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	05/15/2024

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 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. 37905 Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 1 of 4 residents (R54) who had a soiled wet shirt reviewed for dignity. Findings include: R54's quarterly Minimum Data Set, dated dated dated (MDS) 4/11/24, identified R54 was cognitively intact and had diagnoses which included: quadriplegia (paralysis that affects both arms and legs) and traumatic brain injury. Identified R54 was dependent on staff for dressing, bathing and personal hygiene. R54's care plan revised 1/8/24, identified R54 had activities of daily living (ADL) self-care performance deficit related to quadriplegia, morbid obesity, weakness, and dependency on staff. Interventions included assist of one for dressing and dependence for personal hygiene. During an observation and interview on 5/14/24 at 9:17 a.m., R54 was seated in his electric wheelchair in the therapy room. R54 had an irregular shaped wet and brown soiled area on his shirt by the neckline approximately 3-4 inches in diameter. R54 used a communication board during interview, and indicated it bothered him and made him feel uncomfortable that his shirt was soiled and wet. R54 stated he used a towel at home to keep his shirt clean and dry. During an observation on 5/14/24 at 4:22 p.m., R54 continued to have the wet soiled area on his shirt, which appeared larger now, approximately 4-5 inches in diameter. At 5:57 p.m. R54 was seated in his wheelchair in the dining room, now wearing a clothing protector however, was wearing the same shirt. During an interview on 5/14/24 at 6:01 p.m., nursing assistant (NA)-H indicated she had not completed any cares for R54 yet, however, had seen him sitting in the dining room watching television. NA-H stated she had not noticed R54's shirt was soiled and wet and would check him after the supper meal was over. NA-H stated R54 drooled at times, and would have a little wetness on his shirt as a result and if it was a larger spot they would change his shirt. NA-H stated a visibly soiled shirt would affect R54's dignity. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 5/15/24 at 2:04 p.m., NA-H stated R54's shirt was wet and soiled yesterday evening and it appeared to be from drool and chocolate pudding or something similar. NA-H stated she had asked R54 if he wanted his shirt changed and R54 stated he wanted his night gown put on at that time. NA-H stated if she had observed it sooner, she would have asked him if they could change his shirt. During an interview on 5/15/24 at 2:00 p.m., clinical manager registered nurse (RN)-B stated R54 had quadriplegia and communicated with a communication board. RN-B indicated R54 was cognitively intact. RN-B stated if R54's shirt became soiled, she would expect musing staff to change the shirt right away for R54's dignity and comfort. During an interview on 5/15/14 at 2:24 p.m., interim director of nursing (IDON) stated her expectations were if a resident's shirt was soiled or wet, she would expect nursing staff to change it. IDON stated it was important to complete that task in order to maintain a resident's dignity. Review of facility policy titled Resident Rights: Dignity revised 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 promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents.

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 05/15/2024
NAME OF PROVIDER OR SUPPLIER: Edenbrook of St Cloud		STREET ADDRESS, CITY, STATE, ZIP CODE: 1717 University Drive Southeast Saint Cloud, MN 56304	

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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 - Few	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** 37905 Based on observation, interview and document review, the facility failed to ensure housekeeping services were provided for a clean environment for 1 of 2 residents (R115) who had a soiled privacy curtain and floor. Findings include: R115's admission Minimum Data Set (MDS) dated [DATE], identified R115 was cognitively intact and had diagnoses which included anxiety, depression, hip and ankle replacement, and aftercare following joint replacement surgery. During an observation and interview on 5/13/24 at 6:58 p.m., R115 indicated her family was unhappy because her room was filthy. R115 pointed to the privacy curtain which had brown smears and spots covering eight to 10 inches across the bottom center of the curtain. In addition, R115 indicated the floor was not cleaned often and the cupboards needed to be wiped down. R115's floor had dust, crumbs, plastic medication cups and a wadded paper towel under her bed. A drip/spill was noted on the outside of her wardrobe closet. R115 said it had been four to five days since they mopped her floor and indicated they did not mop under the bed. During an observation on 5/14/24 at 2:32 p.m., R115 was lying in her bed, and stated her room was still dirty and the curtain was gross. Areas of dark brown spots and smears continued to be present on the bottom portion of the privacy curtain. R115's floor continued to have dust, crumbs, plastic medication cups and a wadded paper towel under the bed. During an interview on 5/14/24 at 2:37 p.m., housekeeper (HSK)-B indicated her usual practice for resident room cleaning included wiping down handles, bathroom, main area, to sweep and mop the room, including under the bed. HSK-B stated when a curtain was noted to be soiled, they would take them down and replace them. HSK-B observed R115's room, confirmed the curtain was soiled and verified the floor was not clean under the bed. HSK-B said it appeared it had been at least a couple of days since staff had swept under the bed. During an interview on 5/14/24 at 2:52 p.m., housekeeping lead (HSKL) indicated when a floor appeared to be clean then her usual practice was to sweep and mop the floor once or twice a week. HSKL indicated her expectations for cleaning the floors included to move the bed and sweep and mop under the beds as well. HSKL indicated the facility's usual practice was to remove and replace the privacy curtain once a resident moved out, during a turn over, (a deep cleaning of the room), such as when R115 would move out of her room. HSKL stated she would expect the curtain to be taken down if it became soiled. HSKL indicated she was unaware if R115's privacy curtain had been changed prior to her moving into the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 5/15/24 at 10:09 a.m. R115 stated her curtain was soiled when she arrived at the facility, and indicated she had tried to stay away from it, yuck. R115 said she noticed her floor dirty under her bed a day or two after she arrived. R115 said she was concerned about all the dust, that it may affect her breathing. R115 said there were three to four people in her room yesterday cleaning it and her privacy curtain had been changed. The facility policy titled Cleaning A Resident Room revised 5/8/24, procedures included: wash closets/wardrobe-inside and out, thoroughly mop entire floor with approved cleaning solution (under furniture, behind doors, along baseboards). The facility form titled Deep Clean Sheet, undated, tasks included: move bed and furniture to sweep & mop underneath, wipe out nightstands, closets and dressers, and check privacy curtain for stains (remove if dirty and send to wash).

