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	03/18/2022

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27955 Based on interview and document review, the facility failed to allow 1 of 1 resident (R1) reviewed for involuntary discharge to return to facility following hospitalization . Findings include: R1's admission record indicated R1 was admitted [DATE]. R1 was his own responsible person. R1 diagnosis included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), alcoholic cirrhosis of liver, CVA (cerebral vascular accident) and diabetes mellitus. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact. R1 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. R1's care plan indicated R1 wished to remain at the facility for long term care. R1's pulmonology clinic consult dated 8/20/21, indicated continuous oxygen at three liters per minute (LPM). Provider note dated 1/10/21, identified R1's smell of marijuana which suggested either strong or heavy use, and therefore no drug screen was necessary. An untitled document dated 1/17/22, indicated R1 was provided education on illegal substance use and storage in the facility being prohibited. R1 agreed to abstain from illegal substance use and storage in the facility and expressed an understanding of the information. R1 signed the untitled document. A progress note dated 3/8/22, at 4:23 p.m. indicated R1 was smoking in his room while wearing his oxygen and started a fire to his nasal, upper lip area and hands. EMS (emergency medical services) was called and R1 was transported to the hospital for evaluation. (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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 3/9/22, indicated R1 was presented with a written 30-Day Discharge Notice in person by facility staff while he was in the hospital. The hospital social worker was present, and a copy was given to R1 and the social worker. R1 stated he wanted to appeal the discharge. The 30-day discharge indicated the anticipated date of discharge was immediate, up to but no later than April 9, 2022. A Thirty Day Discharge Notice dated 3/9/22, was due to unsafe practices of smoking in his room while using oxygen. It further indicated, R1 was a risk to other residents with his drug addiction and unwillingness to follow safety protocols. It also revealed, R1 was not safe even if the facility provided one to ones. During an interview on 3/17/22, at 12:25 p.m. the director of nursing (DON) stated R1 lacked compliance with having illegal substances in the building. On 3/18/22, the DON stated, in the past, R1 had no consequences given to him when found smoking or suspected of smoking illegal substance in the facility. During an interview on 3/18/22, at 11:17 a.m. the long-term care Ombudsman (LTCO-A) stated R1 was not given an appropriate 30-day discharge. LTCO-A stated the facility was encouraged to readmit R1 for the remaining part of the 30 days. However, the facility failed to comply. During an interview on 3/18/22, at 12:06 p.m. the administrator stated R1 was his own person. The administrator stated R1 was not given any written consequences for previous smoking or suspected smoking of illegal substances. The administrator stated the 30-day discharge notice was given to R1 for lighting himself on fire in his room. The facility had a sprinkler system for fires in the building. The administrator was not aware whether or not R1 had smoked while wearing oxygen before. She stated the company told her to not take R1 back and work with the SCH to find the correct location for him. During an interview on 3/21/22, the hospital licensed social worker (LSW)-A stated R1 was medically ready for discharge from the hospital the week of 3/14-18/22, and the facility declined to allow R1 to return. The facility policy Admission, Readmission, Bed Hold, and Transfer/discharge date d 10/12/21, indicated the facility must permit each resident to remain in the facility, and not transfer or discharge the resident unless, the transfer or discharge is necessary for the residents' welfare and the resident's needs cannot be met in the facility. The transfer or discharge is appropriate because the resident's health has improved sufficiently, and the resident no longer needs the services provided by the facility. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident. The health of individuals in the facility would otherwise be endangered.

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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** 27955 Based on interview and document review the facility failed to ensure 1 of 1 resident (R1) was appropriately supervised and prohibited from keeping a cigarette lighter and smoking material in his room. R1 was smoking with oxygen on while in his room which resulted in burns to his face. The deficiency was identified as past non compliance and issued at Immediate Jeopardy (IJ). The IJ began on 3/8/22, at 4:25 p.m. when R1 received burns to his face while smoking and wearing oxygen. However, the facility immediately implemented corrective action to prevent reoccurrence by 3/15/22 before survey started. The administrator and director of nursing (DON) were notified of the IJ past noncompliance on 3/17/22 at 5:25 p.m. as a result of corrective action taken by the facility. Findings include: R1's admission record indicated R1 was admitted [DATE]. R1 was his own responsible person. R1 diagnosis included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs). R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact. R1 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. The MDS did not identify R1 smoked. R1's care plan dated 6/2/21, lacked any indication R1 smoked cigarettes or used illegal substances. There was no indication in the medical record the faciltiy assessed R1's smoking safety. R1's pulmonology clinic consult dated 8/20/21, indicated R1 had smoked four packs of cigarettes a day for [AGE] years and had a history of using illegal drug. R1 used continuous oxygen at three liters per minute (LPM). Progress