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	11/19/2025

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 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. Based on document review and interview, the facility failed to submit complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (Quarter 3) 2025, (April 1 - June 30) to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS.Findings include: Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705D identified excessively low weekend staffing had triggered. Review of the nursing schedule from April 1st through June 30th of 2025, identified most weekends had scheduled 7 nursing assistance (NA) and 1 licensed nurse for both the morning shift and the afternoon shift. There were 6 weekends identified that fell below the 7 NA's however, there was an additional licensed nurse scheduled. Interview on 11/18/25 at 2:00 p.m., with the administrator identified on the weekends that had lower nursing assistance scheduled due to call ins or no available staff, the facility had scheduled a licensed practical nurse (LPN) to work the floor as a NA. She confirmed she had coded the LPN's time in PBJ as a licensed nurse verses a NA as the PBJ guidance identified to do when there was a change in LPN's normal role. This was likely what triggered the low weekend staffing. A policy on coding the PBJ report was requested but not provided by end of survey.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to implement and maintain an infection control program that included thorough data collection, analysis of facility infections, and tracking and trending to reduce the spread of infections within the facility. The facility failed to include in their surveillance viral-like illnesses not treated with an antibiotic for staff or residents. In addition the facility failed to ensure staff utilized Personal Protective Equipment (PPE), during 1 of 3 (R37) insulin administration observations. Findings include: Review of the monthly infection surveillance and staff call-in logs from August through October 2025 identified in: 1.August 2025, the surveillance identified 6 UTI's, 2 skin infections, and 1 fungal infection. The log did not identify medications prescribed or that an antibiotic time out had been completed. No residents on enhanced barrier precautions were included in the surveillance. The staff illness log identified 5 staff had called in with nausea and vomiting. 1 staff with diarrhea and fever, and 2 staff with upper respiratory symptoms and fever. The log did not indicate when the symptoms had resolved, the last day the staff worked, or when staff returned to work. 2.September 2025, the resident surveillance identified 3 UTI's, 3 skin infections, and 3 respiratory infections. The log did not identify residents on enhanced barrier precautions, and the log did not give a complete and accurate description of medications prescribed that included dose, frequency, or duration. The resident infection log identified each resident was on standard precautions. No other precaution type was identified. The staff illness log identified 5 staff had called off with GI symptoms. 5 staff with respiratory symptoms, and 3 staff with other. The log did not identify when the symptoms resolved, the last day worked, or when the staff had returned to work. 3.October 2025, the resident surveillance log identified 6 residents with urinary infection symptoms, 3 with respiratory symptoms, 1 with GI symptoms, and 4 with skin. The log did not identify medications prescribed or that an antibiotic time out had been completed. No resident on enhanced barrier precautions were included in the surveillance and the resident infection log identified each resident was on standard precautions. No other precaution type was identified. The staff call in log identified 7 staff had called in with nausea and vomiting and 3 staff with respiratory symptoms. The staff log did not identify when the symptoms had resolved, the last day worked, or the date they returned. Interview on 11/17/25 at 3:00 p.m., with the infection preventionist agreed with the above findings, she identified there was missing information on both the resident infection log and the staff illness log. She reported several staff that were out with nausea and vomiting and respiratory symptoms returned to work the next day, and at least one staff did not stay out for any time. She said that when staff call off, they must take a covid test and if it is negative they are allowed to return to work. She did not follow up with any of the staff that had called in ill with GI symptoms to see if their symptoms had resolved prior to them returning to work. She revealed that she does not get the staff illness information until the end of each pay period, and that caused difficulty with tracking staff illness. Interview on 11/18/25 at 8:14 a.m., with licensed practical nurse (LPN)-C identified when a resident has symptoms of a respiratory infection, they complete a covid test. If the