STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgebrook Care Center	505 Trosky Road West Edgerton, MN 56128

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 39988 Based on interview and document review, the facility failed to notify the resident and/or their representative, in writing, of the care facility's bed hold policy, including any potential costs included with the bed hold, at the time of transfer to the hospital for 1 of 5 residents (R10) reviewed for hospitalization s. Findings include: R10's 9/17/24, quarterly Minimum Data Set (MDS) identified R10 had unclear speech, was usually understood, had severe cognitive impairment, displayed continuous disorganized thinking, altered level of consciousness, and had verbal behaviors daily. R10 used a wheelchair for mobility and required total assistance with cares. R10 was identified to have Alzheimer's disease. She had no indications of pain; she had no falls and did not take any psychoactive medication. R10's 6/28/24, progress note identified R10 was positive for COVID-19 and was on droplet precautions. On 6/29/24, at around 7:00 p.m., R10 was assessed and found to have unstable vital signs with shortness of breath and was transported to the emergency room for evaluation. The family was notified of the transfer to the hospital. On 7/2/24, R10 returned to the facility with diagnosis of pneumonia and COVID. R10 had received 3 days of IV antibiotics while at hospital and was to start oral antibiotics twice a day for next 7 days. The progress notes indicated the family had been notified of the hospital transfer however, there was no indication that the nurse had discussed the bed hold policy or that the family had been provided the bed hold policy, including potential cost included with the bed hold. Interview on 10/14/24 at 2:12 p.m., with registered nurse (RN)-A identified typically when a resident was sent to the hospital the charge nurse would ask the family if they would like a bed hold. If the family wanted a bed hold the nurse would document a verbal confirmation on the bed hold form and the family will come in and sign the bed hold at their convenience. Interview on 1014/24 at 3:45 p.m., with director of nursing identified facility staff had not discussed or provided the bed hold notice to the family of R10 when she discharged to the hospital on 6/29/24. (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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 12/7/23, Bed-Hold-Rehab/Skilled policy identified in emergency transfer the notice of bed hold policy would be sent with the resident to the hospital. The family would be provided the bed hold policy within 24 hours of the transfer. This was to ensure the resident or family was made aware of the bed hold policy including potential cost prior to or upon transfer to the hospital in order to determine if a bed hold was wanted.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34083 Based on interview and document review, the facility failed to ensure the required amount of staff determined by their resident census and care levels, resident assessments and individual plans of care, and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Findings include: Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705D identified the following dates triggered for review: 4/1/24 through 6/30, 24 days Triggered = Submitted Weekend Staffing Data Excessively Low. Review of the facility's staffing requirements for weekends during the identified PBJ period of 4/1/24 through 6/30/24 identified staffing numbers required were: Days: 1 nurse: 6:30 a.m. -7:00 p.m. 1 nurse: 6:30 a.m. -3:00 p.m. 1 trained medication aide (TMA)/or Restorative aide (RA) 6:30 a.m. - 2:30 p.m. 1 RA: 6:00 a.m. - 2:30 p.m. 4 nursing assistants (NA): 6:30 a.m. - 2:30 p.m. and 1 NA/bath aide. 6:30 a.m. - 1:00 p.m. Evenings: 2 NAs: 2:30 p.m. - 11:00 p.m. 2 NA's: 2:30 p.m. -9:30 p.m. 1 NA: 5:00 p.m. - 8:00 p.m. 2 TMA's: 4:30 p.m. - 8:30 p.m. 1 nurse: 7:00 p.m. - 7:00 a.m. Nights: 1 overnight nurse: 7:00 p.m. - 7:00 a.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 NA's: 10:45 p.m. - 6:15 a.m. Review of working schedules and time cards for Fiscal year Quarter 3, 2024 (April 1 through June 30, 2024) identified less than the amount of identified staff worked for 4 of 8 weekend evening shifts with the above identified number of needed staff on duty to provide care and services to the residents. On: 1) 4/7/24 (Sunday), review of time cards identified 2 of the scheduled 4 NAs and 1 of 2 scheduled TMA's worked on the evening shift. 2) 4/14/24 (Sunday), review of time cards identified 3 of 4 scheduled NAs and one of 2 scheduled TMA's were on duty for the evening shift. 