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	01/18/2022

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on interview and record review the facility failed to ensure assistance with cares were completed to maintain dignity for 1 of 1 residents (R5) who required staff assistance with cares. Findings include: R5's significant change Minimum Data Set (MDS) dated [DATE], indicated he was cognitively intact, had no behaviors, no wandering, required extensive assist of two with bed mobility, transfers and toileting and assist of one with personal hygiene and eating. R5's care plan dated 12/28/21, indicated for activities of daily living (ADL)'s R5 had impaired balance, limited mobility and was a quadriplegic (paralysis of the arms and legs caused by neurological damage). In addition R5's care plan indicated he required extensive assistance with personal hygiene. R5's Occupational Therapy assessment dated . 10/5/21, indicated R5 had quadriplegia, alcohol addiction and abuse, nicotine dependence, depression and anti-social personality disorder (a mental disorder in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others). The assessment further indicated R5 lacked capacity for chronic disease management and lacked insight into condition. During observation 1/13/22, at 10:14 a.m. R5 was observed from his room lying in bed next to the window from the hallway with no clothing from the waist down he was yelling Can I get up! Will someone help me! Surveyor entered room and R5 was observed to be unclothed from the waist down. R5's genitalia was observed and colostomy bag. Surveyor left room as R5 stated he wanted to talk later after he was up in his wheelchair. Approximately three minutes later while R5 was still yelling, licensed practical nurse (LPN)-A was observed to walk into the room and talk to R5 for 20 seconds and left R5's room without covering R5 and leaving R5's room with his door open the entire time. Approximately two minutes later LPN-A returned to move R5's wheelchair and housekeeping arrived to mop his floor due to pop which was spilled on his floor. During the entire observation R5's door was never shut and R5 was never covered for privacy. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview 1/13/22, at 3:00 p.m. R5 stated he had just moved into his room and was not aware anyone could see him from the door and if he knew staff or visitors could see him it would definitely bother him. In addition R5 stated I think sometimes the staff just forget to shut the door or cover me up but it does upset me. During interview 1/18/22, at 9:30 a.m. LPN-A stated she was caring for R5 on 1/13/22, and was in and out of the room in the morning and remembered not shutting the door and really did not notice R5 was uncovered and if she did she should have covered R5 up or shut the door for dignity purposes. LPN-A stated she should look closer at the residents when she enters the room to make sure they are fully covered. Facility policy Privacy and Dignity dated 1/10/22, indicated Privacy is provided during cares and resident is appropriately covered

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on interview and document review, the facility failed to report to the state agency (SA) for 1 of 1 resident's who required supervision on facility grounds who left the facility unsupervised and was found intoxicated at a near by gas station and required emergency medical treatment for alcohol intoxication. Findings include: R5's Face Sheet undated, indicated R5 admitted to the facility on [DATE]. R5's Care Plan revised 11/22/21, indicated R5 was considered a vulnerable adult due to his cognitive and functional deficits and was not to leave the facility without supervision from his guardians or aunt, and R5 refuses to comply with plan to not leave the facility unsupervised without his guardians or aunt. (date initiated 8/17/21). R5's significant change Minimum Data Set (MDS) dated [DATE], indicated he was cognitively intact, had no behaviors, no wandering, required extensive assist of two with bed mobility, transfers and toileting and assist of one with personal hygiene and eating. R5's MDS further indicated he received antidepressant medications (used to address symptoms of depression), antipsychotic medications (used to manage psychosis, including delusions, hallucinations, paranoia or disordered thought) and hypnotic medications (produce sleep). R5's Wandering Risk Scale assessment dated [DATE], indicated R5 was dependent on activities of daily living (ADL)'s, and cannot move with out assistance and required assistance from staff for transfers and was independent with the use of an electric wheelchair. The assessment further indicated R5 was at low risk for wandering. R5's Risks vs Benefits assessment dated [DATE], indicated a recommendation R5 would not leave facility unsupervised by nursing staff and nurse practioner due to high risk for abuse by others and exploitation due to his cognition and quadriplegia diagnosis. In addition, the assessment indicated R5's guardian agreed with the plan not to allow R5 to leave the facility without supervision however, the guardian did express R5 is going to do what [R5] wants to do. Review of R5's progress notes indicated on 8/27/21, the facility received a phone call from St. Cloud police that R5 was found at a nearby gas station. R5's speech was mumbled and did not appear to be able to safely drive himself back to the facility in his motorized wheelchair. He was sent to the emergency room (ER) and treated for alcohol toxicity. Review of R5's record there was no report made to the state agency of R5's incident occurrence that occurred on 8/27/21. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview 1/13/22, at 4:05 p.m. assistant director of nursing (ADON) stated she had concerns with R5 leaving the facility and coming back smelling like Marijuana along with his old roommate. The ADON stated he was hospitalized in the past for alcohol intoxication. The ADON stated he will make phone calls and go off the facility grounds to buy marijuana which they would then confiscate from him. During interview on 1/14/22, at 1:00 p.m. the director of nursing (DON) stated R5 had a motor vehicle accident in his teens and was diagnosed with a Traumatic Brain Injury following the car accident and now used a motorized wheelchair for mobility. The DON stated she was unsure how he obtained the alcohol for his 8/27/21, ER visit. Further the DON stated R5 had made plans to go get medical marijuana that day (8/27) and his dad said he could not go, so the facility canceled his cab. The DON stated the facility was aware R5 was upset and took off (left campus unsupervised) but did not consider this an elopement. He was found later at the gas station very intoxicated by the police. The DON stated she never really thought these incidents were reportable and after thinking according to policy they probably should have been. A facility Policy Abuse and Prevention Program revised 1/10/22, indicted all residents are protected from abuse, neglect and harm while they are residing at the facility and no harm of any type will be tolerated. In addition the policy indicated a mandated reporter shall make a report to the state reporting agency immediately of the alleged incident!

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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** 44650 Based on observation, interview, and document review, the facility failed to ensure assistance was provided with routine grooming and personal hygiene for 1 of 3 residents (R1) who was dependent on staff for grooming and nail care reviewed for activities of daily living (ADLs). Findings include: R1's discharge Minimum Data Set (MDS), dated [DATE], indicated R3 was cognitively intact. In addition, the MDS identified R1 required extensive assistance for personal hygiene which included combing hair, shaving, washing/drying of hands. R1's care plan dated 1/4/22, did not address R1's ADL function and required assistance with grooming. On 1/13/22, at 9:57 a.m. R1 was observed in his bed looked disheveled with long facial hair and fingernails. Underneath the fingernails was a large amount of dirt. Also R1 had multiple small scratches and scabs on his left forearm and elbow. On 1/13/22, at 11:22 a.m. interviewed R1's power of attorney (POA) who stated R1 was never groomed and had long facial hair and dirty long fingernails. The POA stated she brought a razor for staff to use but they were not using it and R1 appeared disheveled all the time. The POA further stated she did not like seeing R1 not well groomed. -At 12:10 p.m. the POA stated R1 had always been a picker ever since he was a child and gets scratches and scabs on his left arm frequently. POA then stated maybe R1 would not have as many scratches and scabs if the fingernails were kept short. On 1/13/22, at 12:15 p.m. interviewed POA's fiance` who stated he had known R1 for a long time and when he and the POA visited R1 he always appeared disheveled with long head hair, facial hair and fingernails and R1 had always been a clean shaven person and well-kept prior to his admission to the facility. On 1/14/22, at 9:20 a.m. interviewed R1 who stated they had not cut his fingernails or facial hair. R1 appeared as he did on 1/13/22. R1 stated he had not gotten a shower in a long time, but staff did clean him up some with some towels while in his bed the previous day on 1/13/22. On 1/14/22, at 9:25 a.m. interviewed nursing assistant (NA)-A who stated R1 received his bath on 1/13/22, which was his bath day scheduled one time per week. NA-A stated she was not aware of any bathing concerns for R1. NA-A stated R1 was a full assist for most cares including grooming. On 1/14/22, at 10:09 a.m. interviewed licensed practical nurse (LPN)-A who stated R1 does refuse cares sometimes. She then stated how staff approached R1 was important for and she could typically convince R1 to allow cares. LPN-A further stated R1 had been allowing bed baths and R1 required full assist for ADLs and grooming. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/22, at 12:20 p.m. interviewed the director of nurse (DON) who stated she was unaware of concerns with R1's grooming. The DON stated grooming should be done with his weekly bathing. The DON acknowledged R1's care plan was incomplete and had not been properly updated after the recent re-admission to the facility on [DATE]. DON acknowledged R1's long fingernails were contributing to the left arm scratches and scabs. The DON further stated staff should be making sure R1's grooming got done. The facility Policy and Procedure Activities of Daily Living, dated 3/15/21, indicated the facility will provide a comprehensive assessment of a residents to identify needs and choices. In addition, the policy indicated the facility will provide care and services for the following ADLs: hygiene, mobility, elimination, dining and communication.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 28598 Based on observation, interview, and document review, the facility failed to comprehensively develop appropriate interventions to ensure adequate supervision was provided to prevent known off-campus activities which increased the risk of harm and/or injury for 1 of 1 resident (R5) assessed and care planned to require supervision in the community and identified to repeatedly be leaving the nursing home to purchase and/or use alcohol and marijuana (an illegal psychoactive drug). These findings constituted an immediate jeopardy (IJ) situation for R5. The IJ began on 8/27/21, when R5 left the nursing home campus and was later found at a gas station intoxicated by the local police department. R5 demonstrated mumbled speech and was unable to safely operate his electric scooter. R5 was returned to the nursing home; however, was not comprehensively or accurately reassessed for his wander risk nor were interventions placed to ensure adequate supervision. This resulted in R5 repeatedly leaving the campus, purchasing, and using alcohol and/or marijuana which increased his risk of serious injury or harm while off-campus. The administrator and director of nursing (DON) were notified of the IJ for R5 on 1/14/22, at 4:35 p.m. The IJ was removed on 1/18/22, at 11:35 a.m. after an acceptable removal plan was implemented, however, non-compliance remained at an isolated pattern with potential for more than minimal harm which is not immediate jeopardy (Level D). Findings include: R5's Face Sheet undated, indicated R5 admitted to the facility on [DATE]. R5's Care Plan revised 11/22/21, indicated R5 was considered a vulnerable adult due to his cognitive and functional deficits and was not to leave the facility without supervision from his guardians or aunt, and R5 refuses to comply with plan to not leave the facility unsupervised. (date initiated 8/17/21). R5's significant change Minimum Data Set (MDS) dated [DATE], indicated he was cognitively intact, had no behaviors and no wandering. R5's MDS further indicated he received antidepressant medications (used to address symptoms of depression), antipsychotic medications (used to manage psychosis, including delusions, hallucinations, paranoia or disordered thought) and hypnotic medications (produce sleep). R5's Wandering Risk Scale assessment dated [DATE], indicated R5 was dependent on activities of daily living (ADL)'s, and cannot move with out assistance and required assistance from staff for transfers and was independent with the use of an electric wheelchair. The assessment further indicated R5 was at low risk for wandering. R5's Risks vs Benefits assessment dated [DATE], recommeded R5 would not leave facility unsupervised due to high risk for abuse by others and exploitation due to his cognition and quadriplegia diagnosis. In addition, the assessment indicated R5's guardian agreed with the plan not to allow R5 to leave the facility without supervision however, the guardian did express R5 is going to do what [R5] wants to do. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R5's Occupational Therapy assessment dated [DATE], indicated R5 had quadriplegia (paralysis of the arms and legs caused by neurological damage), alcohol addiction and abuse, nicotine dependence, depression and antisocial personality disorder (a mental disorder in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others). The assessment further indicated R5 lacked capacity for chronic disease management and lacked insight into condition. R5's Medical History undated, indicated he was diagnosed with quadriplegia and a traumatic brain injury following a car accident and uses a mobilized wheelchair for mobility. Review of R5's progress notes indicated on 8/27/21, the facility received a phone call from St. Cloud police that R5 was found at a nearby gas station. R5's speech was mumbled and did not appear to be able to safely drive himself back to the facility in his motorized wheelchair. He was sent to the emergency room (ER) and treated for alcohol toxicity. During interview 1/13/22, at 4:05 p.m. assistant director of nursing (ADON) stated she had concerns with R5 leaving the facility and coming back smelling like marijuana along with his old roommate. The ADON stated he was hospitalized in the past for alcohol intoxication. The ADON stated he will make phone calls and go off the facility grounds to buy marijuana which they would then confiscate from him. During interview on 1/14/22, at 1:00 p.m. the director of nursing (DON) stated R5 had a motor vehicle accident in his teens and was diagnosed with a traumatic brain injury following the car accident and now used a motorized wheelchair for mobility. The DON stated she was unsure how he obtained the alcohol for his 8/27/21, ER visit. Further