., director of nursing (DON) stated it is an expectation that dialysis residents have vital signs and weights completed upon return from dialysis. The DON stated she is aware staff are charting vital signs and weights at the end of the shift rather than charting at time of completion. The DON stated accurate charting is important so staff and providers have the correct information about when a task was completed.During an interview on 2/12/2026 at 9:24 a.m., nurse practitioner (NP) stated she expected vital signs and weights to be collected and entered as ordered. Further, she expected vital signs to be documented at the time they were collected, not documented at time of end of shift. NP stated she had difficulty at times with (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accurate charting, she has had to find out from the nurse if the time for vital signs was charted at time of completion or at the end of shift. It can be difficult to adjust cardiac medications when she is unsure if the blood pressure was taken before or after the medication was given. The NP expected that if nurses are charting later, they back chart to the correct time not just use the default time of entry when they chart at end of shift. Accurate daily weights are another charting issue she struggles with, staff may get resident weights in the morning before breakfast, however, they are documenting them as collected after their shift ends in the afternoon. Ultimately, the NP expected the charted time to be the time the task was completed, not the end of shift charting time.During an interview on 2/12/26 at 10:37 a.m., the administrator confirmed accurate charting was an issue the facility knows about. Administrator confirmed the charting should reflect the actual time of completion not the time of charting at the end of the shift.A facility policy titled Charting and Documentation dated 11/13/24, a treatment administration record shall be maintained which records the resident care procedures and/or treatments ordered by the physician that is performed and by whom the procedure/treatment was performed.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and document review the facility failed to have an appropriately trained staff member assist a resident with meals. This affected 1 of 4 (R24) residents reviewed for dining services.Findings include:R24's annual Minimum Data Set (MDS) assessment dated [DATE] indicated severe cognitive impairment. Diagnoses included dementia and Alzheimer's.R24's care plan revised on 8/11/25 indicated an activity of daily living (ADL) self-care performance deficit along with a cognitive deficit.During an observation on 2/09/26 at 12:28 p.m., cook (C)-A was assisting R24 to eat lunch. After C-A gave R24 four bites of food, C-A walked away to tend to something else. At that time a nurse assistant took over assisting R24 to eat.During an observation on 2/11/26 at 8:16 a.m., C-A was approaching R24 and stated to R24 they needed to eat. R24 was looking at her food and had not eaten. After several more minutes C-A was observed giving R24 two bites of food. C-A reminded R24 she needed to eat and then walked away. During an interview on 2/11/26 at 8:33 a.m., C-A confirmed she had assisted R24 with the meal on 2/9/26 and 2/11/26. C-A stated she was not a nurse assistant in the state of Minnesota.During an interview on 2/11/26 at 8:40 a.m., the culinary director (CD) confirmed C-A was a cook in the facility. The CD stated the facility did not use any paid feeding assistants and was sure the only people allowed to assist with feeding residents were nursing staff or people trained to feed the residents.During an interview on 2/12/26 at 9:18 a.m., the director of nursing (DON) stated the only staff that should feed residents are the clinical staff or somebody trained to assist with meals dietary staff should not assist residents with their meals.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to address clothing burns for 1 of 1 resident (R31) reviewed for smoking safety.Findings include:R31's quarterly Minimum Data Set (MDS) assessment, dated 12/10/25, indicated R31 was cognitively intact. R31's diagnoses included a contracture of the right hand (soft tissues such as muscles, tendons, ligaments, or skin undergo structural changes that make them stiff, tight, and shortened, resulting in a loss of full range of motion) and vascular dementia (decline in cognitive function, causing memory loss, cognitive decline, behavioral changes, and communication difficulties). R31's care plan dated 9/24/25 indicated contractures of the right hand, requiring assistance with dressing and undressing. R31's smoking care plan lacked interventions for clothing protectors. R31's smoking assessments dated 5/23/24 through 12/4/25 indicated R31 was safe to smoke without supervision. During observation on 2/10/26 at 9:48 a.m., R31's coat had two burn holes on the right forearm. R31 stated the burn holes happened right after she got her new coat a couple months ago. R31 stated she was right-handed and was having difficulty lighting her cigarette with her left hand because she didn't have much movement in her right hand due to the contracture. R31 stated she was upset about the burn holes because her jacket was brand new and it already had holes in it. R31 stated other than the two burns holes, she feels mostly safe smoking outside alone. During an interview on 2/10/26 at 10:39 a.m., nurse manager (NM)-B stated the process to complete a smoking assessment included reviewing the facility smoking process, staff assessed resident ability to go out to smoke independently and safely, provide smoking education, and provide safety equipment if needed (apron, blanket, etc.). NM-B stated R31 did not have any smoking safety equipment. NM-B stated if staff observed burn holes in the clothing; they would assess the resident for wounds and conduct another smoking assessment to ensure resident was safe to continue smoking independently. NM-B stated she was not aware of burn holes in R31's jacket. During an interview on 2/10/26 at 10:47 a.m., director of nursing (DON) stated the process to assess a resident for safety while smoking included review facility smoking policy, smoking education, and conduct a smoking assessment by observing the resident from start to finish of smoking independently. DON stated smoking assessments were completed quarterly and if/when the staff felt the resident was no longer safe to smoke independently. DON stated residents need to be free of burn holes in clothing, extinguish cigarettes appropriately, understand smoking policy and education, and be able to smoke outside independently. DON stated she was not aware R31 had burn holes in her jacket; staff don't routinely check clothing for clothing burns. DON stated a resident with burns in clothing should be reassessed immediately for safety to independently smoke. A facility policy titled Smoking and E-Cigarettes dated 3/1/21, the facility will complete a smoking assessment upon admission, quarterly, or with a change in condition.