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview and document review, the facility failed to change soiled clothing for 1 of 3 residents (R54) reviewed for activities of daily living (ADL's). In addition, the facility failed to remove facial hair for 1 of 3 residents (R36) who was dependent on staff for assistance with grooming and personal hygiene. Findings include: R54's quarterly Minimum Data Set (MDS) dated [DATE], identified R54 was cognitively intact and had diagnoses which included: quadriplegia (paralysis that affects both arms and legs) and traumatic brain injury. Indicated R54 was dependent on staff for dressing, bathing and personal hygiene. R54's care plan revised 1/8/24, identified R54 had an ADL self-care performance deficit related to quadriplegia, morbid obesity, weakness and dependency on staff. Interventions included assist of one for dressing and dependent for personal hygiene. During an observation and interview on 5/14/24 at 9:17 a.m., R54 was seated in his electric wheelchair in the therapy room. R54 had an irregular shaped wet and brown soiled area on his shirt by the neckline approximately three to four inches in diameter. R54 used a communication board during interview, and indicated it bothered him and made him feel uncomfortable that his shirt was soiled and wet. R54 stated he used a towel at home to keep his shirt clean and dry. During an observation on 5/14/24 at 4:22 p.m., R54 continued to have the wet soiled area on his shirt, which appeared larger, approximately four to five inches in diameter. At 5:57 p.m., R54 was seated in his wheelchair in the dining room, now wearing a clothing protector, however continued to wear the same shirt. During an interview on 5/14/24 at 6:01 p.m., nursing assistant (NA)-H indicated she had not completed any cares for R54 yet. NA-H stated she had not noticed R54's shirt was soiled and wet, however would check him after the supper meal was over. NA-H stated R54 drooled at times,would have a little wetness on his shirt however, if it was a larger spot they would change his shirt. During a follow up interview on 5/15/24 at 2:04 p.m.,NA-H stated R54's shirt was wet and soiled yesterday evening and it appeared to be from drool and chocolate pudding or something similar. NA-H stated she had asked R54 if he wanted his shirt changed and R54 stated he wanted his night gown put on at that time. NA-H stated if she had noticed it sooner, she would have asked him if they could change his shirt. During an interview on 5/15/24 at 2:00 p.m., clinical manager registered nurse (RN)-B stated R54 had quadriplegia and communicated with a communication board. RN-B stated R54 was cognitively intact. RN-B indicated if R54's shirt was soiled, she would expect staff to change it right away. 45844 R36 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36's significant change MDS dated [DATE], identified R36 had severe cognitive impairment and had diagnoses which included hypertension (elevated blood pressure) Benign Prostatic Hyperplasia (condition in men where the prostate gland is enlarged), and traumatic brain injury. Identified R36 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and personal hygiene. R36's current care plan last revised 8/22/23, indicated R36 had deficits with ADL's related to weakness and impaired cognition. Indicated R36 required staff assist with personal hygiene. R36's significant change Care Area Assessment (CAA) dated 3/25/24, identified R36 was dependent on staff for ADL's. During an observation on 5/13/24 at 2:30 p.m., R36 was lying in bed and had several gray one inch long facial hairs present on his cheeks, chin and above his lips. During an interview on 5/13/24 at 2:39 p.m., family member (FM)-A stated R36 preferred to have a mustache however, always shaved the rest of his face every day. FM-A stated at times someone in the family would shave R36 at the facility because his facial hair was long. During an observation on 5/14/24 at 8:03 a.m., R36 was seated in his wheelchair in the dining room. R36 continued to have several gray one inch long facial hair present on his cheeks and on his chin. During an interview on 5/14/24 at 8:16 a.m., nursing assistant (NA)-A stated R36 required staff assistance to shave facial hair. NA-A stated she had assisted R36 with cares that morning however, had not offered to assist R36 with shaving and was unsure of the last time R36 had been shaved. During an interview on 5/14/24 at 8:20 a.m., licensed practical nurse (LPN)-A stated R36 required staff assistance to shave facial hair. LPN-A verified R36 had several long facial hairs present and was unsure of when the last time R36 had been shaved. LPN-A stated her expectation was that staff would have shaved R36 daily or when facial hair was present. During an interview on 5/14/24 at 4:44 p.m., interim director of nursing (IDON) indicated R36 required staff assistance with shaving. IDON stated her expectation was R36 would have been shaved daily or when facial hair was present. During an interview on 5/15/14 at 2:24 p.m., IDON stated her expectations were if a resident's shirt was soiled or wet, staff would change it. Review of a facility policy titled Activities of Daily Living (ADL's) dated 3/15/21, indicated the facility would provide care and services such as hygiene, bathing, dressing, and grooming. Indicated ADL's would be provided based on resident preferences.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620 Based on observation, interview, and document review, the facility failed to ensure timely assistance with repositioning and failed to implement care planned interventions for 1 of 4 resident (R26) with current pressure ulcers and at risk for further development of pressure ulcers. Findings include: R26's quarterly Minimum Data Set (MDS), dated [DATE], identified R26 had diagnoses which included cognitive impairment, hypertension,dementia and anxiety. R26 required total assistance of two staff for bed mobility and transfers. Indicated R26 was a risk for pressure ulcers, currently had an unhealed pressure ulcer in foot. R26's comprehensive Care Area Assessment (CAA), dated 2/14/24, identified R26 was at risk for skin breakdown and potential pressure ulcers due to requiring total assistance with bed mobility. R26's care plan revised on 5/15/24, identified R26 had actual complications with impaired skin integrity related to a pressure ulcer on the right heel. Indicated R26 was to have heel protectors on while in bed and staff were to reposition every two hours. R26 was dependent on staff for all cares. Special air mattress to bed to relieve pressure. Check each shift to make sure pressure was correct. During an observation on 5/14/24 at 2:43 p.m., R26 was laying in bed without heel protectors on, heels rested on the mattress and the air mattress for the bed was off. During an observation on 5/14/24 at 3:56 p.m., R26 was laying in bed without heel protectors on, heels rested on the mattress and the air mattress for the bed was off. During continuous observations on 5/15/24 from 7:04 a.m. to 10:25 a.m., revealed the following: -R26 was seated in wheelchair (Broda chair-specialized tiltable wheelchair) at area near nurses desk. -R26 was seated in the dining room being assisted with breakfast. R26's feet rested on wheelchair foot pad. - R26 continued to be in the same position. R26 was seated at the dining room table talking with other residents. - R26 was pushed back to area by nurses station. - R26 continued to sit in her wheelchair by the nurses station. - R26 continued to sit in her wheelchair in the same location by the nurses station. - R26 continued to sit in her wheelchair in the same location by the nurses station. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R26 continued the same position and in the same location. - R26 continued the same position and in the same location. - At 10:22 a.m., infection preventionist (IP) and licensed practical nurse (LPN)-D assisted R26 to lay down in bed when prompted by surveyor. R26 was covered with a blanket. R26 had not been offered to reposition every two hours as directed by her care plan. R26 had not been offered to be or repositioned for a total of three hours and 21 minutes during the entire observation. During an interview on 5/15/24 at 2:00 p.m., nursing assistant (NA)-F identified staff completed all activities of daily living (ADLs) for R26. NA-F stated R26 was to be transferred with two people and the hoyer lift. NA-F stated R26 required total assistance with turning and repositioning. NA-C indicated she was unaware of the order to place heel protectors on R26's heels while in bed. NA-F stated R26 did not have heel protectors on when NA-F assisted R26 out of bed that morning. NA-F was unaware if R26 had a special air mattress to her bed. During an interview on 5/15/24 at 10:28 a.m., IP indicated staff were expected to reposition R26 every two hours. IP reviewed and confirmed the above orders for R26. IP explained R26 had a wound on her right heel that staff were to complete dressing changes and to monitor. IP confirmed R26 was laying on her right side and did not have heel protectors on R26's heels. IP was unaware the special air mattress was not on and attempted to turn it on. The air mattress did not turn on and IP indicated she would change it out when R26 was assisted up for lunch in a few hours. IP was not aware R26 had been sitting in the same position since 7:04 a.m. IP did not place heel protectors on R26. IP indicated her expectations were staff would reposition residents every two hours and were to follow the provider's orders along with resident's care plans. During an interview on 5/15/24 at 3:41 p.m., director of nursing (DON) was not aware R26 had not been repositioned within two hours. DON confirmed the above findings and explained R26 should not have experienced prolonged sitting. DON indicated staff should have placed heel protectors on R26 while in bed. DON stated her expectations were staff would be following providers orders and if staff were unable to complete the orders they would inform the DON or charge nurse. Review of facility policy titled Turning and Repositioning dated 8/1/15, would be to provide comfort to the resident, to prevent skin irritation and breakdown, and to promote good body alignment. Indicated dependent residents would be turned every two hours. Float the heels off the bed if the resident is at risk for heel breakdown.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview and document review, the facility failed to provide hand splinting and range of motion (ROM) services to prevent a potential decrease in ROM for 1 of 2 residents (R11) reviewed who required hand splinting and range of motion for restorative nursing exercises. Findings include: R11's significant change Minimum Data Set (MDS) dated [DATE], identified R11 had moderate cognitive impairment and had diagnoses which included stroke, hemiplegia (paralysis on one side of body) and hemiparesis (weakness on one side of body) and aphasia (loss of ability to understand or express speech). Indicated R11 had no behaviors, no rejection of cares, and was dependent on staff for dressing, hygiene and transfers. The MDS lacked identification of R11 being on a restorative nursing program. R11's care plan revised 4/5/24, identified R11 had a self care performance deficit related to hemiplegia, impaired balance, limited mobility and contractures. R11's interventions included resting hand splint on in morning (am) and off at bedtime (HS). Identified restorative program related to right hand splint with goal to maximize ROM for quality of cares. Interventions included to apply blue palm protector to right hand in AM to be worn during day. Apply gray splint to right hand at bedtime. See instructions on closet door for step by step instructions. Nursing rehab/restorative: passive ROM program number one to right upper extremity ten reps per instructions. R11's Restorative Nursing Program form dated 11/23/23, identified the following: Details-complete passive ROM (PROM) to right hand each morning during activities of daily living (ADL) routine before donning blue palm protector. Frequency-Daily. Goal-Decrease further contractures/Improve tone. Education provided to-Staff. R11's Restorative Nursing Program dated 11/30/23, identified the following: Details-gray splint donned every bed time (QHS) Blue Palm protector every day (QD). Frequency-Gray splint-night (NOC) Blue palm protector-Day. Goal-sustain maximum (max) ROM for quality of cares and contracture management. R11's Occupational Therapy Toolkit Passive Range Of Motion form dated 11/23/23, included the following: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Do the checked exercises one time per day, seven days per week. Notes: complete the checked exercises in the morning during ADL routine before donning blue palm protector. -PROM right side weakness fingers and thumb-make a fist, finger spread, thumb across, all to be repeated five times. -Wrist flexion and extension-with instructions. Review of R11's Occupational Therapy (OT) Discharge Summary dated 12/11/23, identified the following: -R11 continued to demonstrate (demo) need for ROM daily splinting for further contraction prevention. -Restorative program established/trained=restorative ROM program, restorative splint and brace. -ROM program established/trained: Required daily ROM in UE shoulder, fingers, wrist hand. -Splint and brace program established/trained: daily, nightly. Review of R11's Occupational Therapy Treatment Encounter Notes from 11/24/23 to 12/11/23, identified the following: -11/24/23 at 8:53 a.m., -R11 demonstrated improved tolerance to all Right Upper Extremity (RUE) prolonged stretching. Plan-initiate training of staff for decreased overall flexion tone. -11/27/23 at 2:30 p.m. -plan to address staff training. -11/28/23 at 3:08 p.m., R11 demonstrated improved tone in right hand/wrist/fingers. Continue staff education. -11/29/23 at 11:43 a.m.,-staff education provided with optimal use of splints. -11/30/23 at 11:33 a.m., -staff education provided for increase success with NOC plaint and day palm protector. Updated instructions on closet to include use of palm protector during the day. -12/1/23 at 12:52 a.m., -R11 compliant with adaptations and compliant with skilled interventions. -12/4/23 at 3:43 a.m.,- R11 continued to benefit from daily PROM in RUE wrist, elbow and shoulder. R11 continued to benefit form using of splint at HS and right palm protector during day time. -12/7/23 at 4:23 p.m., -R11 demonstrated need for ongoing gains in PROM in UE plan-continue ROM retraining. -12/11/23 at 3:19 p.m., -all ROM in RUE improved from original tightness in right hand, finger, wrist and shoulder. R11 program established for ongoing ROM, splint wearing. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R11's OT Evaluation & Plan Of Treatment dated 11/7/23 to 12/6/23, identified the following: -Right Upper Extremity (RUE) ROM-shoulder=impaired:Elbow/Forearm=impaired: Wrist=impaired: Hand=impaired: Thumb=impaired:Index Finger=impaired: Middle Finger=impaired: Ring Finger=impaired: Little Finger=impaired. AROM-right shoulder-flexion=10 degrees, Extension=0 degrees. AROM-right elbow/forearm Flexion =30 degrees, extension =0 degrees. AROM right wrist flexion=30 degrees, extension=50 degrees. Review of R11's Occupational Therapy (OT) Discharge Summary dated 12/11/23, identified the following: -R11 continued to demonstrate (demo) need for ROM daily splinting for further contraction prevention. -Restorative program established/trained=restorative ROM program, restorative splint and brace. -ROM program established/trained: Required daily ROM in UE shoulder, fingers, wrist hand. -Splint and brace program established/trained: daily, nightly. Review of R11's Documentation Survey Report v2 from 11/1/23 to 5/14/24, identified the following: -11/1/23 to 11/30/23: -apply blue palm protector to right hand in AM to be worn during the day, every shift (Qshift) 6 a.m. to 2 p.m.: -entries included: began on 11/30/23-A (accepted) one time -apply gray splint to right hand at bedtime. See instructions on closet door for step by step instructions, Qshift 6 a.m. to 2 p.m. and Qshift 2 p.m. to 10 p.m. : -entries included: 97 (not applicable)- three times, 98 (refused)- four times, 7 (refused)-twenty two times, 8 (activity did not occur or family or non-facility staff completed)-twenty nine times, and one entry left blank. -12/1/23 to 12/31/23: -apply blue palm protector to right hand in AM to be worn during the day, Qshift 6 a.m. to 2 p.m.: -entries included: A-fourteen times, R (removed)- two times, 97-three times, 98-ten times, and two entries left blank. (continued on next page)