test was negative and they do not have a fever they do not place them on precautions. They just notify the primary doctor to see if they want to do any additional testing or medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility Surveillance policy dated 11/10/25, lacked any indication of what should be included in the infection surveillance log, when a resident should be placed on precautions, or what type of precaution should be implemented. In addition, the policy does not give any guidance on staff illness surveillance. Observation on 11/18/25 at 11:32 a.m., with licensed practical nurse (LPN)-C as she prepared to administer R37's Lispro insulin identified R37 had physician orders for Lispro insulin 5 units, subcutaneous (SQ) before meals (AC) if his blood glucose (BG) was greater than 200. LPN-C used hand sanitizer, retrieved the Insulin Lispro Injection pen from the drawer of the medication cart, cleansed the end of the pen with an alcohol pad, applied the disposable needle, primed the pen by wasting 2 units, then dialed the dose to 5 units and presented the pen to be viewed. At 11:35 a.m. LPN-C proceeded to R37's room. She confirmed his BG on his Dexacom meter, explained she needed to administer his insulin, raised his shirt, wiped his skin with an alcohol pad and administered the insulin dose. She then wiped the area with the alcohol, pad, disposed of the used pad in the trash, returned to the medication cart where she removed the used needle and disposed in the sharp's container, and returned the pen to the top drawer of the cart. Throughout the process of administering and disposing of the used sharps, LPN-C failed to apply gloves. Interview on 11/18/25 at 11:40 a.m. with LPN-C confirmed she had forgotten to apply gloves and she stated she should have done so. She usually wore gloves when preparing and administering insulin, but she had not done so this time. Interview on 11/19/25 at 8:15 a.m. with the director of nursing (DON) identified her expectation for staff to follow infection control (IC) practices of wearing gloves when administering insulin and/or doing any practice that had the potential for exposure to blood or body fluids. A policy for the use of PPE was requested but not received by the end of the survey period.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and document review, the facility failed to ensure appropriate oversight by the infection preventionist (IP) to ensure thorough implementation of the infection control program. Findings include: Review of the monthly infection surveillance and staff call-in logs from August through October 2025 identified in: 1.August 2025, the surveillance included no map that identified location of the infections. The log identified 6 UTI's, 2 skin infections, and 1 fungal infection. The log did not identify medications prescribed or that an antibiotic time out had been completed. No residents on enhanced barrier precautions were included in the surveillance. Resident infection log identified each resident was on standard precautions. No other precaution type was identified. The staff illness log identified 5 staff had called in with nausea and vomiting, 1 with diarrhea and fever, and 2 with upper respiratory symptoms and fever. The log did not indicate when the symptoms had resolved, the last day the staff worked, or when they returned to work.2.September 2025, the resident surveillance included no map that identified the location of the infections. The log identified 3 UTI's, 3 skin infections, and 3 respiratory infections. The log did not identify residents on enhanced barrier precautions, and the log did not give a complete and accurate description of medications prescribed that included dose, frequency, or duration. Resident infection log identified each resident was on standard precautions. No other precaution type was identified. The staff illness log identified 5 staff had called off with GI symptoms, 5 with respiratory symptoms, and 3 with other. The log did not identify when the symptoms resolved, the last day worked, or when the staff had returned to work.3.October 2025, the resident surveillance included no map that identified the location of the infections. The log identified 6 residents with urinary infection symptoms, 3 with respiratory symptoms, 1 with GI symptoms, and 4 with skin. The log did not identify medications prescribed or that an antibiotic time out had been completed. No resident on enhanced barrier precautions were included in the surveillance and the resident infection log identified each resident was on standard precautions. No other precaution type was identified. The staff call in log identified 7 staff had called in with nausea and vomiting and 3 staff with respiratory symptoms. The staff log did not identify when the symptoms had resolved, the last day worked, or the date they returned. Interview on 11/17/25 at 3:00 p.m., with the infection preventionist agreed with the above findings, she identified there is missing information on