3) 4/20/24 (Saturday), review of time cards identified 3 of 4 scheduled NAs and 1 of 2 TMA's were working during the evening shift. 4) 4/27/24 (Saturday), review of time cards identified 3 of 4 scheduled NAs and 1 of 2 scheduled TMA's worked on the evening shift. Interview on 10/15/24 at 5:07 p.m. with the administrator and director of nursing (DON) reported she included contract staff in the PBJ report, and was not certain why it had triggered. The administrator reported she reviewed and approved the time punches but the national campus did the actual submission of the PBJ report. They reported when a staff person called in the process was to call unscheduled staff by using the On Shift (a computerized program utilized to notify staff of an open shift). If that process was not effective in finding a replacement, the next step was to contact the nurse on call and either they or the DON covered the shift. The administrator and DON identified they attempted to fill an open shift if there was a call in on all shifts. They reported other options to fill shifts included use of contract staff, or to mandate staff to work extended hours. Review of the 7/2/24, Facility Assessment identified the facility was to assess daily needs and utilize a program called On Shift to send messages to staff when needed to fill shifts. The facility noted the utilized contracted staff to cover open shifts and were to mandate staff stay to ensure safe staffing levels. They measured and monitored staffing needs for their resident population to ensure shifts were filled. There was no indication in the above documents the facility utilized approaches to fill the shifts when their numbers could not be attained.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40614 Based on observation, interview, and document review, the facility failed to ensure a system for periodic reconciliation of controlled substances for the emergency kit stored in a refrigerator. Findings include: On interview and observation 10/13/24 at 3:27 p.m., a tour of the medication room with registered nurse (RN)-A included an unlocked refrigerator with a plastic container that had a breakaway tag on with number 6229540. Inside of the plastic kit was 1 vial of morphine liquid 100 mg/5 ml, Tramadol 50 mg tablets, and 2 vials of lorazepam 2 mg/ml. RN-A indicated they switched pharmacies a few months ago and she stated they have not been counting the narcotics, nor verifying the security of the lock, for medications kept in the refrigerator but probably should be. On interview 10/13/24 at 7:00 p.m., trained medication aide (TMA)-A indicated she does participate in narcotics counts at the end of the shift, but has never counted the narcotics in the medication room refrigerator, or verified the lock was intact. There was no mention of doing either in the medication reconciliation book. On interview 10/13/24 at 7:01 p.m., licensed practical nurse (LPN)-A stated they have not been reconciling or verifying the lock remained intact for narcotic medications in the refrigerator and was unsure if they were reconciling them prior to the pharmacy change. On interview 10/13/24 at 7:02 p.m., the director of nursing confirmed the narcotics in the refrigerator in the medication room are not being reconciled or locks verified to remain intact, and haven't been since the new pharmacy took over in September 2024. The Medications: Acquisition, Receiving, Dispensing and Storage policy, dated 3/29/24, included, controlled drugs (Schedule II) and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments, except when a single unit package drug distribution is used. If the medication requires a refrigerator, these need to be locked in a separate container. These drugs will be reconciled at least daily through an appropriate system of records of receipt and disposition established by the licensed pharmacist.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40614 Based on observation, interview and document review the facility failed to ensure the infection control program used enhanced barrier precautions (EBP) per Centers for Disease Control (CDC) recommendations for 2 of 2 residents (R47 and R19) who had indwelling device present or multi-drug-resistant organism (MDRO). Findings include: R46's diagnosis list printed 10/14/24 included gastrostomy (a feeding tube inserted into the stomach through the abdomen) status. R46's plan of care, dated 9/13/24, included the resident requires tube feeding related to dysphagia (difficulty swallowing). Interventions included no water pitcher at bedside due to nothing per mouth status and elevate head of bed 30-45 degrees during and 30 minutes after the tube feeding is stopped. R46's plan of care did not include EBP precautions. On observation and interview on 10/13/24 at 5:03 