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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	

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-apply grey splint to right hand at bedtime. See instructions on closet door for step by step instructions, Qshift 6 a.m. to 2 p.m. and Qshift 2 p.m. to 10 p.m. : -entries included: 97-five times, 98-nine times, 7-twenty one, 8-twenty three times, and three entries left blank. -1/1/24 to 1/31/24: -apply blue palm protector to right hand in AM to be worn during the day, Qshift 6 a.m. to 2 p.m.: -entries included: A-thirteen times, R-two times, 97-two times, 98-eleven times, and three entries left blank. -apply grey splint to right hand at bedtime. See instructions on closet door for step by step instructions, Qshift 6 a.m. to 2 p.m. and Qshift 2 p.m. to 10 p.m. : -entries included: 97-three times, 98-eight times, 7-nineteen times, 8-twenty seven times, and five entries left blank. -2/1/24 to 2/29/24: -apply blue palm protector to right hand in AM to be worn during the day, Qshift 6 a.m. to 2 p.m.: -entries included: A-nineteen times, R-four times, 97-one time, 98-four times. -apply grey splint to right hand at bedtime. See instructions on closet door for step by step instructions, Qshift 6 a.m. to 2 p.m. and Qshift 2 p.m. to 10 p.m. : -entries included: 97-four times, 98-fourteen times, 7-thirteen times, 8- twenty two times, and two additional 8 entered. -3/1/24 to 3/31/24: -apply blue palm protector to right hand in AM to be worn during the day, Qshift 6 a.m. to 2 p.m.: -entries included: A- fifteen times, R -three times, 97- two times, 98- ten times -apply grey splint to right hand at bedtime. See instructions on closet door for step by step instructions, Qshift 6 a.m. to 2 p.m. and Qshift 2 p.m. to 10 p.m. : -entries included: 97-eleven times, 98-thirteen times, 7-seventeen times, 8-nineteen times. -4/1/24 to 4/30/24: -apply blue palm protector to right hand in AM to be worn during the day, Qshift 6 a.m. to 2 p.m.: -entries included: A- twenty times, R- four times, 98- three times, 97-three times. (continued on next page)