both the resident infection log and the staff illness log. She reports that several staff that were out with nausea and vomiting and respiratory symptoms returned to work the next day and at least one staff did not stay out for any time. She said that when staff call off they have to take a covid test and if it is negative they are allowed to return to work. She did not follow up with any of the staff that had called in ill with GI symptoms to see if their symptoms had resolved prior to them returning to work. She revealed that she does not get the staff illness information until the end of each pay period, and this has caused difficulty with tracking staff illness. She revealed she was aware of the concerns with tracking and trending but had not implemented any changes to ensure the surveillance was thoroughly documented. She further agreed she had not provided oversite as the infection preventionist of the infection control program. The Infection Prevention and Control Program-All Service Lines policy identified an infection prevention and control program is a set of evidence-based policies, procedures, and practices implemented in healthcare settings to prevent and minimize the spread of infections among residents/patients/clients, employees, and visitors. An Infection Preventionist, or healthcare setting-specific equivalent, must bedesignated with responsibility for oversight of the infection prevention and control program. The Infection Preventionist, or appointed designee, will oversee the infection prevention and control program, in collaboration with the Safety Committee and Quality Assurance and Process Improvement Committee. The Rehab/Skilled and LTC Infection Preventionist must:1. Have primary professional training in nursing, medical technology,microbiology, epidemiology, or other related field; and2. Be qualified by (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	education, training, experience, or certification; and3. Work at least part-time onsite at the facility; and4. Have completed specialized training in infection prevention and control(i.e., CDC Nursing Home Infection Preventionist Training Course).There was no mention how the facility was to ensure appropriate oversight occurred.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to accurately assess 1 of 1 resident (R6) for a wrist brace/splint present upon admission. Findings include: R6's 10/28/25 5-day admission Minimum Data Set (MDS) assessment identified her cognition was intact, she required the assistance of 1 staff for activities of daily living, (ADLS) and transfers, and had an indwelling Foley catheter in place. She had diagnosis of diabetes type II, high blood pressure, cellulitis, (a bacterial infection of the skin's deeper layers, causing symptoms like redness, swelling, pain and warmth) of her left lower leg, lymphedema (swelling in limbs caused by malfunctioning of lymphatic system), morbid obesity, weakness, urinary retention, disorders of bone density, and heart failure. The MDS failed to include the use of a glove and wrist splint worn daily on her right wrist since admission. Observation of R6 during the period of 10/27/25 through 10/29/25, noted she wore a protective glove under a wrist splint on her right wrist. Interview on 10/27/25 at 2:00 p.m. with R6 reported she had a bone infection of her right wrist and wore the glove and splint because of that. She denied any pain or discomfort in her wrist, but reported she had worn the splint for a long time. She was not able to recall when she had the infection, or any treatment other than the use of the splint but identified she had been wearing the splint when she was admitted to the facility and every day since then. No staff had ever asked her about the use of the brace. R6's current undated care plan, physician orders, Medication administration record (MAR), and treatment record (TAR) identified no mention of R6's use of the protective glove and right wrist splint. R6's 10/22/25, Nursing Admit Re-Admit Data Collection form, completed by licensed practical nurse (LPN)-C, failed to include any restriction of mobility of her right hand and wrist or identify the use of a protective glove and splint. Interview on 11/19/25 at 7:30 a.m., with registered nurse (RN)-B reported she was not aware R6 was admitted with or currently was using a right wrist splint. RN-B noted it should have been assessed at the time of admission and included on the MDS assessment, the care plan, and on the TAR to monitor for any skin issues. Interview on 11/19/25 at 9:30 a.m., with RN-A (co-director of nursing) identified her expectation for a resident admitted with a splint or other device should be assessed, an order obtained and documentation placed in the care plan. She identified this was not present on R6's medical record and had not been assessed at the time of admission. Review of the 12/2/24, [NAME] Policy care Plan-R/S, LTC, Therapy & Rehab identified development of a comprehensive care plan to meet the individual needs of the resident. Identified needs, problems were to include measurable goals with time frames for achievement of both medical, functional, and physical plans for reaching identified goals. A policy for use of splints, or therapeutic devices was requested but not provided by the end of the survey period.