notes revealed the following: -10/24/21, registered nurse (RN)-A documented R1's room smelled of smoke and R1 was told to not smoke in the room due to high risk of causing fire because R1 was on continuous oxygen. -10/28/21, director of nursing (DON) documented smell of smoke coming from R1's room. R1 denied smoking. -11/12/21, licensed practical nurse (LPN)-C documented R1 was found smoking. -1/16/22, RN-B documented R1 was observed smoking by the chapel door. She searched R1's room and notified the DON. -1/30/22, LPN-B documented R1 was observed smoking in the corner on the fireside area of facility, DON notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-2/22/22, LPN-A documented staff smelled smoke coming from R1's room, staff took contraband and educated on facility smoking policies. -2/22/22, LPN-B documented entry into R1's room and observation of R1 lighting smoking material. She contacted the DON, searched the room and R1 was yelling I will smoke whenever I feel like it and refused to give LPN-B the contraband. -3/1/22, the administrator documented R1's room smelled of smoke he was informed resident rooms were not authorized smoking areas. -3/8/22, RN-C documented approximately at 4:20 p.m. R1 had lit his oxygen on fire attempting to smoke in his room. Emergency medical services (EMS) were called to transport to the hospital. When RN-C asked him what happened R1 stated nothing. R1's face was black, the air smelled of burnt hair and flesh. A lighter was found on the bedside table. R1's nasal cannula was destroyed. EMS arrived and took R1 to the hospital for evaluation. R1's room was searched and the contraband was given to the administrator. Provider note dated 1/10/21, identified R1's smelled of marijuana which suggested either strong or heavy use, and therefore no drug screen was necessary. An untitled document dated 1/17/22, indicated R1 was provided education on illegal substance use and storage in the facility was prohibited. R1 agreed to abstain from illegal substance use and storage in the facility while he resided. He expressed an understanding of the information and signed the document. During an interview on 3/17/22, at 11:53 a.m. licensed practical nurse (LPN)-A stated she had found R1 in his room on 2/22/22, with a pipe and lighter in his hands. LPN-A informed R1 he could not smoke in the facility. LPN-A searched R1's room, confiscated and removed the contraband. LPN-A told R1 that he could blow himself and others up if R1 kept smoking with his oxygen on. LPN-A stated she had informed the director of nursing (DON) what had occurred. LPN-A stated she had caught R1 smoking a few times before this. However, LPN-A could not recall if his oxygen was on. During an interview on 3/17/22, at 12:25 p.m. the DON stated R1 lacked compliance with having smoking substances in the building. On 3/18/22, the DON stated R1 had no consequences given to him when found smoking or suspected of smoking in the facility in January 2022. The DON stated she did not know that R1 smoked anything, however she suspected. The DON stated there was no smoking assessment completed for R1. They should have completed a smoking assessment when they became aware of R1 smoking in January 2022. LPN-B stated on 3/8/22, at 4:30 p.m. she heard R1 calling out and found from him in his room calling out oh boy several times and the room smelt of burnt flesh. R1 was putting out flames on his upper chest, beard area, nose, lips, left arm and hand. R1's had black soot on his face and chest area. LPN-B helped to smother out the flames. The oxygen concentrator was on in the room and LPN-B shut it off and removed the oxygen concentrator out of R1's room. LPN-B stated the oxygen nasal cannula tubing had been burnt and was in two pieces, it had not burned to R1's face but came off easily. The smoking contraband was confiscated. LPN-B stated she did not see R1 smoking but smelled it in the room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/18/22, at 12:06 p.m. the administrator stated R1 was his own person. R1 had signed a contract but was never given any written consequences for previous smoking infringements. The administrator stated this was the first time R1 had lit himself on fire with the oxygen on. The administrator was not aware that R1 had smoked with the oxygen on before this event. The facility policy Smoking ad E-Cigarettes dated 3/1/21, revealed smoking was only permitted in posted designated areas. No oxygen containers/tanks/materials or other flammable substances are permitted in the designated smoking area. It further indicated, smoking will only be permitted by residents after safety assessment by the interdisciplinary team. The past non-compliance that began on 3/8/22, was verified during the 3/17/22, in the afternoon and identified the immediacy was corrected on 3/15/22. During an interview on 3/17/22, at 12:25 p.m. the DON stated the facility had reviewed all care plans and updated with smoking assessments, risk verses benefits, illegal substances contracts, and acknowledgement of smoking policy. Further, if smoking substances were found, a room search would be ordered and put on the treatment administration record (TAR). All residents on oxygen had signs put on their doors. The facility had a Safety Council meeting, updated the contraband, smoking, and oxygen use policies, conducted a facility wide smoking education and a mock fire drill. Audit of resident documents verified smoking assessments were completed and care plans were updated on 3/9/22. Documented notes verified a Safety Council Meeting and fire drill on 3/9/22. Staff interviews on 3/17/22, confirmed training had been completed and were aware of smoking policy, and the reporting of smoking concerns. Staff interviews indicated staff were aware of R1's smoking restrictions. Other documentation provided, revealed that as of 3/15/22, the facility had over 90% of staff re-educated on Improper/Unsafe Resident Smoking and the Prohibition of Illegal/Illicit Materials in the facility. Facility conducted audits on resident smoking safely.