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	10/12/2021

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43084 Based on observation, interview, and document review, the facility failed to assess the practice of self-administration of medications was safe for 1 of 1 resident (R38) observed to self-administer a nebulized medication. Findings included: R38's admission Minimum Data Set (MDS), dated [DATE], indicated R38's cognition was severely impaired. R38's face sheet, dated 10/7/21, noted R38's diagnoses included Alzheimer's Disease, dementia, and shortness of breath. R38's medication list signed by her provider on 10/6/21, noted R38 had an order to receive Ipratropium-Albuterol Solution inhaled by nebulizer four times a day related to shortness of breath. R38's care plan dated 9/3/21, failed to identify R38's need for assistance with administration of medications by nebulizer. On 10/6/21, at 12:03 p.m. registered nurse (RN)-A was observed setting up liquid medication for administration by nebulizer for R38. RN-A applied the face mask to R38 and reminded her to leave the mask on while receiving the medication. RN-A turned the nebulizer machine on, then walked towards R38's bedroom door. RN-A noted R38 was attempting to remove the face mask. RN-A returned to R38, reapplied the mask, reminded R38 to leave the mask in place until RN-A returned to remove, then left R38's room. After RN-A left R38's room, another surveyor observed R38 while the nebulizer was running. R38 did not make further attempts to remove the mask. On 10/6/21, at 12:15 p.m. nursing assistant (NA)-G was observed entering R38's room. NA-G turned off the nebulizer machine and removed the mask. (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
	245438	A. Building B. Wing	10/12/2021

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/6/21, at 1:49 p.m. RN-A confirmed she did not remove the mask or turn off the nebulizer machine, rather, she directed unlicensed staff, NA-G, to complete the task. RN-A stated self-administration of a nebulizer involved the resident placing the solution in the medication cup, applying the mask, and turning on the machine. RN-A did not consider leaving a severely cognitively impaired resident alone while receiving nebulized medication to be self-administration of medication. RN-A indicated she usually set up R38's nebulizer then left her unattended. She is really good about keeping it on. RN-A stated she would check on R38 frequently while receiving the nebulizer. RN-A confirmed she did not perform frequent checks on R38 during this observation, and had NA-G check on R38 to remove the mask after 10 minutes of nebulizing. RN-A stated self-administration of medication required a doctor's order. RN-A confirmed R38 did not have an order to self-administer medications. On 10/7/21, at 1:53 p.m. NA-G confirmed she had removed the nebulizer mask and turned off the machine and had not been trained in this process. On 10/7/21, at 4:13 p.m. director of nursing (DON) indicated administration of nebulized medication included placing the solution in the medication cup, applying the mask, turning on the machine and staying with the resident until the medication was fully administered. Removing the mask and turning off the machine were also part of the administration process. DON expected medication administration was completed by a licensed nurse or those who were trained to administer medications. DON indicated self-administration of medications, including nebulized medication, required an assessment of the resident's ability to safely self-administer medications and a doctor's order. DON confirmed, R38 had not been assessed to safely self-administer medications, nor did R38 have a doctor's order to self-administer medications. DON stated based on R38's cognitive status, she would not be appropriate for self-administration of medications. Facility policy, Self-Medication Assessment, revision date 1/2/19, noted residents shall have an assessment completed by a licensed nurse.

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	10/12/2021

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 0565 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 27955 Based on interview and document review the facility failed to ensure residents were allowed to conduct periodic resident council meetings. This had the potential to affect all 67 residents residing in the facility. Findings include: A request of the last three resident council meeting minutes revealed one resident council meeting occurred on 7/22/21. The facility was unable to provide any further meeting notes. During an interview on 10/7/21, at 8:47 a.m. the activity director (AD) stated activities focused on one to one activities for the residents. The AD stated there was no discussion of grievances or rights while doing one to one activities with residents. The AD stated since she was hired in June there was only one resident council meeting on 7/22/21. The AD stated resident council meetings should be held monthly. Due to COVID they did not have resident council, they were in lock down for the year except July when they had a resident council meeting. They were unable to find any other resident council meeting minutes for the year. During an interview on 10/8/21, at 10:14 a.m. the administrator stated ideally resident council would happen monthly. The administrator stated they were unable to locate any further resident council meeting minutes for the year. The facility's Resident Council policy, dated 2/26/20, indicated the facility would provide residents with the opportunity to air any grievances that they may have and to give suggestion on what they would like. Along with any changes they think should be made.

