

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  12/19/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43367</p> <p>Based on interview and record review the facility failed to ensure dignified and respectful maintain or promote their quality of life for 2 of 3 residents (R2, R4) reviewed when services were not provided to empty bedside urinals and bathing was not provided as scheduled.</p> <p>Findings include:</p> <p>R2's admission Minimum Data Set (MDS) dated [DATE], identified he had moderate impaired cognition, sometimes socially isolated himself without behaviors. R2 had impaired mobility of one lower extremity and required partial to moderate assistance of staff for roll left/right, lying to sitting, sit to stand, chair/bed/chair/toilet transfers, and toileting hygiene. R2 was occasionally incontinent of bladder and continent of bowel. R2 used a walker and wheelchair for mobility. R2 had a diagnosis of benign prostatic hyperplasia (BPH) (enlargement of the prostate found just below the bladder and can block the flow of urine), diabetes mellitus, manic depression, and schizophrenia.</p> <p>R2's Kardex undated identified he required assistance with emptying urinal every shift, required assistance of one for shower every Friday evening (PM) shift, dressing and toileting. R2 required assist of one for bathing, uses urinal independently needs staff to empty.</p> <p>During interview/observation on 12/17/24 at 4:20 p.m. R2 stated the sign on the door leave me alone when the door was closed was the reason some staff told him they do not come into his room. R2 currently had three empty urinals located on his bedside table next to his bed. He wanted some privacy but still needed help with the urinals and staff to check on him. One week ago, a staff told him he was independent now and was able to empty his own urinals. During the night he had to urinate a lot, which was reason he had three full urinals sitting on his bedside table, the staff do not want to empty them especially during the night shift. When R2 uses his call light on to get them emptied it takes up to one hour for staff to assist him. R2 stated he was able to use the urinals himself but had to have more than one because he was afraid if one had filled up and used it again, he would spill urine on himself.</p> <p>During an observation on 12/18/24 at 10:47 a.m. R2's room door was open and located on his bedside table was a urinal 3/4 full of yellow colored urine visible from the hallway. R2 was not in his room.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's care plan dated 12/19/24 identified R2 had a self-care deficit related to impaired mobility and pain. Staff were directed to have assisted with cleaning post incontinence. R2 used urinal independently and needed staff to empty urinal.</p> <p>During an interview on 12/19/24 at 8:30 a.m. licensed practical nurse (LPN)-A stated staff were expected to go into R2's room at least every two hours and check to see if his urinal should be emptied. LPN-A stated R2 was unable to empty the urinals (had three of them) himself and required staff assistance. LPN-A stated when the urinal filled up, sat on his bedside table for a length of time would be considered an infection problem and could have spilled onto the floor. LPN-A stated every resident should be checked on at least every two hours to make sure their needs were met. LPN-A stated for R2 it was a dignity issue made him not want to be here because he was not getting the care he needed, and he felt bad about it. LPN-A stated she had talked to R2 about his lack of help he had received, and he was very frustrated about it. LPN-A stated she had planned to provide that information to the facility social worker.</p> <p>During an interview/observation on 12/19/24 at 8:50 a.m. R2's room door was open with television on. Three urinals were located on the bedside table visible from door. All three urinals had yellow urine in them: #1 urinal full (approximately 1000 milliliters (ml) ), #2 was 3/4 full (approximately 750 ml), #3 was 1/2 full (approximately 500 ml). R2 was in his wheelchair and stated my urinals were not emptied on nights and that was why there are three urinals almost full on my table. R2 stated staff had not checked on him this morning, been up since 5:00 a.m. and would have expected staff to empty the urinals before the night shift left. R2 place his call light on at 8:55 a.m. R2 stated he had urinary urgency problems, staff had scanned his bladder at times, saw a urologist, scheduled to see him again on January 14th, 2025, and still unable to urinate a lot at