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-apply grey splint to right hand at bedtime. See instructions on closet door for step by step instructions, Qshift 6 a.m. to 2 p.m. and Qshift 2 p.m. to 10 p.m. : -entries included: 97- twenty five times, 98- seven times, 7- thirteen times, 8-fifteen times. -5/1/24 to 5/14/24: -apply blue palm protector to right hand in AM to be worn during the day, Qshift 6 a.m. to 2 p.m. -entries included: A-three times, 97-three times, 98-six times, and two entries left blank -apply grey splint to right hand at bedtime. See instructions on closet door for step by step instructions, Qshift 6 a.m. to 2 p.m. and Qshift 2 p.m. to 10 p.m. : -entries included: 97-eight times, 98- seven times, 7- four times, 8- seven times, and one entry left blank. Review of R11's Documentation Survey Report v2 from 11/1/23 to 5/14/23, identified R11 approved of blue palm protector application 85 times and all other entries were identified as not applicable, refused, activity did not occur, or were left blank. R11's grey splint entries all identified the splint was not worn due to not applicable, refused, activity did not occur or were left blank. R11's Document Survey Report v2 documentation lacked documentation of the PROM restorative nursing program. Review of R11's progress notes from 11/3/23 to 5/15/24, lacked documentation of implementation of R11's restorative nursing program, R11's refusal of restorative nursing services, notification of refusals to licensed nurses/provider or re-evaluation of R11's ROM. During an observation on 5/13/24 at 3:09 p.m., R11 was seated in his wheelchair in his room, no hand splint or palm protector was worn. -A hand written note on an eight by eleven white paper was taped to R11's wardrobe cupboard. The sign read: Nighttime Splint: -Donn in bed when relaxed, approximately (aprox) 8 p.m.-8 a.m. -follow instructions on closet. -Doff in the morning. -Blue palm protector during day. Right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/15/24 at 9:46 a.m., R11 was seated in his wheelchair in the fire place lounge. R11 was not wearing a palm protector and R11's right hand was tightly fisted. At 2:17 p.m., R11 was seated in his wheelchair in his room. R11 continued to not have his palm protector on and R11's right hand was tightly fisted. At 4:43 p.m., R11 was wheeled by registered nurse (RN)-A out to the smoking area. R11 continued to not have his blue palm protector on. At 5:07 p.m., R11 was in his wheelchair in the dining room. It was noted R11 continued to not have the blue palm protector on and R11 held his right tightly fisted hand in his left hand resting on his lap. During an observation and interview on 5/15/24 at 7:07 a.m., R11 was dressed in street clothes seated in his wheelchair near the nurses' station. R11 had no brace or palm protector on his right hand. At 7:31 a.m., licensed practical nurse (LPN)-C transported R11 down the hall to the nurses cart. At 7:45 a.m., LPN-C was in R11's room administering medications. From 8:04 a.m. to 9:02 a.m., R11 was observed to be in the dining room and at 9:02 a.m., was brought back to his room. R11 continued to not have the palm protector on, while he held his right tightly fisted hand in his left hand on his lap. At 9:29 a.m., LPN-C prepared supplies for R11's wound care, applied a gown, gloves and entered R11's room. In addition, RN-C applied gown and gloves and entered R11's room. LPN-C indicated R11 wore the splint at night and confirmed R11 did not have the blue palm protector on. LPN-C looked around and found the blue palm protector on top of R11's wardrobe cupboard, with a gray hand splint under it, and other items such as clothing and boxes. LPN-C stated R11's blue palm protector was hit or miss when asked if it ever was worn. LPN-C indicated the nursing assistants were responsible to complete R11's range of motion and apply hand splints. At 9:41 a.m., RN-B and LPN-C transferred R11 to bed using a mechanical lift, completed incontinence cares and wound cares. RN-B indicated R11 had been on hospice for about 2 months. After the interview was completed, LPN-C attempted to apply R11's blue palm protector at that time however, R11 refused. During an interview and observation on 5/15/24 at 10:39 a.m., certified occupational therapy assistant (COTA)-A reviewed R11's past ROM measurements, went to R11's room and assessed R11's ROM. COTA-A talked with R11, while moving his right wrist, then stated it seemed tighter. COTA-A moved R11's arm and stated his elbow extension appears to have decreased extension a little bit. COTA-A stated it was obvious R11 did not have as much ROM in the wrist and elbow extension now. COTA-A indicated his ROM decline could have been caused by not wearing the splint, not completing ROM exercises and inadequate positioning. COTA-A stated if R11 had worn the splint regularly and completed ROM exercise daily, there would have been a better chance R11's contractures would have been at least maintained. During an interview on 5/15/24 at 10:48 a.m., nursing assistant (NA)-G indicated R11 wore a splint, which nursing staff were expected to apply at night and was removed in the morning. NA-G stated R11 did not wear a hand brace during the day, however indicated if it was on at night, they took it off in the morning. NA-G stated R11 did not have the splint on that morning when they got him up from bed. NA-G indicated she was unaware if R11 was to receive ROM services. NA-G stated therapy performed all ROM and restorative services at the facility. NA-G stated she had never completed passive ROM for R11. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 12:59 p.m., NA-F stated restorative nursing services were provided by nursing assistants and the services to complete were usually posted on the resident's closet door. NA-F indicated nursing staff were expected to look at the pictures posted on the closet doors and read through them to know what to do for restorative nursing services. NA-F stated she was not sure who was in charge of the facility's restorative nursing program. NA-F stated she had tried to complete ROM for R11 in the past however, stated R11 became upset and was reluctant to do it. NA-F could not remember the last time she had attempted to complete ROM on R11. NA-F indicated she had documented that she was not able to complete the task. NA-F stated she could not recall if she had notified the nurse about R11's refusals. NA-F indicated R11 would not let them apply his hand braces and indicated she had never seen him wear one. NA-F stated she had never been instructed on how to apply the hand braces. During an interview on 5/15/24 at 1:05 p.m., therapy director COTA-B indicated it was possible that not completing ROM exercises could cause a decline in R11's ROM. COTA-A stated if R11 had received ROM exercises routinely, it could have assisted R11 to maintain function. COTA-B stated was unaware of who was in charge of the facility's restorative program however, indicated the therapy department provided the restorative program information to the nursing staff when therapy discontinued services. COTA-B stated the hand braces, including the blue palm protector were to keep things neutral and decrease pain and could have assisted in preventing decline. COTA-B agreed with COTA-A that R11 may have had a decline and stated his condition was also in decline. COTA-B stated would expect staff to notify the therapy department if a resident refused or if staff were not able to complete the restorative program. Once the therapy department had been notified, they could re-screen to see if was appropriate to begin therapy again or to complete re-education if needed. COTA-B stated they provided a general education on splinting to nursing during new employee orientation however, did not provide ROM education to nursing staff. COTA-B indicated when a resident was transitioning from therapy to nursing they attempted to educate two shifts on the restorative program and leave written instructions with the nursing staff. During an interview on 5/15/24 at 1:31 p.m., NA-E indicated R11 wore a brace at night and a different one during the day. NA-E stated she could not remember the last time she had seen R11 wear a brace on his right hand. NA-E stated she had tried with LPN-C earlier that day to apply R11's blue brace after LPN-C had attempted to apply brace however, he refused. NA-E stated R11's plan of care (POC) identified the braces and ROM, and indicated R11 would not let her complete passive ROM. NA-E stated if R11 refused she would have informed the nurse however, could not recall the last time she had informed a nurse of R11's refusals. During an interview on 5/15/24 at 1:35 p.m., clinical manager RN-B stated the restorative nursing program consisted of therapy writing up the resident's restorative plan once therapy discontinued services and then placing the plan in the resident's POC for nursing staff to complete and document on. RN-B stated she was not in charge of the nursing restorative program and confirmed there was no designated individual in charge of the nursing restorative program. RN-B indicated no staff had ever reported to her that R11 refused his brace or ROM exercises. RN-B stated if she had been informed, she would have evaluated why R11 refused and if he consistently refused. RN-B stated she would expect the refusals to be documented in the progress notes and therapy to be notified so they could reassess the restorative program. RN-B stated she could not remember the last time she had seen R11 wear his brace. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/15/24 at 4:28 p.m., R11's primary care physician (PCP)-A confirmed she had not been informed by the facility ROM exercises and the braces were not being consistently implemented for R11. PCP-A indicated she would expect the nursing staff to report when R11 was not wearing the braces or ROM exercises were not being completed so they could re-assess to determine if the orders were still needed. PCP-A stated R11 was now on hospice and stated they would consider backing down on passive ROM exercises and possibly R11's braces at that time. PCP-A indicated if the brace was not worn or the ROM exercises were not completed, it could cause an increase in contractures from his stoke and tightness. During an interview on 5/15/24 at 2:29 p.m., interim director of nursing (IDON) indicated she was not aware if the facility had a restorative nursing program in place. IDON indicated she would expect staff to follow the POC and resident tasks and instructions. IDON stated when a resident refused, she would expect the resident to be re-approached, document the refusals, notify the nurse and inform therapy as well. IDON stated it was important to complete the ROM and apply the hand braces so residents did not lose their function and were able to maintain their highest level of function as possible. During an observation and interview on 5/15/24 at 4:33 p.m., COTA-B and PTA-A were in R11's room, while he sat in his wheelchair. PTA-A completed measurements on R11's right elbow flexion and noted it was 120 degrees and extension was 90 degrees. R11's right wrist flexion was 33 degrees and R11's wrist extension was lacking four degrees, which PTA-A stated meant R11 could not reach full extension. COTA-B confirmed R11 had a decline in the ROM of his right elbow and wrist. The facility policy titled Establishment Of An Individual Restorative Program dated 8/1/15, identified the facility provided treatment and services to maintain and improve functional abilities per physician orders. The policy identified restorative program may be recommended by the therapists for evaluation and establishment of a restorative program following a therapy screen. The policy indicated the residents recommended for restorative programming would be referred by the nurse in charge of restorative programming using the Restorative Assessment form. The individualized goals and interventions towards achievement would be developed by the interdisciplinary team and implemented by the restorative nurse and restorative aide with input from the therapist when applicable.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 5 of 5 resident bathrooms and the sink at the eye wash station tested for safe water temperatures. This deficient practice had the potential to affect 4 residents who were independent with mobility on the memory care unit and 2 residents on the main units. Findings include: On 5/13/24 at 1:30 p.m., during a resident screening the water temperature in R 29's room [ROOM NUMBER] bathroom felt very hot to the touch after running water for only a few minutes. On 5/13/24 at 1:36 p.m., the sink at the eye wash station in the memory care unit felt very hot after running the water briefly. On 5/13/24 at 1:55 p.m., maintenance director (MD) verified the water in R29's room and at the eye wash station felt too hot and used a thermometer to measure the water temperatures using the facility thermometer in several other resident bathrooms they were as follows: -Memory Care eye wash station sink was 123 degrees Fahrenheit (F) - MD verified these temperature were too hot and had the potential to cause a burn. -RB 102 was 122 degrees F. -RB 118 was 121 degrees F. -RB 119 was 122 degrees F. -RB 152 was 131 degrees F. -RB 157 was 130 degrees F. During an interview 5/13/24 at 2:05 p.m., licensed practical nurse (LPN)-A verified there were four residents who were independent with mobility on the memory care unit who had the potential to turn on the above sinks. During an interview on 5/13/24 at 2:33 p.m., MD stated he had not been checking any of the water temperatures and was not aware they were running hot. MD stated water temperatures should remain between 110 degrees F and 120 degrees F because any water temperatures above 120 degrees F had the potential to burn someone. During a resident council meeting on 5/15/24 at 10:21 a.m., R37 stated the water from her bathroom had recently felt warm when the staff were providing her personal cares. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/24 at 11:00 a.m., administrator stated his expectation was that the water temperatures would remain within the State and Federal guidelines. Review of a facility document titled Water Management Program dated 5/18/22, identified federal guidelines advise water temperatures to be kept below 120 degrees F. Indicated resident rooms at the end of wings should have been routinely checked for water temperatures as well as common area bathrooms and any other areas having sinks should have been checked and temperatures recorded.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37905 Based on observation, interview and document review, the facility failed to ensure food items were properly labeled and dated after packaging was opened. In addition, the facility failed to maintain a clean and sanitary kitchen area and failed to serve food in a sanitary and clean manner. This deficient practice had the potential to affect all 65 residents residing in the facility. Findings include: During an initial tour of the kitchen on 5/13/24 at 12:37 p.m., with registered dietician (RD)-A and kitchen supervisor (KS)-A the vegetable and fruit freezer were noted to have some multicolored, irregular shaped spills and crumbs on the bottom of the freezer covering a few inches in the front bottom area. In the meat freezer, a package of chicken patties was opened and undated. There was a box of breaded steaks three quarters full opened and undated. RD-A stated foods should have been dated when opened. There were three slices of garlic bread in a bag, opened and undated and a Styrofoam covered cup with straw not labeled and undated on the top shelf. RD-A indicated dietary manager (DM)-A should have been inspecting the kitchen, including the freezers, routinely. In the chest freezer, there was a bag of garlic bread opened, undated and about 12 breadsticks in a bag opened and undated. In the dry storage area, there were four plastic covered containers of dishes stored on the floor under the shelves. KS-A and RD-A stated they should not have been stored on the floor and identified those dishes were not being used at the time. Metal steam table containers were stored upside down on a shelf and one still had water drops on the inside. RD-A said she would have it re-run through the dishwasher. In front of a shelving unit storing bread, buns, and muffins, a metal fan covered with brown fuzzy substance on two thirds of the front and back was noted. RD-A picked up the fan, took it to a storage room and confirmed that it was very dirty and should not have been stored in the kitchen. A long metal table with clean food trays was stored next to the steam table. One of the trays had drops of water on it and another one had a red food crumb item on it. RD-A confirmed they were wet and soiled and removed them from the area. In the refrigerator in the main kitchen, there was a bag of shredded carrots opened and undated, a box of orange juice open and undated, ten small covered containers of tarter sauce undated and one container of beef base opened and undated. During an observation on 5/13/24 at 5:12 p.m., cook (CO)-A moved the cart with trays on it towards the steam table. CO-A was wearing gloves and serving brats with buns and other food items. CO-A was observed to touch paper meal tickets, trays, other utensils, handle the buns from the bag, place them onto the plates repeatedly without removing gloves, washing hands, or replacing gloves. On 5/14/24 at 4:11 p.m. a voice mail was left for CO-A for interview however, no return call was received. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/14/24 at 3:41 p.m., dietary manager (DM)-A confirmed boxes of dishes should not have been stored on the floor. DM-A stated it was the expectation that all foods would have been labeled and dated when opened and was important for food safety. DM-A stated it was expected staff used gloves for single use only and if they had to switch from using utensils and other food items; they should change gloves, wash hands and put on new gloves before touching foods. DM-A stated he had just reviewed hand hygiene and glove use a week ago with dietary staff. DM-A stated proper infection control techniques were important for residents' health and to prevent food born illness. DM-A stated multiple people could have been touching those meal slips and the cooks should not touch them prior to touching the foods. DM-A stated dietary aides should have placed the meal slips on the trays. Review of the facility policy titled Basics For Handling Food Safety, undated, identified safe steps in food handling, cooking, and storage were essential to prevent foodborne illness. In every step of food preparation, follow the four steps of the Food Safe Families campaign to keep safe, which included: clean- wash hands and surfaces often, separate-don't cross-contaminate, cook-to the right temperature, and chill-refrigerate promptly. The facility policy titled Handwashing, undated, identified keeping hands clean through improved hand hygiene was one of the most important steps we could take to avoid getting sick and spreading germs to others. The policy included when hands were to be washed, which included: before, during and after preparing foods, before switching from one to a different food prep task, before each meal service, and before handling food for service.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48740 Based on interview and document review, the facility failed to submit complete and accurate data for staffing information based on payroll during Quarter 1 (October 1-December 31, 2023) to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This deficient practice had the potential to affect all 66 residents residing in the facility. Finding includes: Review of the Payroll-Based Journal Report (PBJ) [NAME] report 1705D identified the Quarter 1 from 10/1/23-12/31/23, identified excessively low weekend staffing. 10/14/23 was identified for low weekend staffing. During an interview on 5/14/24 at 1:15 p.m., the administrator stated the director of human resources (DHR) director submitted the PBJ. The administrator provided copies of staff timecard punches for the weekends. Review of the facility schedules and time cards from 10/1/23 to 12/31/23, revealed the following: Nursing assistant(NA)-C was scheduled for a three-hour shift on 10/14/23. NA-C worked a total of 6.25 hours according to her timesheet. NA-C worked from 1:45 p.m. to 8:30 p.m. LPN-B was not on the schedule to work according to the schedule. According to her time card punches, LPN-B worked a total of eight hours from 6:30 a.m. to 3:00 p.m. A review of the facility's staffing schedules and timecards identified discrepancies with the facility schedules, time cards, and the PBJ report. During an interview on 5/14/24 at 4:29 p.m., the director of human resources (DHR) stated the process for submitting the PBJ included the cooperate office running a spreadsheet and then sending it to the DHR. The DHR added data to the spreadsheet and then sent the spreadsheet back to cooperate. DHR reported weekend staffing consisted of four to six nursing assistants. The number of nursing assistants depended on the facility's census. The facility scheduled two nurses on the night shift and three nurses on the day shift. During a follow-up interview on 5/14/24 at 5:56 p.m., DHR verified an inaccuracy with the schedule compared to the time card punches for two staff NA-C, and LPN-B on 10/14/23.