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	10/12/2021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43084 Based on interview and document review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 1 residents (R15) who alleged physical abuse by a staff member and 2 of 2 residents (R2 and R16) reviewed for resident to resident abuse. Findings include: R15's significant change Minimum Data Set (MDS), dated [DATE], indicated R15's hearing and vision were adequate and R15 was usually able to make himself understood. R15 required physical assistance from staff for bed mobility, transfers and toilet use. R15's diagnoses included aphasia (a communication disorder that impairs a person's ability to process language but does not affect intelligence). The facility's investigation file indicated on 8/9/21, the facility filed a report of alleged abuse with the State Agency (SA). The report resulted from an allegation made by R15 towards nursing assistant (NA)-F, who was no longer employed with the facility. Documents indicated on 8/9/21 at 5:05 p.m. the Administrator interviewed the Therapy Director about a concern form that she had filled out. This form indicated R15 alleged that NA-F kicked him in the back. Facility investigation and interviews completed and submitted to the SA on 8/9/21, included interviews with staff who witnessed the incident, however, the investigation failed to include interviews from other residents who also received care provided by NA-F. On 10/7/21, at 4:18 p.m. director of nursing (DON) stated a complete investigation for allegations of abuse, included interviews with residents who also received care from NA-F. DON confirmed, the investigation into R15's allegations was not completed because it did not include interviews with other residents. DON indicated it was important to interview other residents who received care from NA-F to determine if there was a pattern of abuse and to ensure other residents felt safe when cared for by NA-F. 44645 R2's quarterly Minimum Data Set (MDS), dated [DATE], indicated R2 did not have deficits in vision, hearing, or speech, and was understood and able to understand others. R2 had no cognitive impairment. R2's face sheet, printed 10/8/21, indicated R2's diagnoses included encephalopathy (a disease of the brain that alters brain function or structure), dementia, and depression. R2's care plan, revised 9/29/21, indicated R2 had been verbally threatening with others, and directed staff to move R2 to a quiet area, allow her to express her feelings, and ensure the safety of self and others. R16's quarterly MDS, dated [DATE], indicated R16 had severe cognitive impairment. R16 did not have vision, hearing or speech deficits, and was usually understood and usually able to understand others. (continued on next page)

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	10/12/2021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's face sheet printed 10/8/21, indicated R16's diagnoses included dementia with behavioral disturbance, and adjustment disorder with anxiety. R16's care plan, revised 8/12/21, indicated R16 had behavior symptoms of being physically and verbally aggressive with others. Additionally, the care plan directed staff to intervene before agitation escalates, guide R16 away from source of distress, and calmly engage R16 in conversation. R16's care plan further indicated R16 had hit another resident on 6/7/21, and 7/7/21. On 10/4/21, at 6:14 p.m. R2 stated about two weeks ago, a resident hit me, and I hit them back. R2 further stated, if someone hits me, I will hit them back. An allegation of abuse regarding a resident-to-resident physical altercation between R2 and R16 was reported to Minnesota Department of Health (MDH) on 9/22/21, at 2:08 p.m. and the subsequent investigation report was submitted to MDH on 9/29/21, at 1:20 p.m. The facility's investigation documentation for the 9/22/21 allegation, included an Investigation Summary Report dated 9/29/21, which indicated podiatry staff reported R16 hit R2 to nursing assistant (NA)-H at approximately 1:07 p.m. on 9/22/21. Video footage showed NA-H was in process of escorting R16 to another location when R2 hit R16 on 9/22/21 at 1:15 p.m. Additionally, the facility investigation documentation included an undated, typed statement signed by RN-A stating she did not notice any interaction between R2 and R16 leading up to the incident while podiatry was on site. The facility's documentation did not show evidence podiatry employee(s) that reportedly witnessed R16 hit R2 was interviewed. Also, there was no indication the facility interviewed the residents involved in the incident. On 10/8/21, at 10:08 a.m. director of nursing (DON) stated R2 had not retaliated in the past. R2 was feisty, but not usually physical with other residents. The DON confirmed the residents and the podiatry staff were not interviewed as a part of the investigation. The facility Vulnerable Adult Abuse and Neglect Prevention policy revised 11/17/20, indicated upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately, and the DON or assigned designee, will coordinate an investigation, which will include completion of witness statements and all parties involved including two of the following - staff, residents or visitors, who were potentially involved, or observed the alleged incident are to be interviewed by the DON, Director of Social Services, or their designees.