one time. He explained it was difficult for him to empty the urinals himself, unable to walk and carry the urinals, and a tight fit to get into bathroom with his wheelchair. He has had urinary accidents because he was unable to get into the bathroom and that was why he has used urinals instead. When the urinals filled up, he had to ask to have them emptied and felt like a burden, wished he could go home because it was hard to see people walk by and see them on the bedside table full of urine, and he felt embarrassed. R2 stated he had placed his call light on waited up to 45 minutes, went out and smoked a cigarette, returned to his room [ROOM NUMBER] minutes later, the call light was turned off and urinals remained on the table by the bed full of urine. He placed the urinals on the table next to the bed so that it would be high enough up for staff to see and they would be emptied but has not worked. R2 stated he was upset, frustrated, and no longer wanted to live at this facility and just need to move out. He had talked to the social worker and staff nurse about his concerns. At 9:05 a.m. (15 minutes later) nursing assistant (NA)-A entered the room, asked what R2 needed, applied gloves, emptied the urinals, removed gloves, washed hands, and exited the room.</p> <p>R4's admission MDS dated [DATE], identified intact cognition without behaviors. R4 had an impairment on upper extremity located on one side. R4 required partial to moderate assistance with personal hygiene, substantial to maximal assistance with roll left and right, sit to lying, lying to sit, sit to stand, chair/bed/chair and toilet transfers, and dependent for toileting hygiene and ambulation. R4 used a wheelchair for locomotion. R4 was frequently incontinent of bowel and bladder. R4's diagnoses included cancer, peripheral vascular disease (PVD), diabetes mellitus, and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R4's care plan dated 12/19/24 identified she had a self-care deficit, limited mobility, and directed staff to have provided assistance of one for personal hygiene and toileting, and transfers with front wheeled walker. R4 had an alternation in urinary elimination, overflow bladder incontinence, and directed staff to have provided incontinence cares after each incontinent bowel or bladder episode. R4 preferred to use bed side commode.</p> <p>R4's Kardex date 12/19/24 identified she required assistance of one for bathing on Tuesday and Friday morning (a.m.), dressing, transfers, personal hygiene, and offer and assist with toileting.</p> <p>R4's bath schedule dated 12/16/24 identified her bath was scheduled for Tuesday morning (a.m.).</p> <p>R4's bath schedule undated, identified her bath times were changed to two days a week and scheduled for Tuesday and Friday a.m.</p> <p>R4's NA bathing documentation from 11/29/24 through 12/17/24 identified:</p> <ul style="list-style-type: none"> <li>-11/29/24 physical help required.</li> <li>-12/6/24 did not occur.</li> <li>-12/10/24 did not occur.</li> <li>-12/13/24 total dependence required.</li> <li>-12/17/24 did not occur.</li> </ul> <p>R4's urinary toileting record from 12/1/24 through 12/5/24 identified:</p> <ul style="list-style-type: none"> <li>12/1/24 at 12:45 a.m. refused</li> <li>12/1/24 at 1:53 p.m. continent</li> <li>12/2/24 at 1:59 p.m. continent</li> <li>12/2/24 at 9:59 p.m. incontinent</li> <li>12/2/24 at 11:15 p.m. continent</li> <li>12/3/24 at 1:59 p.m. continent</li> <li>12/3/24 at 9:49 p.m. incontinent</li> <li>12/4/24 at 2:56 a.m. continent</li> <li>12/4/24 at 1:59 p.m. continent</li> <li>12/4/24 at 8:46 p.m. incontinent</li> </ul> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/4/24 at 11:57 p.m. incontinent</p> <p>12/5/24 at 1:55 p.m. incontinent</p> <p>12/5/24 at 9:19 p.m. incontinent</p> <p>R4's Treatment Administration Record (TAR) for the month of November 2024, there was no order entered for bath/shower to be signed off that it was given.</p> <p>R4's TAR from 12/1/24 through 12/19/24, identified ensure resident received scheduled bath/shower every day shift every Tuesday and Friday. Order date 12/13/24 at 1:37 p.m. On 12/17/24 signed off No (N).