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and document review, the facility failed ensure staff clarified a treatment order and accurately documented the administration of an order for 1 of 1 resident (R3) with physician orders for the application of lymphatic boots (devices using air compression to move lymph fluid out of the affected limbs and back into the circulatory system). Findings include: R3's accepted Minimum Data Set (MDS) assessment on 11/11/25, identified R3's cognition was moderately impaired. R3 required substantial assistance with cares and total assistance with toileting. R3 was noted during assessment period to have physical behaviors towards others 1-3-days, verbal behaviors towards others 1-3 days, and other behaviors (not directed at others) for 1-3 days. R3 was noted to wander within the facility 1-3 days and had a wander guard placed. R3 hallucinated and had delusions. R3 had diagnoses of Alzheimer's disease and depression. R3 took an antianxiety, antidepressant, and scheduled pain medication. R3's 9/15/25, provider dictated note identified R3 had been seen by another provider on 8/27/25 related to chronic venous disease left lower extremity status post left great saphenous vein ablation (procedure for vein destruction used to redirect blood flow). The plan was to have R3 continue wearing compression socks and start using her lymphedema pumps. R3's 9/15/25, Clinic Referral form, used for communication with physicians during appointments, identified handwritten orders on the form to please place patient in recliner after lunch with legs elevated to help with edema for 15-20 minutes at least. Ensure patient is using lymphedema pumps. R3's November 2025, Treatment Administration Record (TAR) identified the following orders:After noon dinner, offer to place R3 in recliner to elevate her legs and put on her lymphedema pumps.Use lymphedema pumps for 1 hour daily at HS (hour of sleep) and as needed. The administration record had a check mark as completed in each day through 11/18/25, except for 11/5/25. R3's 10/30/25, Clinical Referral form for visits to the doctor identified handwritten orders on the form to continue with lymphedema pumps nightly, compression hose on in morning and off at night, and to elevate legs in evening. Observation on 11/17/25 at 2:55 p.m., of R3 in her room identified R3 was seated in her recliner with her legs elevated and covered with a blanket. No lymphedema boots were noted to be on. At 6:28 p.m., R3 was again noted to be in her room, seated in her wheelchair, with no lymphedema boots were observed being on. R3's TAR identified on 11/17/25, at 12:30 p.m., staff marked her lymphedema compression boot order as administered. On 11/18/25 at 12:30 p.m., staff also marked the boots were applied and the treatment administered. Further review of R3's TAR for the month of November 2025 identified a check mark was completed each day as administered, except for 11/11/25 and 11/12/25, which had been noted by staff as refused. Further observations at various times from 11/18/25 through 11/19/25, of R3 in her room after meals and HS identified no lymphedema boots had been applied as indicated on the TAR. Interview on 11/18/25 at 2:09 p.m., with nursing assistant (NA)-A identified sometimes R3 would sit in her recliner after lunch but today she had refused. Staff would offer her to assist in helping her sit in the recliner each day after lunch. R3 did not wear her boots during the day. The nurse was to put them on her in the evening. Interview on 11/18/25 at 4:22 p.m., with licensed practical nurse (LPN)-C identified R3 had not allowed the lymphedema pumps to be put on after lunch for a long time now. When staff attempted to apply the boots, R3 would often become combative. Interview on 11/18/25 at 4:40 p.m., with the interim director of nursing (IDON) identified that the order to offer R3 to sit in recliner after lunch and put the lymphedema boots on had been charted daily for the month of November except for the 11th, and 12th which had been documented as refused by R3. She confirmed the order to apply the lymphedema boots on at HS for 1 hour had been charted as done each day except one day where there was no charting. The IDON noted R3 did refuse to wear the lymphedema boots frequently and on the TAR, two days had been charted as refused, but the other days the IDON revealed it looked like the treatment was administered. The IDON was made aware R3 had refused to sit in her recliner after lunch on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/18/25, but it had still been charted as administered, she agreed the documentation could be interpreted two ways, as either completed as pumps