STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of St Cloud	1717 University Drive Southeast Saint Cloud, MN 56304

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47083 Based on observation, interview, and document review, the facility failed to maintain safe storage of medications when the nurses left medication carts unlocked and unattended in 2 of 3 medication carts. Findings: On 4/23/24 at 11:48 a.m., licensed practical nurse (LPN)-A gathered supplies to check R2's blood glucose. LPN-A pressed the north medication cart lock partially into the cart. LPN-A walked away from the medication cart in the hall and into R2's room. LPN-A closed the door for privacy. Following the procedure, LPN-A returned to the cart and pulled the medication cart lock out with his fingers, and accessed the contents of the medication cart. LPN-A did not use a key to access the medication cart. LPN-A stated the importance of locking the medication cart when not in attendance was to make sure no medications were stolen. LPN-A stated he trusted the people and the residents at the facility. LPN-A stated the lock on the medication was in working order. LPN-A stated leaving the medication cart unlocked and unattended was not a safe idea. On 4/23/24 at 12:01 p.m., LPN-B was observed from approximately 30 feet away, walking down the hall, approaching the west medication cart and pulling the lock out with her fingers to access the medication cart. LPN-B did not use a key to access the medication cart. LPN-B stated she had a key to the medication cart and the locking mechanism was in working order. LPN-B stated, I guess I just do it that way, when asked why the medication cart was not locked. On 4/23/24 at 12:34 p.m., LPN-C stated the medication carts were to be locked if the nurse was not near the cart. CM-A stated the unlocked cart posed a danger that residents, staff or family could access the cart. On 4/23/24 at 2:12 p.m., the director of nursing (DON) stated the medication carts should be locked whenever the nurse was not in direct attendance of the cart. The DON stated the medication carts should not be left unattended and unlocked as anybody could get into the medication cart. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility document Medication Storage dated 2/12/24, directed to ensure medications and biological are stored in a safe, secure storage and safe handling. Compartments containing medications should be locked when not in use. Trays or carts used to transport such items should not be left unattended. (Note: Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes).

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083 Based on observation, interview and document review, the facility failed to maintain infection control practices while conducting blood glucose checks for 2 of 3 residents (R2, R3) reviewed for medication administration. Findings include: R2's admission Minimum Data Set (MDS) dated [DATE] indicated R2 had a diagnosis of diabetes mellitus type 2. R2's Physician's Order dated 4/15/24, directed to check blood glucose three times daily. On 4/23/24 at 11:51 a.m., after checking R2's blood glucose, licensed practical nurse (LPN)-A was observed to place a contaminated lancet and cotton ball in the cover of the plastic container used to hold R2's glucometer, insulin pens, and blood glucose testing supplies. LPN-A carried the container to the medication cart, and placed the contaminated lancet (a pricking needle, used to obtain drops of blood for testing) in a plastic cup sitting on the top of the medication cart. There were a total of five used lancets in the cup. LPN-A closed the plastic container in the medication cart, and did not disinfecting the glucometer or the plastic container. LPN-A stated the sharps container was on the medication cart. The sharps container on the medication cart was observed to be full with lancets pressing out of the top of the container. The contents was approximately two inches above the full line. LPN-A stated glucometers were cleaned once weekly, unless they were used for another resident, then you would have to use the disinfectant wipe on it. R3's significant change MDS dated [DATE], indicated R3 had diagnosis of diabetes mellitus type 1 and end stage renal disease. R3's Physician's order dated 1/4/24, directed to check blood glucose four times per day. On 4/23/24 at 12:03 p.m., LPN-B was observed to gather supplies from the medication cart to test R3's blood glucose. LPN-A removed the plastic container from the medication cart. LPN-A inserted the test strip into the glucometer. She prepared R3's finger by wiping it, then pricked R3's finger with the lancet, and put pressure on R3's finger with both of her ungloved hands to produce a drop of blood. LPN-B stated gloves should be worn when handling bodily fluids such as vomit, urine, bowel movements, or blood. LPN-B stated she was never instructed to wear gloves when checking blood glucose. LPN-B stated glucometers were only cleaned once weekly, unless visibly dirty. LPN-B stated there was not a process for the day of the week the glucometers were cleaned. On 4/23/24 at 12:34 p.m.,LPN-C stated gloves were to be worn for all glucometer testing. LPN-C stated the sharps containers were to be changed when the contents reached the fill line. LPN-C stated the nurses working on the medication carts were responsible to replace the sharps container and properly dispose of the full ones. On 4/23/24 at 1:49 p.m., CM-A stated the glucometers were to be properly disinfected after each use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/24 at 2:12 p.m., the director of nursing (DON) stated glucometers were expected to be cleaned after each use. The DON stated gloves should be worn with all glucometer checks. The DON stated sharps containers should be replaced when the contents reached the full line. The DON stated it was unacceptable to place five contaminated lancets on top of the medication cart in a plastic cup. She stated the lancets should be discarded promptly after each use. A facility document Care of the Diabetic Resident dated 8/22/23, directed blood glucose monitoring procedure: Wash your hands or use hand sanitizer to clean hands Put on gloves Discard test strip when finished Clean the glucometer per facility policy Remove and discard gloves; wash hands Store the glucometer in a clean and dry location A facility document Cleaning and Disinfection of a Glucometer dated 3/8/23, directed: 1. Gather necessary equipment for procedure. 2. Perform hand hygiene and apply gloves. 3. Wipe all external surfaces, including top, bottom and sides, using the approved cleaning solution or commercially prepared EPA germicidal wipe; avoid allowing the solution to penetrate the test strip and/or key code ports of the meter. 4. Ensure the meter remains wet for the time recommended by the manufacturer of the wipe and allow to air dry for an additional minute before using on the next resident. 5. If blood is visibly present on the meter, the procedure should be repeated a second time. 6. Discard soiled items in approved containers. 7. Remove gloves and perform hand hygiene.