</p> <p>During an interview on 12/18/24 at 11:19 a.m. R4 stated it was hard to get staff into her room for assistance to the bathroom and the long wait times frequently resulted in her having urinary incontinence, wetting herself in her pants. It made her feel awful, embarrassed. R4 stated she took water pills (a medication to excrete excess fluid from the body). About two weeks ago, she had to use the bathroom and could not wait any longer then had urinate in her pants. R4 stated a person should have not had to wait that long to get some help but was now able to take myself to the bathroom. There are still days when she is tired when staff need to help her to the bathroom though. R4 stated would have liked a shower twice a week but there were times when she was unable to get one shower a week. She was scheduled to have a shower yesterday; staff came and asked her if she was ready and was just going to have breakfast. She waited for someone to come after breakfast, but no one came back. She said her last shower was last Friday (5 days ago), her hair needed to be washed, and scalp felt itchy. R4's hair appeared unkept and uncombed. She was ok at times with one shower a week but then had to go two weeks without one in the past month, one of those days the facility had no hot water about two weeks ago. R4 stated her family had not assisted with her weekly bathes.</p> <p>During an interview on 12/18/24 at 2:16 p.m. NA-C stated he had transferred R4 on and off toilet in the a.m. and then therapy came in and worked with her around 11:00 a.m. R4 was supposed to have a assistance with bathing, did not offer to assist her with washing up, it did not get done. NA-C stated it was staff responsibility to have helped R4 and to check back with her. NA-C identified on the shower/bath schedule located on a clip board dated 12/16/24, indicated R4 was scheduled for a shower one day a week on Tuesdays. NA-C stated if R4's frequency of a bath had changed staff was not aware of it, they followed the bath schedule.</p> <p>During an interview on 12/19/24 at 1:38 p.m. NA-B stated staff were expected to have checked on each resident at least hourly. Resident urinals should have been emptied at least on each walk around and/or as soon as you saw urine in them. It would be important to keep them empty, and not have them sitting around for an extended amount of time because it could cause infection, and the resident might be unable to use the urinal if it is full due to spillage of urine. NA-B stated the urinals should be emptied as soon as possible after use, dumped in the bathroom toilet, and rinsed out. NA-B stated a urinal with urine in it and visible to others can affect dignity and not pleasant for others to see and could embarrass a resident. On 12/17/24 NA-B charted no bath was given to R4 and verified she had not received her bath that day due to staff called in sick and they ran behind all day. When this happens, the evening (p.m.) shift should have done R4's bath and it was missed. NA-B stated he was not aware R4's bathes had increased to two times a week the bath schedule should have been updated to reflect that.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/24 at 1:55 p.m. floor manager LPN-B stated staff were expected to offer the resident a bath/shower once a week. R4's bathes were changed from one a week to two a week and should have started on 12/13/24. LPN-B stated the bath/shower would have been important to monitor skin, general hygiene, to prevent skin breakdown and dignity in general.</p> <p>During an interview on 12/19/24 at 3:09 p.m. director of nursing (DON) staff was expected to complete hourly safety rounds, turn/reposition/toileting every 2 to 3 hours, and a.m. morning cares to have included: wash face/hands/all crevasses/abdominal folds, perineal cares, toileting, comb hair, and brush teeth. DON stated staff were expected to empty urinals if in the resident's room and saw it being used and for sure at the end of the shift as well. DON stated the urinals get smelly and bacteria grows when not emptied.</p> <p>During an interview on 12/19/24 at 3:30 p.m. administrator stated one of R2's interventions was for staff to empty his urinals but R2 was able to empty his own urinal and struggled with motivation to do it himself. The administrator stated a urinal full of urine located on the table could be a dignity issue when people walked by his room, and it was visible.</p> <p>Facility policy Activities of Daily Living (ADLS) dated 3/15/21, the facility must provide necessary care and services consistent to the resident's needs and choices and to maintain or improve his or his ability to carry out the activities of daily living. The facility will provide care and services such as hygiene: bathing, dressing, grooming and oral cares and elimination/toileting.</p> <p>Facility policy Resident Rights: Dignity dated 10/24/23, identified the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence and to be treated with respect, kindness, and dignity.