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	05/15/2024

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

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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 - Some	Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45844

Based on observation, interview and document review, the facility failed to ensure donning/doffing of personal protective equipment (PPE) was performed in order to prevent the spread of infection for 1 of 15 residents (R36) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) In addition, the facility failed to identify and ensure implementation of EBP for 14 of 15 residents (R3, R6, R18, R22, R26, R30, R36, R38, R47, R62, R115, R116, R266, R268) observed for EBP. Further, the facility failed to ensure personal laundry was transported and delivered in a manner that prevented risk of contamination for and hand hygiene was completed as required during observation for linen transportation for 3 of 5 hallways.

Findings include:

Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items.

Review of CDC guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) which include a gown and gloves in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated when performing high contact resident care activities with any resident with an Infection or colonization with an MDRO when Contact Precautions do not otherwise apply or has Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status any residents Examples of high-contact resident care activities requiring gown and glove use for EBP include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.

ENHANCED BARRIER PRECAUTIONS AND PPE USE

R36's

R36's significant change Minimum Data Set (MDS) dated [DATE], identified R36 had severe cognitive impairment and had diagnoses which included: hypertension (elevated blood pressure) Benign Prostatic Hyperplasia (condition in men where the prostate gland is enlarged), and traumatic brain injury. Identified R36 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and personal hygiene.

R36's care plan revised 5/2/24, identified R36 had a urinary catheter (a medical device that helps drain urine from the bladder). Instructed staff to change urinary catheter as ordered.

R36's Order Summary Report dated 5/2/24 identified R36 had a urinary catheter and directed staff to change the catheter monthly.

(continued on next page)