the DON stated R5 had made plans to go get medical marijuana that day (8/27) and his dad said he could not go, so the facility canceled his cab. The DON stated the facility was aware R5 was upset and took off (left campus unsupervised) but did not consider this an elopement. He was found later at the gas station very intoxicated by the police. During interview on 1/14/22, at 11:39 a.m. receptionist stated she was informed about 2 weeks ago that she could let R5 leave the building to smoke and was given no instruction to observe him. She stated she was unable to see him or keep him in her line of sight while he was outside. She does not keep track of how long he was outside or when/if he returns. During observation and interview on 1/14/22, at approximately 11:00 a.m. surveyor was informed R5 had left the facility and the DON had just called 911. Both surveyor and ADON went outside and found R5 driving down the middle of the road in his motorized wheelchair toward the facility during moderate snow fall, with difficult visibility. R5 was observed to be wearing just a sweatshirt and pants with footwear, no jacket or other outerwear. The temperature was 10 degrees. The facility was unsure what time R5 may have left the building that morning. -while outside looking for R5, the ADON pointed out a secured smoking area that was monitored by staff. Later at 3:30 p.m. the ADON was interviewed and asked why R5 does not use the secured smoking area, at which time the RN manager stated that R5 does what he wants, when he wants. During interview on 1/14/22, at 2:10 p.m. the DON stated R5 had left the facility unsupervised at least 5 times since admission. The DON further indicated on multiple occasions he was found with marihuana they had to confiscate from him. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of R5's drug screening indicated on 8/12/21, 8/27/21, and 12/28/21, R5 tested positive for tetrahydrocannabinol (THC). During interview on 1/14/22, at 2:53 p.m. nursing assistant (NA)-B stated R5 was allowed to go outside for about 10 minutes. She is not sure who monitors him, it would have to be the person who let him out. NA-B indicated she received training that R5 and his roommate could go outside but had to have coats on first. She was not aware they had to be supervised. Review of Realis computer training records indicated on 1/7/22, R5 and his roommate can go outside for 10 minutes if they put a coat on. Communication to employees lacked evidence R5 required supervision if leaving the facility as indicated in his Care Plan. During interview on 1/14/22, at 2:57 p.m. licensed practical nurse (LPN)-B stated R5 was allowed to leave the facility. In addition, LPN-B stated with his behavior changes they are reassessing if this should be allowed. LPN-B also stated that today he had an incident and they did not know where he was so they had to call 911. During interview on 1/14/22, at 3:04 p.m. ADON stated R5 was able to go outside for 10 minutes and could not leave the grounds, and needs supervision per his guardian. Furthermore the ADON stated she just had gotten off the phone with R5's dad minutes before this interview and stated his dad does not want him to be leaving the facility grounds because he engages in self destructive behavior such as heavy drinking, drugs, ect. and R5 is very difficult to work with. In addition, the ADON stated she had been instructed when R5 leaves the facility it was not considered an elopement since he had a destination he was going to. During interview at 1/14/22, at 3:30 p.m. the DON stated the facility does not have any formal plans for when R5 leaves the facility grounds to direct the staff what to do if they suspect he had been under the influence of alcohol or drugs. In addition the DON stated they were not following the care plan as stated and should have had a better system in place for staff to be monitoring when R5 was leaving and returning, including the staff at the front desk monitoring his exit. During interview 1/17/22, at 11:00 a.m. R5's guardian stated he does not want R5 to leave the facility grounds without supervision since he does not make safe decisions. The facility's Elopement Policy revised 9/2/21, indicated, It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents identified will have these issues addressed in their individual care plan. The IJ which began on 8/27/21, was removed on 1/18/22 at 11:28 a.m., when the facility successfully implemented a removal plan which included reviewing the applicable policies and procedures, ensured all residents were reassessed and care planned for their elopement risks and needs, and ensured all facility tools (i.e. w binder) were updated with current, correct information to help staff ensure safety and prevent elopements of residents identified to be at risk and those at risk are supervised. On 1/18/22, from approximately 9 a.m. to 11:00 a.m. direct care staff were interviewed and verified education had been completed and systems were in place to ensure residents were not at continued significant risk of elopement and those at risk are supervised but, non-compliance remained at an isolated pattern with potential for more than minimal harm which is not immediate jeopardy (Level D).