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367</b></p> <p>Based on observation, interview and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 6 of 6 residents (R2, R3, R4, R5, R6, R7) reviewed who had food concerns. This deficient practice had the potential to affect all 63 residents residing in this facility.</p> <p>Findings included:</p> <p>Review of November 2024 grievances identified dinner was cold 11/11/24 and 11/12/24.</p> <p>Review of resident council meeting minutes dated 12/2/24 at 11:00 a.m. identified three officers and seven residents in attendance. Dietary: meals were still cold. The overview of action plan included a chart: current situation, what is our goal, what do we need to get there, who will help us get there, and status (resolved, not resolved/action needed, partially resolved/further steps needed) was left blank.</p> <p>During an interview on 12/17/24 at 9:30 a.m. family member (FM) stated sometimes the food was undercooked, chicken was pink, overcooked vegetables such as broccoli were mushy, and cold such as pizza, toast, and eggs. FM stated there were times when the biscuits and French toast were hard, and the residents could not bite into them. FM stated she had brought in food for her family member and warmed it up in the microwave.</p> <p>During an interview on 12/17/24 at 3:40 p.m. R3 stated this morning the temperature of food was cold. His French toast sticks and a tiny piece of ham steak was cold, hard, and tough to bite into. On other occasions when food was cold, he would tell staff and sometimes they offered to warm up his meal but then it became hard and unable to eat. Today R3's lunch included spaghetti and meatballs, broccoli, which were cold, and the sherbet was melted. He had seen the meal cart located in the hallway up to 30 minutes before the meal was served to residents. R3 stated we have the option of going to the dining room or stay in our rooms, and he had done both.</p> <p>During an interview on 12/17/24 at 4:21 p.m. R2 stated meals were frequently served late and the hot food was cold and overcooked most of the time. R2 stated pancakes edges were crispy, hard to cut with a knife and eat. R2 stated the garlic bread was chewy and unsure why. R2 stated he had informed the manager of the kitchen of the concerns but was hard to talk to and things had not improved.</p> <p>Facility regular dinner menu dated 12/17/24, identified:</p> <p>Homemade vegetable beef soup</p> <p>Grilled cheese sandwich</p> <p>Marinated cucumbers</p> <p>Cinnamon applesauce</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Milk</p> <p>During a continuous observation on 12/17/24 at 5:16 p.m. located in main dining room [ROOM NUMBER] residents sat at tables and waited for supper to be served. At 5:20 p.m. noted from kitchen doorway two staff placed the food onto the plates with gloves on. The grilled cheese sandwiches were located in the steam table and when removed cut up in half or fourths with a large knife. The vegetable beef soup was located in a large metal pot located on the steam table and steam was seen coming from the top of the soup after it was placed into a bowl for each resident. At 5:40 p.m. R6 sat at table in dining room, yelled out twice can I get a sandwich that was not cold cannot eat this one. An unidentified staff went over to R6, removed her grilled cheese sandwich, brought it into the kitchen and at 5:42 p.m. returned with a grilled cheese sandwich. R6 stated thank you, took a bite and stated the sandwich was warm. R6 stated food was served cold frequently, wait time was long for meals to be served, and was frustrated, would have liked a hot meal once without requested to be warmed up. R6 stated the soup was too hot and blew on it until it was the temperature she wanted and ate the grilled cheese sandwich.</p> <p>Review of the Food Temperature Log on 12/17/24 at approximately 5:45 p.m. identified dinner food temperatures were documented once at an undetermined time:</p> <p>Soup 180 degrees Fahrenheit (F.)</p> <p>Regular meat 175 degrees F.</p> <p>Ground meat 175 degrees F.</p> <p>Vegetable 180 degrees F.</p> <p>Pureed vegetable 180 degrees F.</p> <p>Starch 185 degrees F.</p> <p>Alternatives 165 degrees. F</p> <p>Dessert 35 degrees F.