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 05/15/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/13/24 at 5:41 p.m., there was no identification R36 who had a urinary catheter, was in EBP. In addition, there was no PPE located near R36's room for staff to wear when performing high contact care activities for R36. During an observation on 5/15/24 at 7:05 a.m., there was a small bin on the floor outside R36's room which contained hand sanitizer gloves and masks. There was also a sign on R36's door that said Enhanced Barrier Precautions; Everyone Must clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer gown, and gloves. During an observation on 5/15/24 at 7:06 a.m., R36 was lying in bed and nursing assistant (NA)-A and NA-B turned R36 back and forth to place a hoyer lift sheet under R36. NA-A wore a gown and gloves and NA-B only wore gloves during the high contact activity. NA-A and NA-B proceeded to hook R36 up to the hoyer lift and placed R36 into his wheelchair. NA-A and NA-B stood within an inch of R36 during the hoyer lift transfer. NA-A removed her gown and gloves and sanitized her hands and NA-B removed her gloves and sanitized her hands. During an interview on 5/15/24 at 7:10 a.m., NA-B verified the only PPE she had worn while transferring R36 into his wheelchair were gloves. NA-B stated she had asked a nurse for a gown since there were none in the bin however, had not received a gown prior to transferring R36 into the wheelchair. NA-B indicated she was not familiar with EBP and had not received any clear education on what PPE was required while caring for a resident on EBP. 49620 HAND HYGIENE During an observation on 5/14/24 at 4:22 p.m., dietary aide (DA)-A passed empty drink glasses in the dining room to all tables. DA-A took each glass from the dining cart and flipped them over touching the top of the glass with his bare hands and placing the glass onto each designated area for the residents at the tables. DA-A touched the top of the glasses with the palm of his hand and his fingers. During an interview on 5/14/24 at 4:31 p.m., DA-A verified he had touched the top of the glasses with his bare hands when removing them from the dining cart. DA-A stated he should have touched only the bottom area of the glasses to prevent the possible spread of germs. LAUNDRY/ HAND HYGIENE (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/14/24 at 2:29 p.m., nursing assistant (NA)-D pushed the laundry cart down the hallway uncovered and delivered laundry to R268's room. Visitors were observed to walk past the uncovered cart. NA-D proceeded to deliver laundry to R62's room, knocked on R267's door and delivered laundry to R267. NA-D delivered laundry to R56's room and R266's room. NA-D pushed the uncovered laundry cart down the hall past visitors and staff, knocked on R265's door and delivered laundry to R265. NA-D delivered laundry to R6's room, R27's room and R40's room. NA-D knocked on R26's door, delivered laundry to R26, knocked on R12's door and delivered laundry to R12. NA-D did not sanitize her hands and the cart remain uncovered during the entire laundry pass observation. During an interview on 5/14/24 at 2:29 p.m., NA-D verified the laundry cart should have been covered to prevent cross-contamination of germs from others and stated she should have sanitized her hands in between resident rooms to prevent the spread of germs. During an observation on 5/15/24 at 8:26 a.m., housekeeper (H)-A delivered laundry to R26's room H-A exited R26's room with used hangers and hung on the laundry cart. The laundry cart was observed to be partially covered with a blanket on half of the cart. Visitors and residents were observed to go past the uncovered cart. The blanket was observed to fall onto the floor, H-A picked the blanket up and again covered half of laundry in the cart. H-A delivered laundry to R23's room, hung clothing in R23's closet and exited R23's room with used hangers and hung hangers on the laundry cart. H-A delivered laundry to R35's room. H-A knocked on R5's door, opened R5's closet door, hung clothing in closet, removed hangers and placed on cart. H-A delivered laundry to R46's room and placed in R46's closet. H-A brought laundry cart into R4's room, opened closet door and hung laundry in R4's closet, removed hangers and placed on cart. The laundry cart remained partially covered and H-A was not observed to sanitize her hands during the entire observation. During an interview on 5/15/24 at 8:34 a.m., H-A verified she did not sanitize her hands during the entire laundry pass observation. H-A stated she only touched the door handles and did not feel she needed to sanitize her hands. H-A stated she was unaware of the laundry pass policy on sanitizing hands and keeping the cart completely covered. ENHANCED BARRIER PRECAUTIONS R3 R3's significant change MDS dated [DATE], identified R3 had no cognitive impairment and had diagnoses which included type two diabetes, anxiety, chronic kidney disease, paranoid schizophrenia, obesity, non-pressure chronic ulcer of skin of other sites with fat layer exposed. Identified R3 required substantial assistance with ADL's which included bed mobility, transfers, and personal hygiene. R3's care plan revised 3/1/24, identified R3 had a moisture associated skin damage to her left thigh. Staff to administer treatments as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Order Summary Report dated 5/16/24, identified R3 had a left medial thigh wound. Staff were to cleanse with wound cleanser, pat dry, apply medihoney to wound bed, cover with four by four dressing with silicone border foam dressing. Change every three days and as needed if soiled or dressing fell off. During an observation on 5/13/24 at 5:45 p.m., there was no identification R3 who had a wound, was in EBP. In addition, there was no PPE located near R3's room for staff to wear when performing high contact care activities for R3. R62 R62's admission MDS dated [DATE], identified R62 had no cognitive impairment and had diagnoses which included displaced fracture of right tibia, depression, fusion of spine. Identified R62 required supervision with activities of ADL's which included bed mobility, transfers, and personal hygiene. R62's care plan revised 3/22/24, identified R62 had an alteration in skin integrity related to surgical incisions. Staff to administer treatments as ordered. R62's Order Summary Report dated 5/16/24, identified R62 had a surgical incision. Staff to monitor incisions to right ankle every day and evening shift. During an observation on 5/13/24 at 5:45 p.m., there was no identification R62 who had a surgical incision, was in EBP. In addition, there was no PPE located near R62's room for staff to wear when performing high contact care activities for R62. R115 R115's admission MDS dated [DATE], identified R115 had no cognitive impairment and had diagnoses which included aftercare following artificial hip joint replacement, bipolar disorder, chronic kidney disease, depression. Identified R115 required moderate assistance with ADL's which included bed mobility, transfers, and personal hygiene. R115's care plan revised 5/11/24, identified R115 had an alteration in skin integrity related to surgical incision to right hip and cellulitis. Staff to administer treatments as ordered. R115's Order Summary Report dated 5/16/24, identified R115 had a surgical incision to right hip. Document status in progress note every shift. During an observation on 5/13/24 at 5:45 p.m., there was no identification R115 who had a surgical incision, was in EBP. In addition, there was no PPE located near R115's room for staff to wear when performing high contact care activities for R115. R268 R268's admission MDS dated [DATE], identified R268 had no cognitive impairment and had diagnoses which included aftercare following surgical amputation of both lower extremities below the knee, type two diabetes, hypertension. Identified R268 required extensive assistance with ADL's which included bed mobility, transfers, and personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R268's care plan revised 5/9/24, identified R268 had an alteration in skin integrity related to surgical incision to bilateral lower extremities. Staff to administer treatments as ordered. R268's Order Summary Report dated 5/16/24, identified R268 had a surgical incision to bilateral lower extremities. Monitor incisions every shift. During an observation on 5/13/24 at 5:45 p.m., there was no identification R268 who had a surgical incision, was in EBP. In addition, there was no PPE located near R268's room for staff to wear when performing high contact care activities for R268. R22 R22's admission change MDS dated [DATE], identified R22 had no cognitive impairment and had diagnoses which included depression, other symptoms and signs involving the musculoskeletal system, hallucinations, post-polio syndrome, chronic obstructive pulmonary disease. Identified R22 required total assistance with ADL's which included bed mobility, transfers, and personal hygiene. R22's care plan revised 4/4/24, identified R22 had an alteration in skin integrity related to pressure injury to right and left buttocks. Staff to administer treatments as ordered. R22's Order Summary Report dated 5/16/24 identified R22 had wound care. Apply thin layer of barrier ointment or paste to buttocks and gluteal folds twice a day. During an observation on 5/13/24 at 5:45 p.m., there was no identification R22 who had a pressure injury, was in EBP. In addition, there was no PPE located near R22's room for staff to wear when performing high contact care activities for R22. R266 R266's admission MDS dated [DATE], identified R266 had severe cognitive impairment and had diagnoses which included displaced fracture of left and right femur, hypertension, type two diabetes, dementia. Identified R266 required extensive assistance with ADL's which included bed mobility, transfers, and personal hygiene. R266's care plan revised 5/3/24, identified R266 had an alteration in skin integrity related to surgical incisions to left and right hip. Staff to administer treatments as ordered. R266's Order Summary Report dated 5/16/24, identified R266 had a surgical incision to right hip. Check on wound dressings to right and left hips every shift to ensure dressings are in place. Replace dressings as needed if dressing missing or not adhered every shift. During an observation on 5/13/24 at 5:45 p.m., there was no identification R266 who had a surgical incision, was in EBP. IN addition, there was no PPE located near R266's room for staff to wear when performing high contact care activities for R266. R116 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R116's admission MDS dated [DATE], identified R116 had no cognitive impairment and had diagnoses which included infection due to internal right knee prosthesis, depression, schizoaffective disorder, non-pressure chronic ulcer of skin of other sites. Identified R116 required total assistance with ADL's which included bed mobility, transfers, and personal hygiene. R116's care plan revised 5/14/24, identified R116 had an peripherally inserted central catheter line (PICC) a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the resident's heart. A PICC line is used to get medication treatments over a period of time. R116's care plan revised 5/8/24, identified R116 had an alteration in skin integrity related to surgical site to right knee. Staff to administer treatments as ordered. R116's Order Summary Report dated 5/16/24, identified R116 had a PICC line to be monitored for signs of infection and infiltration every shift and a surgical incision to right knee. Document status in progress note every shift. During an observation on 5/13/24 at 5:45 p.m., there was no identification R116 who had a surgical incision, was in EBP. In addition, there was no PPE located near R116's room for staff to wear when performing high contact care activities for R116. R26 R26's quarterly MDS dated [DATE], identified R26 had severe cognitive impairment and had diagnoses which included dementia, chronic kidney disease, acute kidney failure. Identified R26 required total assistance with ADL's which included bed mobility, transfers, and personal hygiene. R26's care plan revised 5/11/24, identified R26 had a urinary catheter (a medical device that helps drain urine from the bladder). Instructed staff to change urinary catheter as ordered and an alteration in skin integrity related to pressure injury. Staff to administer