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	10/12/2021

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645 Based on interview and document review, the facility failed to ensure 1 of 5 residents (R53) reviewed for Advance Directives, had their current health care wishes identified clearly in the medical record. Findings include: R53's admission Minimum Data Set (MDS) assessment, dated [DATE], indicated severe cognitive impairment, and required staff assistance with all activities of daily living (ADLs). R53's order summary report, printed [DATE], indicated R53 was admitted to the facility on [DATE], and had diagnoses of Alzheimer's disease, severe protein-calorie malnutrition, depression, and anxiety disorder. R53's Provider Orders for Life-Sustaining Treatment (POLST), signed by responsible party [DATE], indicated DNR (do not resuscitate), comfort-focused treatment to allow a natural death, no artificial nutrition by tube, and oral antibiotics only (no IV/IM). The POLST was signed by family member (FM)-A on [DATE], however, had not been signed by the health care professional who prepared the document. Also, there was no DNR orders found in R53's chart. R53's care plan last revised [DATE], indicated the following for advance directives: See current signed advance directive and/or POLST in resident's record. On [DATE], at 10:31 a.m. director of nursing (DON) verified the POLST indicated DNR, comfort-focused treatment, no artificial nutrition by tube, and oral antibiotics only. DON stated, I don't see a provider signature or the health care professional who prepared the document's signature. DON confirmed the POLST was not a valid DNR order, she had been unaware of the error, and she would correct it immediately. The facility's policy, Advanced Directives, revised [DATE], directed Residents without an advanced directive or DNR order, full CPR is performed unless clinically contraindicated. The policy further indicated, If a resident becomes unresponsive, either witnessed or unwitnessed, the resident's Advanced Directives/POLST will be followed.

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	10/12/2021

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43084 Based on observation, interview and record review the facility failed to ensure the emergency medication kit (E-Kit) was properly secured in 1 of 2 medication rooms reviewed for medication storage. This has the potential to effect residents whom resided on the north wing. Findings include: On 10/8/21, at 9:34 a.m. during inspection of the north medication room with registered nurse (RN)-C the E-Kit was noted to not be secured with a color-coded zip tie. RN-C confirmed the E-kit was not secured with a color-coded zip tie. Review of Talahi Care Center Fridge E-Box, [NAME] Contents identified it had the contents of Lantus (used for diabetes) pen solostar 3 ml, 1 pen; Aspart (Insulin for diabetes) 3 ml, 1 pen; Novolin (Insulin for diabetes) R 10mL, 1 vial; Novolin (Insulin for diabetic) NPH 10mL, 1 vial; and Ativan (Lorazapam)(used for anxiety) 2 mg/ml, 2 injectable. On 10/8/21, at 9:37 a.m. RN-C stated she was not aware of the process for removal of medications from the E-Kit but did not think it included securing the box with a color-coded zip tie, otherwise I think there would be one already on there. RN-C confirmed the E-Kit was delivered from pharmacy with a colored zip tie in place. The zip tie was removed when someone accessed the E-Kit. RN-C stated she was not sure how to determine who removed the original zip tie or for what reason. Retrospective Item Withdrawal Instructions, undated were adhered to the top of the E-Kit and included directions for removing medications, replacing the security seal(s) and returning the kit to the designated E-kit area. On 10/8/21, at 1:40 p.m. director of nursing (DON) stated there was a tracking book for the E-Kit. She expected the number on the zip tie removed was written in the book as well as the number on the different colored zip tie that was used to secure the E-Kit after it was opened, and a medication was removed. DON expected the E-Kit was checked each shift, by licensed nurses, to ensure it was secured.