p.m., registered nurse (RN)-A gathered supplies for tube feeding, put on a gown she brought with her to R46's room. RN-A stated that when providing cares such as tube feedings or medication administration with the gastrostomy tube (GT) they need to wear a gown and gloves. RN-A entered R46's room and R46 stated he needed to go the bathroom before his tube feeding. RN-A called for assistance stating she didn't want to contaminate her gown since she was going to give the tube feeding. On the back of the entry door was a sign that stated Enhanced Barrier Precautions which included gowns and gloves were required for all high contact resident care activities that included changing briefs, assisting with toileting. A yellow bag with gowns present in the pockets was hanging on R46's bathroom door. At 5:03 p.m., nursing assistant (NA)-A entered room and without gowning or gloving assisted R46 to the bathroom. NA-A put on gloves and assisted R46 with wiping and perineal care, then removed gloves, washed hands and assisted R46 to his bed. NA-A stated they do not need to gown when providing direct patient care. RN-A stated gowns are not required for direct patient care unless related to the GT. On observation and interview on 10/14/24 at 12:14 p.m., R46 was in his bathroom brushing his teeth. Licensed practical nurse (LPN)-B was present and assisted R46 out of bathroom to his wheelchair when R46 stated he just wet himself. LPN-B assisted R46 to the toilet, put on gloves and changed soiled pad and using disposable wipes provided perineal care. LPN-B assisted R46 to pull his pants up then assisted R46 to his wheelchair. LPN-A did wear gloves with direct care but did not wear a gown. LPN-B indicated staff only have to gown when doing tube feedings and his medications which are also through the GT, otherwise for general care, gowns are not needed. R19's care plan included the resident requires EBP related to MDRO colonization (CRE - Carbapenem resistant enterobacerales). Interventions included wear gown and gloves when performing high contact care activities including dressing, bathing, providing hygiene such as changing incontinence product, checking and changing and assisting with toileting task. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On observation and interview 10/14/24 at 8:25 a.m., R19 returned to her room from breakfast. On the back of room door was a yellow bag with EBP sign present. On the bathroom door, a sign indicated Contact Precautions. R19 stated she gets herself to the bathroom. R19 indicated staff only wear a gown when she goes to the bathroom due to her MDRO being in her urine. Otherwise when assisting her with personal cares, they don't wear a gown. On observation and interview 10/14/24 at 12:38 p.m., LPN-B stated staff only have to wear gown and gloves when toileting R19 but not for personal cares. When questioned about the contact precautions sign on the bathroom door, LPN-B stated she wasn't sure why that was there. During interview on 10/14/24 at 2:32 p.m., the director of nursing (DON) also identified as infection preventionist, indicated staff only need to gown for R46 if using the GT because that is why he is on EBP. The DON indicated for R19, staff only need to gown and glove if possible contact with urine because R19's MDRO is in her urine. The DON stated I don't know why we would gown and glove for anything else. The DON stated she was not aware of R19 being on contact precautions or why that sign is in her room and will have it removed. After the DON reviewed the facility policy, the DON stated for EBP, staff should be wearing gowns and gloves for all high contact resident care activities and not just with cares related to the reason for being on EBP. A Standard and Transmission-Based Precautions Policy and procedure dated 4/2/24 included: Enhanced Barrier Precautions: - Enhanced barrier precautions expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. - EBP are needed for residents with chronic wounds, and residents with indwelling medical devices. - EBP are also needed for residents with CDC-targeted epidemiology important MDRO infection and colonization when contact precautions do not apply. - High contact resident care activities include: Transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, working with the resident in the therapy gym, changing linens, device care or use and wound care. - Post clear signage indicating the type of precautions and required PPE: gown and gloves for EBP. - Signage should also clearing indicate the high-contact resident care activities that require the use of gown and gloves. - Gowns and gloves should be readily available immediately outside of the resident room unless contraindicated for a resident-specific need.