treatments as ordered. R26's Order Summary Report dated 5/16/24, identified R26 had a urinary catheter and directed staff to change the catheter monthly and a wound. Apply bordered foam to bilateral buttocks and left hip every three days and as needed. Wound care to right heel-cleanse with soap and water. Cover with silicone/mepilex foam dressing. Change every three days and as needed. During an observation on 5/13/24 at 5:45 p.m., there was no identification R26 who had a urinary catheter and a pressure injury, was in EBP. In addition, there was no PPE located near R26's room for staff to wear when performing high contact care activities for R26. R47 R47's quarterly MDS dated [DATE], identified R47 had severe cognitive impairment and had diagnoses which included dementia, quadriplegia, congestive heart failure. Identified R47 required total assistance with ADL's which included bed mobility, transfers, and personal hygiene. R47's care plan revised 2/26/24, identified R47 had an alteration in skin integrity related to moisture associated skin damage to sacrum and an arterial wound to right fifth toe. Staff to administer treatments as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R47's Order Summary Report dated 5/16/24, identified R47 had wound care orders for left fifth toe-cleanse with soap and water. Apply skin prep to scabbed areas two time a day. Wound care orders for sacrum-cleanse with wound cleanser. Apply Calmoseptine cream to open area two times a day. During an observation on 5/13/24 at 5:45 p.m., there was no identification R47 who had a surgical incision, was in EBP. In addition, there was no PPE located near R47's room for staff to wear when performing high contact care activities for R47. R30 R30's significant change MDS dated [DATE], identified R30 had moderate cognitive impairment and had diagnoses which included dementia, muscle wasting and atrophy unspecified, adult failure to thrive, hypertension. Identified R30 required total assistance with ADL's which included bed mobility, transfers, and personal hygiene. R30's care plan revised 3/14/24, identified R30 had an alteration in skin integrity related to moisture associated skin damage to left rear thigh. Staff to administer treatments as ordered. R30's Order Summary Report dated 5/16/24, identified wound care to right and left rear thighs-cleanse with soap and water. Apply Calmoseptine cream to open areas two times a day. During an observation on 5/13/24 at 5:45 p.m., there was no identification R30 who had a surgical incision, was in EBP. In addition, there was no PPE located near R30's room for staff to wear when performing high contact care activities for R30. R38 R38's significant change MDS dated [DATE], identified R38 had moderate cognitive impairment and had diagnoses which included neuromuscular dysfunction of bladder, chronic kidney disease, type two diabetes, dementia, unspecified open wound of lower leg. Identified R38 required total assistance with ADL's which included bed mobility, transfers, and personal hygiene. R38's care plan revised 4/21/23, identified R38 had a urinary catheter (a medical device that helps drain urine from the bladder). Instructed staff to change urinary catheter as ordered. R38 had a pressure ulcer to right heal and sacrum. Staff to administer treatments as ordered. R38's Order Summary Report dated 5/16/24, identified R38 had a urinary catheter and staff to change monthly. Wound care to right heel-cleanse with wound cleanser, apply calcium Alginate with silver to wound bed. Cover with dressing and wrap with kerlix every shift. Wound care to sacrum-cleanse with soap and water, apply triad paste two times a day. During an observation on 5/13/24 at 5:45 p.m., there was no identification R38 who had a surgical incision, was in EBP. In addition, there was no PPE located near R38's room for staff to wear when performing high contact care activities for R38. R6 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's significant change MDS dated [DATE], identified R6 had no cognitive impairment and had diagnoses which included open wound of abdominal wall, complications of amputation stump, acquired absence of right and left below knee amputation, fetal alcohol syndrome, depression. Identified R6 required extensive assistance with ADL's which included bed mobility, transfers, and personal hygiene. R6's care plan revised 4/11/24, identified R6 had an alteration in skin integrity related to left buttock pressure injury, sacrum pressure injury and gluteal fold moisture. Staff to administer treatments as ordered. R6's Order Summary Report dated 5/16/24, identified R6 had wound care to left buttock-cover with mepilex border dressing, this may stay on for one week as needed and change dressing every Monday. Wound care to sacrum-cleanse with wound cleanser, apply Calazime paste, Purscol Plus dressing, exufiber into ulcer fold and change daily and as needed. During an observation on 5/13/24 at 5:45 p.m., there was no identification R6 who had a surgical incision, was in EBP. In addition, there was no PPE located near R6's room for staff to wear when performing high contact care activities for R6. During an observation on 5/15/24 at 7:05 a.m., there were no enhanced barrier precautions in place outside of R266's room or a sign posted on the door. R18 R18's annual MDS dated [DATE], identified R18 had moderate cognitive impairment and had diagnoses which included dementia, gastrostomy status, adjustment disorder with depressed mood. Identified R18 required extensive assistance with ADL's which included bed mobility, transfers, and personal hygiene. R18's care plan revised 1/14/24, identified R18 had a gastrostomy tube (a surgically placed device in the abdomen used to give direct access to the stomach for supplemental feeding, hydration or medicine) with moisture associated skin damage to gastrostomy tube site. Staff to assess skin integrity weekly. Staff to provide tube feeding as ordered. R18's Order Summary Report dated 5/16/24, identified R18 had a gastrostomy tube feed order to administer one carton TwoCal HN three times a day and flush with water three times a day. Calmoseptine to tube site three times a day. During an observation on 5/13/24 at 5:45 p.m., there was no identification R18 who had a surgical incision, was in EBP. In addition, there was no PPE located near R18's room for staff to wear when performing high contact care activities for R18. During an interview on 5/15/24 at 3:49 p.m., director of nursing (DON) confirmed her expectation that staff would not touch the area of a drinking glass with their bare hands due to possible contamination and could result in residents becoming ill. DON verified her expectation was staff would sanitize their hands in between resident rooms to prevent the spread of germs and the laundry cart would remain covered to prevent cross-contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled Handling Linens and Laundry Policy revised 1/16/23, indicated laundry should have been packaged, transported and stored in a manner that ensured cleanliness and protected the laundry from dust and soil. Clothing was to be taken out of cart and covered again while unattended in the hallways. Laundry staff were to sanitize hands on the way out of the resident room. Review of a facility policy titled Hand Hygiene Policy revised 1/16/23, indicated staff would utilize hand washing and hygiene techniques to aid in the prevention of the transmission of infections. During an interview on 5/15/24 at 2:10 p.m., infection prevention nurse (IP) stated she had not been aware CDC made recommendations for EBP. IP indicated the facility was training staff about EBP beginning that day. IP stated EBP was important to prevent the spread of infections. During a follow-up interview on 5/15/24 at 3:49 p.m., DON verified EBP had not been implemented for residents per CDC recommendations. DON stated her expectations were staff would utilize EBP and PPE per recommendations.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620 Based on interview and document review, the facility failed to ensure 2 of 5 residents (R2, R44) were offered or received pneumococcal and/or influenza vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the current CDC recommendations 3/15/2023, revealed The Center for Disease Control and Prevention (CDC) identified adults age 19 of age or older should receive the influenza vaccination annually and adults [AGE] years of age or older who had not previously received Pneumococcal 13-valent Conjugate Vaccine (PCV13) and who had previously received one or more doses of Pneumococcal Polysaccharide Vaccine 23 (PPSV23) should receive a dose of Pneumococcal 15-valent Conjugate Vaccine (PCV15) or one dose of Pneumococcal 20-valent Conjugate Vaccine (PVC20). The dose of PCV15 or PCV20 should be administered at least one year after the most recent PPSV23 dose. In addition, the CDC identified adults 65 and older who had previously received both PCV13 and PPSV23 was received at age 65 and older, based on shared clinical decision-making, one dose of PCV20 at least five years after the last pneumococcal vaccine dose. Review of R2's immunization report, R2, age 77, was admitted to the facility on [DATE]. Review of R2's Minnesota Immunization Information Connection (MIIC) undated, recommended R2 to receive the influenza vaccine. R2's medical record indicated R2 received the influenza vaccine 12/27/22. R2's medical record lacked documentation R2 had been offered or received the influenza vaccine for the current seasonal flu year. Review of R44's immunization report, R44, age 67, was admitted to the facility on [DATE]. Review of R44's MIIC undated, recommended R44 to receive the pneumococcal vaccine. R44's medical record lacked documentation R44 received the PCV15 or PCV20 vaccines based on shared clinical decision-making with the provider. During an interview on 5/15/24, at 2:10 p.m. infection preventionist (IP) confirmed her expectation was for all residents on admission to be offered the influenza and pneumococcal vaccinations if eligible. IP stated the influenza and pneumococcal vaccine was on the facility standing orders to be provided to the residents. IP verified she was unaware if R2 and R44 had been offered or received the vaccinations and the facility lacked a process to ensure immunizations were completed for residents. During an interview on 5/15/24, at 3:53 p.m. director of nursing (DON) confirmed her expectation was for all residents on admission to be offered the influenza and pneumococcal vaccinations if eligible. DON stated she would expect (IP) to follow the facility policies of vaccinations offered and to document results. DON confirmed she was unaware if R2 and R44 had been provided education or offered the vaccinations. (continued on next page)

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 05/15/2024
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)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Seasonal Influenza Vaccine, revised 9/29/23, identified all residents would be offered influenza vaccines to aid in prevention of influenza infections. The policy identified residents would be assessed for eligibility to receive the influenza vaccine, and when indicated would be offered unless medically contraindicated or the resident had already been vaccinated. The policy indicated before receiving the vaccine, the resident or legal representative would receive information and education regarding the benefits and potential side effects of the vaccine. The policy identified residents had the right to refuse vaccination, and if refused, appropriate entrees would be documented in each residents' medical record indicating the date of the refusal. The facility policy titled Pneumococcal Vaccine, revised 6/28/23, identified all residents would be offered pneumococcal vaccines to aid in prevention of pneumococcal infections. The policy identified residents would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated would be offered the vaccine series unless medically contraindicated or the resident had already been vaccinated. The policy indicated before receiving the vaccine, the resident or legal representative would receive information and education regarding the benefits and potential side effects of the vaccine. The policy identified residents had the right to refuse vaccination, and if refused, appropriate entrees would be documented in each residents' medical record indicating the date of the refusal.