</p> <p>Milk/juice/coffee 35 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation/interview on 12/17/24 at 5:48 p.m. cook (C)-A had placed a cut grilled cheese sandwich along with a bowl of soup on a plate and it was delivered by an unidentified staff to a resident in the dining room. C-A stated the foods that remained on the steam table she had just finished serving at 5:45 p.m. to residents were grilled cheese sandwiches and vegetable beef soup. C-A stated she had checked the temperature of the hot foods prior to when she started to serve the meals and entered the temperatures onto the log sheet. C-A stated she had never checked temperatures on the food during serving. C-A stated a female resident had complained the grill cheese sandwich was cold and her sandwich was replaced three times. At 5:52 p.m. C-A was asked to check the temperature on one of the grilled cheese sandwiches that remained in the steam table. Kitchen manager (KS) walked over to steam table and placed the thermometer into the center of a sandwich while it remained in the steam table and verified it was 124 degrees F. KS stated the temperature of the grilled cheese sandwich was low, should have been above 130 degrees F. or higher, and verified the steam table remained turned on. KS stated they had been having issues with the steam table, sometimes warmed up but not hot enough, and waited on verification of a new steam table. KS stated in the meantime, staff were expected to have checked food temperatures to make sure they were they should be and served safely. KS wiped off end of thermometer and place the end of it into the large pot of vegetable soup and read 182 degrees F. stated should have been 135 to 160 degrees F. but 182 degrees F was fine. KS stated those foods were safe to have been served to the residents.</p> <p>Facility regular noon menu dated 12/18/24, identified:</p> <ul style="list-style-type: none"> <li>-pork chops</li> <li>-cream gravy</li> <li>-roasted butternut squash</li> <li>-French green beans</li> <li>-banana cream cheesecake</li> <li>-milk</li> </ul> <p>Facility Temperature Record for lunch dated 12/18/24, indicated all hot foods must be held at 140 degrees Fahrenheit (F) or higher. Recommended temperature for foods held on the serving line is 160 to 180 degrees F. Identified food temperatures were documented once at an undetermined time:</p> <p>Regular meat 180 degrees F.</p> <p>Ground meat 180 degrees F.</p> <p>Vegetable 176 degrees F.</p> <p>Starch 176 degrees F.</p> <p>Gravy 168 degrees F.</p> <p>Alternatives 177 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dessert 169 degrees F.</p> <p>Milk/Juice/Coffee 169 degrees F.</p> <p>During an observation on 12/18/24 at 12:00 p.m. over 20 residents sat at tables in the large dining room while staff served them lunch.</p> <p>During an observation on 12/18/24 at 12:20 p.m. no residents remained in large dining room. At least 15 plates were observed on the tables with approximately up to 50 % of the food remained on the plates.</p> <p>During an observation on 12/18/24 at 12:25 p.m. two kitchen staff, C-B, and dietary aide (DA) prepared plates of food to be delivered to the resident rooms. The resident plates were stacked freely on the counter. C-B dished up hot foods (pork chops in sour cream gravy, squash, French green beans located in the steam table, the steel container of carrots was located outside of the steam table on top of steam table covers, placed the foods on a plate on top of a silver steel plate from a stack located on the counter. DA placed a cover that had a hole in the top of it over the plate of food and a piece of banana cream cake with whipped topping on each tray. DA placed each tray onto a shelf into a large brown colored cart. There were steel containers located on top of the steam table covers over the third and fourth well with foods in them: pureed meat, carrots, mashed potatoes, minced pork meat, squash, and boneless chicken breasts. At 12:40 p.m. all trays of food were loaded up into the brown cart and the doors were closed. C-B confirmed the steam table remained turned on (all four burners). C-B stated she had taken the temperature of all the foods when she cooked them and again prior to serving them to residents. C-B stated she had entered the temperatures into the log sheet. C-B stated the steam table was turned on hours before the food was placed in there at 6:00 a. m. C-B stated there were four knobs one for each part of the steam table to total four knobs. Four sections in the steam table were observed. C-B stated she had set the first knob and turned it one click to the right and the same with knob three and four. C-B stated there were no markings on the knobs that indicated what each one was set at. C-B stated the second knob was the only one out of the four that had a silver plate with markings on it so that she knew to set it just below high. C-B verified three of the four dials were missing the silver plate and each dial was for a separate section of the steam table. At 12:45 p.m. C-B completed a temperature check on the following foods:</p> <p>Pork chops in sour cream gravy (no meat remained in the large metal container located in the steam table first section) Large amount of sour cream gravy remained in the metal tray located in the steam table section one and was temped at 167 degrees F.