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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** Based on observation, interview and record review the facility failed to prevent the risk of infection for 2 of 3 (R30, R2) residents reviewed for infection control when it was identified the catheter bags were dragging on the floor. Additionally, the facility failed to implement enhanced barrier precautions (EBP) when caring for indwelling medical device for 1 of 1 (R52) resident reviewed for infection prevention.Findings include: R30's quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, indicated a moderate cognitive impairment. Diagnoses included heart failure and renal insufficiency and R30 had an indwelling catheter. R30's care plan dated 9/29/25, indicated an actual/potential for alteration in elimination related to urinary retention. Interventions included suprapubic (a tube inserted through a small incision in the lower abdomen to drain urine directly from the bladder when normal urination is not possible) catheter changes at clinic per provider schedule. R30's care plan dated 12/2/25 indicated a urinary tract infection (UTI) due to positive urinalysis results. Interventions included take antibiotics as per provider orders. R30's progress notes dated 11/29/25 at 10:01 p.m., indicated R30 had an indwelling catheter and had been treated with antibiotics for a UTI. On 2/9/26 at 2:38 p.m., R30 was observed in his wheelchair in his room. The catheter tubing and bag were observed laying on the floor next to the resident and lacked a barrier between the catheter bag/tubing and the floor. R2's significant change MDS assessment dated [DATE] indicated a moderate cognitive impairment. Diagnoses included coronary artery disease and heart failure. R2 had an suprapubic catheter R2's care plan dated 11/28/25 indicated an actual/potential for alteration in elimination related to memory care deficit, heart failure, and reflux uropathy with a goal resident would have no complications related to the suprapubic catheter. On 2/10/26 at 9:24 a.m., R2 was observed rolling himself down the hallway to his room. His catheter bag and tubing was observed hanging on the bottom of the wheelchair. The tubing and catheter bag were noted to be dragging along the floor as he headed to his room. During an interview on 2/10/26 at 9:33 a.m., nurse assistant (NA)-C confirmed R2's catheter and tubing was dragging the ground as he rolled himself down the hallway. NA-C stated she had gotten R2 up this morning for breakfast and placed the foley bag and tubing under the wheelchair. NA-C stated catheter bags and tubing should not be able to come into contact with the floor. During an interview on 2/12/26 at 9:27 a.m., nurse manager (NM)-B confirmed R30 had a UTI in 12/25 and had an indwelling catheter when the UTI occurred. NM-B stated foley tubing and catheter bags should not come in direct contact with the ground due to the increased risk of infection. The tubing and bag could pick up bacteria from the floor. During an interview on 2/12/26 at 11:18 a.m., the director of nursing/infection preventionist (DON) (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	02/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated catheter bags and tubing should not come in contact directly with the floor due to the increased risk of infection. Facility policy Foley Catheter Management last revised on 1/28/25, indicated correct positioning of the catheter would be maintained. R52 R52's comprehensive Minimum Data Set (MDS) assessment, dated 10/8/25, indicated R52 had moderate cognitive impairment and was dependent on facility staff for all dressing, hygiene, and mobility needs. R52's medical diagnosis included end stage renal (kidney) disease, requiring dialysis (process of filtering and removing excess waste and fluids from the body) three times per week. During observation on 2/10/26 at 1:21 p.m., licensed practical nurse (LPN)-A exited R52's room without proper personal protective equipment (PPE). LPN-A stated he didn't think R52 needed enhanced barrier precautions (EBP) because her room did not have an EBP sign and did not have the isolation equipment hanging on the door. He confirmed R52 had a dialysis line but didn't think her dialysis port needed EBP. During observation and interview on 2/11/26 at 11:13 a.m., director of nursing (DON) confirmed R52 had a dialysis catheter and should have an EBP sign with isolation equipment hanging on her door. Upon inspection, the DON confirmed R52 did not have an EBP sign or isolation equipment hanging on her door. The DON stated the importance of EBP was to protect the residents from infection. A facility policy titled Enhance Barrier Precautions dated 3/26/24, residents with indwelling medical devices required EBP to prevent infection or colonization from a multi-drug resistant organisms. Facility policy Foley Catheter Management last revised on 1/28/25, indicated correct positioning of the catheter would be maintained.