

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Edenbrook of St Cloud		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083</b></p> <p>Based on observation, interview, and document review, the facility failed to ensure ambulation interventions were implemented for 1 of 3 residents (R3) reviewed for falls. This resulted in actual harm for R3 who fell while ambulating in the hallway and sustained a head laceration requiring emergency medical care. The facility implemented corrective action prior to the investigation so the deficiency was issued at past noncompliance.</p> <p>Findings include:</p> <p>R3's quarterly Minimum Data Set (MDS) dated [DATE] indicated R3 had diagnoses of dementia, and had moderate cognitive impairment. The MDS also indicated R3 required supervision or touching assistance when ambulating.</p> <p>R3's care plan dated 4/14/23 indicated R3 required assistance of one staff and front wheeled walker.</p> <p>On 7/25/24 at 5:45 p.m., a progress note indicated R3 had a fall with bleeding at the back of her head.</p> <p>On 7/25/24, at 9:59 p.m., a progress note indicated R3 had a witnessed fall with a staff member in the hallway while walking to the dining room. R3 had shoes and a transfer belt. R3 reported weakness, lightheadedness, and feeling dizzy. The nursing assistant (NA)-A decided to get R3 her wheelchair, and saw R3 falling to the floor. R3 had laceration on the back of her head. R3 was lifted off the floor with a mechanical lift and three staff members. R3's range of motion to her extremities was normal. Staff cleansed the back of her head and began neuro checks.</p> <p>On 7/25/24 a note from the ER indicated R3 was treated for a 2 centimeter (cm) laceration to the posterior scalp with three staples. R3 had a head CT scan to rule out intracranial hemorrhage while in the emergency room and discharged back to the facility.</p> <p>Review of facility video surveillance footage on 7/25/24 showed NA-A and R3 as they walked out of room. A gait belt can be seen around R3's waist. R3 and NA-A took several steps together, then stopped. NA-A left R3 unattended in the hall and walked back into her room. R3 fell to left side to the floor in the hall as NA-A came out of the room with the wheelchair. The video did not include time stamps.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/29/24 a progress note indicated an interdisciplinary team (IDT ) review of the fall. Early evening 7/25/24 R3 experienced a fall during staff transfer assistance, which resulted in an injury to the back of her head. Emergency Medical Services (EMS) was contacted and R3 was brought to the emergency room (ER) for evaluation and treatment. She received three staples to the back of her head and returned to facility.</p> <p>On 7/31/24 at 3:03 p.m., licensed practical nurse (LPN)-A stated she was called on 7/25/24 just before 6:00 p.m. because R3 had fallen. Registered nurse (RN)-A told her the fall occurred in the hallway. Nursing assistant (NA)-A walked R3 out of her room, into the hallway with her walker. They stopped because R3 felt weak. NA-A walked away from R3 to get her wheelchair from her room, leaving her standing in the hallway with her walker. R3 then fell , NA-A should not have left R3 unattended related to her history of falls.</p> <p>On 8/1/24, at 9:13 a.m., NA-A stated she was working with R3 on 7/25/24, at 5:30 p.m., when R3 fell in the hallway. She was familiar with R3's care plan, and had reviewed R3's Kardex prior to providing cares, stating the Kardex is reflective of the resident's current care plan. The Kardex directed ambulation assist of one staff and a walker for R3. Once R3 walked out of her room into the hallway, she began to feel weak. She asked R3 if she wanted a wheelchair, and R3 stated she did. She knew she shouldn't have left R3 alone to get her wheelchair, but her coworkers were all in the dining room at the time, did not have a walkie talkie so she went into R3's room to get her wheelchair. As she came back into the hallway, she observed R3 fall. NA-A stated she was provided with re-education on 7/25/24, explained she should have remained in attendance with R3. NA-A stated she completed the mandatory re-education required by all staff in response to this incident and understands how to respond to a resident who becomes weak while ambulating.</p> <p>On 8/1/24 at 9:27 a.m., RN-B stated he became aware of the fall when he heard NA-A yell. He responded to the fall and assessed R3. He sent R3 into the ER for further medical treatment due to her head laceration. R3 had a history of falls, and should not have been left unattended. RN-B stated he participated in the required re-education in response to the this incident. RN-B stated staff are expected to remain with the resident at all times and call for help.</p> <p>On 8/1/24 at 10:43 a.m., RN-A stated NA-A should not have left R3 unattended, she should have called for help, keeping hold of the gait belt, and safely lowered R3 to the floor if she started to fall. Education was provided to NA-A immediately following the incident. RN-A stated she completed the mandatory re-education and understood the expectations to respond to a resident who became weak while providing assistance while ambulating.</p> <p>On 8/1/24, at 11:28 a.m., the director of nursing (DON) stated NA-A could have tried to yell for assistance or lowered R3 to the floor. NA-A was re-educated immediately following the incident. All nursing staff were educated over the following days.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Activities of Daily Living (ADLs) Policy and Procedure dated 3/15/21 directed based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. A resident will be given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. The facility will provide care and services for the following activities of daily living including mobility: transfer and ambulation, including walking.</p> <p>The re-education provided to all nursing staff, following the incident included the facility Procedure for Assisting a Weakening Resident During Ambulation to Prevent Falls directed:</p> <ol style="list-style-type: none"> <li>1. Stay close and maintain support.</li> <li>2. Communicate with the resident.</li> <li>3. Guide to a safe position.</li> <li>4. Supportive descent to the floor (if necessary).</li> <li>5. Stay with the resident.</li> <li>6. Call for help.</li> <li>7. Document and report the incident.</li> </ol> <p>By following these steps, staff can help prevent injuries from fall and ensure the safety and well-being of resident during ambulation.</p>