</p> <p>French green beans (located in the steam table first section) 162 degrees F.</p> <p>Food that was located out of the steamer and on top of the metal covers that were placed on top of the steam table section three and four:</p> <p>Chicken boneless 127.0 degrees F. C-B stated she had placed in steamer and just removed it prior to when surveyor came into the kitchen.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Sliced carrots (approx. four inches of carrots in bottom of metal container) 101.4 (stated should be at least 150 degrees F. or higher) were not located in the steam table and C-B stated they were just served to residents. C-B stated the temperature of the carrots was not up to 150 or higher and should have not been served to the residents.</p> <p>Pureed pork chops 92.0 degrees F. C-B stated they should have been at least 160 degrees F. and not sure why they were so cold, had not been that long since they were served, and the steam table should have kept these hot.</p> <p>On 12/18/24 at 12:55 p.m. kitchen manger (KM) entered the large kitchen and walked over to the steam table. Foods were not placed in the steam table and located on top of the metal covers that were placed over the steam table. The following foods were checked by KM for temperatures:</p> <p>Pureed pork 101.0 degrees F.</p> <p>Mashed potatoes 135.0 degrees F.</p> <p>Minced pork meat 104.0 degrees F.</p> <p>Squash 90.0 degrees F.</p> <p>French green beans 100.0 degrees F. located in the steam table. Previous observation identified the green beans were served /delivered to more than 10 residents until 12:40 p.m.</p> <p>KM stated the steam table should have maintained the expected temperature for all the hot foods and where the temperatures should presently be at so that the temperatures were kept at where it would be servable. KM stated not sure why would have collected temperatures of these foods now that they were done serving.</p> <p>On 12/18/24 at 1:00 p.m. while steam table remained turned on surveyor requested a scoop of gravy from pork chop pan located in first section of steam table, French green beans located in the steam table and sliced carrots located in a metal container on top of the metal covers over the steam table be placed on a plate to sample. KM and surveyor sampled the carrots, and both agreed they were not hot, and KM stated just warm, and surveyor identified them as cold. Surveyor sampled the gravy and green beans and were warm. KM stated unsure why the food needed to be sampled now, the residents had already been served their meal.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the interview on 12/18/24 at 1:01 p.m. KM stated all food for the facility and assisted living was made in this large kitchen. Once the cook has made the food they are expected to check all the temperatures, divide it up and place in holding ovens set at 225 degrees F. KM stated one hour prior to serving the steam tables should have been turned on and one to two inches of water added to the bottom of each well, there were four wells in the steam table on the mainline. KM stated the mainstream table had four dials only one had numbers and the other three did not. KM stated it was an old piece of equipment and he instructed his staff to turn the unmarked dials one click to the right when there was steam it was working properly. KM stated the water in the steam table wells could have been tested for the temperature but had not been done. KM stated was not aware or been told by kitchen staff the steam table had not been working properly. KM stated when water was steaming would guarantee it was over 200 degrees F. KM verified C-B would have been expected to have used a perforated pan placed in the steamer for the pureed foods and carrots to have maintained correct temperatures. Those foods that we temped were not servable due to low temperatures that should have been maintained throughout the serving of the meal. KM stated none of the pureed food or the carrots were placed in the team table as expected. KM stated he was aware of resident complaints of cold food during the resident council meeting and completed an audit. KM stated the audit showed the food stayed hot only if the steel plate warmers and a lid were used and served in a timely