were applied, or staff had just offered to apply them. To her it looked like R3 had been placed in the recliner and had lymphedema boots applied on 11/18/25, as it was not charted as refused like 2 of the other days had been. The IDON placed a call to an evening nurse (LPN-B) to verify if the lymphedema boots had been applied and were being worn. LPN-B revealed R3 most often refused to wear the lymphedema boots. LPN-B stated she would mark the order as administered prior to applying the lymphedema boots. When she would attempt to put the boots on R3, and R3 refused, she would forget to go back and mark the order as refused vs. administered. LPN-B acknowledged she should not be documenting a treatment order as administered prior to the administration taking place, in case R3 would refuse. LPN-B noted documenting the administration of an order prior to executing an order was incorrect and could lead to incorrect or misleading documentation. Further interview on 11/19/25 at 11:29 a.m., with LPN-B identified R3 did not wear her lymphedema boots on any of the 5 days (11/6/25, 11/8/25, 11/9/25, 11/13/25, and 11/14/25) she had worked. LPN-B revealed she was not to be charting prior to completing a task. Interview on 11/19/25 at 12:31 p.m., with LPN-A identified she had charted on 11/18/25, for the portion of the treatment order to offer the recliner after dinner and put lymphedema boots on. R3 had refused to get into the recliner, but she had charted yes because she had been offered, and not because it had been administered. She revealed maybe that order should have been clarified and needed to be re-worded to identify if it was to be offered marked as administered. Interview on 11/19/25 at 1:20 p.m., with the IDON identified it was her expectation staff were accurately documenting in the residents' medical records and not charting prior to completing a task. The 2/10/25, Legal Documentation Standards policy identified individuals documenting in the medical record would be trained and competent in fundamental documentation practices and legal standards. Documentation in the medical record will be done following the occurrence and never in advance. The 4/6/25, Physician/Practitioner Orders policy identified clarification of orders were needed when reviewing any type of order that was incomplete or raised questions. Staff were to never attempt to guess or determine what the order might say.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included development of protocols and a system to monitor antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance for 2 of 3 resident (R35 and R42) who had an order for an antibiotic with no indication that an antibiotic time out had been completed.Findings include: R35's 8/31/25 quarterly Minimum Data Set (MDS) assessment, identified his cognition was moderately impaired, he had diagnosis of heart failure, diabetes mellitus, and dementia. R35 was independent with activities of daily living (ADL)'s. R35's August 2025, medication administration record (MAR) identified he was administered cephalexin 500 milligrams three times a day from 8/11/25 to 8/19/25. Review of the facilities monthly infection log identified R35 had been prescribed an antibiotic for a urinary tract infection (UTI) on 8/11/25. The log lacked any indication that an antibiotic time out had been completed. R42's 10/8/25 quarterly Minimum Data Set (MDS) assessment identified his cognition was severely impaired, he had diagnosis of dementia and Parkinson's disease and was dependent on staff to complete ADL's. R42's November 2025, MAR identified he was administered cefdinir oral capsule 300 mg by mouth twice a day from 9/24/25 to 9/30/25. Review of the facilities monthly infection log identified R42 had an upper respiratory infection (URI) with an onset date of 9/21/25. He was prescribed an antibiotic. The infection was resolved on 10/31/25. The infection log had no indication that a antibiotic time out had been completed. Interview on 11/17/25 at 3:00 p.m., with the infection preventionist identified no antibiotic time out was sent to the physician for R35 or R42. Staff should be adding a nursing order on the treatment administration record (TAR) to complete a time out 48 hours after the resident starts the new antibiotic. They have a template for the nurse to complete with the assessment information and that was to be sent to the physician for review. She believed nursing was forgetting to get the order added to the treatment administration record (TAR) and that is why it was being missed. Review of the facilities Antibiotic Stewardship Plan dated 7/8/25, identified staff were to complete an assessment 48-72 hours after a resident starts an antibiotic. The assessment was to include the infection type, the current antibiotic name, dose, route, frequency and start date. The culture results including source/date, identification, and sensitivity. The response to the ordered antibiotic, and the name of the physician who would review the assessment.