manner before 12:30 p. m. (copy of two audits were received and dated 10/10/24 and 10/11/24). KM stated would have expected staff to have turned on the plate warmer and those plates used to keep the food hot. KM stated staff would be expected to re-temp foods that no longer seemed warm enough. KM stated residents could have gotten sick if the pork they served was under 165 degrees F. and should have been thrown out. KM stated the vegetables and gravy should have been maintained at to at least 165 degrees F. to have been safe to be served and eaten. KM stated he assumed the pureed meat temperature were taken to meet the requirements for safety to eat and should have been entered on the log form, but the temperatures were not on the form. KM stated all foods are to be expected to be temped and meet the recommended temperature guidelines prior to serving otherwise service would have to wait until the correct temperature has been reached. KM stated the log form required adjustments so that all foods temped were documented.</p> <p>On 12/18/24, DM provided surveyor an untitled dietary log form that listed all three meals (breakfast, lunch, and supper) for one week with each type of food to have been served during that meal with the acceptable temperature(s) required. DM stated this was the log form the cooks were required to use when they served meals, and they were currently using the wrong form. Each section at the top listed the day of the week with three boxes located below that labeled beginning, middle and end and included a column below each one for the meal.</p> <p>Lunch section identified:</p> <p>Meat/entree 160 to 180 degrees F.</p> <p>Ground Meat/Entree 160 to 180 degrees F.</p> <p>Pureed Meat/Entree 160 to 180 degrees F.</p> <p>Alternative Entree 160 to 180 degrees F.</p> <p>Gravy 180 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Potato/Starch 160 to 180 degrees F.</p> <p>Pureed Potato 160 to 180 degrees F.</p> <p>Main Vegetable 160 degrees F.</p> <p>2nd Vegetable 160 degrees F.</p> <p>Pureed Vegetable 160 degrees F.</p> <p>Soup 170 to 190 degrees F.</p> <p>Alternative Soup 170 to 190 degrees F.</p> <p>Cold Entree/Vegetable 40 degrees F.</p> <p>During a follow up interview on 12/18/24 at 10:55 a.m. R3 stated he had gone to the dining room for supper last night. R3 stated the grilled cheese sandwich was cold and hard. R3 stated was unable to eat the sandwich and had not requested anything different.</p> <p>During an interview on 12/18/24 at 11:15 a.m. R4 stated has had cold food and/or that was barely warm. R4 stated went to the dining room last night for supper. R4 stated the cheese on the grilled cheese sandwiches was not melted and cold. R4 stated staff offered to warm up food when requested.</p> <p>During an interview on 12/18/24 at 4:40 p.m. R7 stated the food during meals was occasionally cold such as sandwiches. R7 stated when she had chosen to eat in her room the food arrived lukewarm and usually colder than what she had received in the dining room. R7 stated there were many times she had made her own sandwich out of her refrigerator located in the room. R7 stated she had not told anyone but felt she should have.</p> <p>During an interview on 12/19/24 at 9:35 a.m. R5 stated usually went to dining room for meals. R5 stated food was good except the hot food was cold, especially the eggs. R5 stated there had been discussion at resident counsel and there were concerns about cold food. R5 stated food was cold the same for all meals, no specific one and this really should not have been happening.</p> <p>Facility policy titled Safe Food Temperatures dated 3/2023, identified foods are to be maintained at a safe a palatable temperature during meal service. Safe food temperatures conform to Hazard Analysis Critical Control Points (HACCP) principles (an internationally recognized method of identifying and managing food safety related to risk and can provide assurance to customers that a food safety program is well managed). All hot foods were to be held at 150 degrees F. or above. Staff were directed to have taken temperature on all foods on the steam table prior to serving and at the end of the serving. If serving had taken longer than 30 minutes, temperatures would also be expected to be taken during the middle of the serving to ensure food were at their optimum holding temperatures. Food temperatures which fail to reach or maintain acceptable minimum temperatures would be required to have received corrective action such as reheated until the acceptable temperature was reached. Completed temperature records would be kept on file.</p>		