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	10/12/2021

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43084 Based on observation, interview and document review the facility failed to ensure time sensitive medications were discarded after the beyond-use date had expired for 1 of 1 resident (R48) whom had eye drops in 1 of 2 medication carts reviewed for medication storage. Findings include: R48's face sheet, dated [DATE], included diagnoses of dementia and glaucoma in both eyes. R48's medication administration record (MAR) indicated R48 received eye drops, Pred Forte 1% (prednisolone acetate), one drop into both eyes two times a day for glaucoma. On [DATE], at 1:31 p.m. licensed practical nurse (LPN)-C was observed during a medication pass. R48's Pred Forte 1% eye drops had an opened date of [DATE]. LPN-C confirmed R48 did not have another bottle of Pred Forte 1% in the medication cart and this bottle was currently in use. LPN-C was not aware of the after opened expiration date for this medication, but stated the medication was probably beyond that date and should have been discarded. On [DATE], at 9:57 a.m. pharmacy consultant (PC)-A stated Pred Forte eye drops needed to be used within 28 days of the open date. The risk of using this medication beyond 28 days after the open date was increased risk for infection. On [DATE], at 1:40 p.m. director of nursing (DON) stated eye drops should be dated when opened. She expected nurses to call the pharmacy if they were not aware of how long eye drops can be used after they are opened. Facility policy regarding dating and use of eye drops was requested but not received.

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	10/12/2021

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 44645 Based on interview and record review the facility failed to establish an antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use for 4 of 5 residents (R160, R26, R158, R50) reviewed for antibiotic use. Findings include: During the recertification survey, the facility's antibiotic tracking tool for September and October 2021, were reviewed. The following was identified: R160 was prescribed Doxycycline (an antibiotic) from 9/28/21 to 10/5/21, for lower respiratory tract infection. The tracking tool further indicated Criteria Met as yes, a CXR (chest x-ray) was completed on 9/28/21, and the column Symptom(s) was blank. The Loeb's Minimum Criteria for Initiating Antibiotic Therapy (LOEBS) [a professionally recognized set of criteria] to determine the presence of infection and guide appropriate antibiotic use, indicated with new infiltrate on CXR consistent with pneumonia, at least one of the following criteria was necessary for starting antibiotic therapy: 1) productive cough, 2) respiratory rate greater than (>) 25 breaths/minute, and/or 3) temperature >100 degrees Fahrenheit (F) or 2.4 degrees F above baseline. However, the facility failed to list any criteria with the CXR to determine the presence of infection. R26 was prescribed Doxycycline from 9/29/21 to 10/6/21, for lower respiratory tract infection. The tracking tool indicated Criteria Met as Yes. However, the columns Symptom(s) and Diagnostic Performed were blank. This potential infection was treated with antibiotics; however, there was no evidence any recognized set of criteria (i.e. LOEBS) was used to determine the presence of infection before the antibiotic was initiated. R158 was prescribed Ceftriaxone (an antibiotic) and Ampicillin (an antibiotic) from 10/2/21 to 10/7/21, for UTI infection. The tracking tool indicated Criteria Met as Yes for each antibiotic. However, the columns Symptom(s) and Diagnostic Performed were blank for both antibiotics. This potential infection was treated with two different antibiotics; however, there was no evidence any recognized set of criteria was used to determine the presence of infection before the antibiotics were initiated. R50 was prescribed Cefpodoxime (an antibiotic) from 10/4/21 to 10/22/21, for UTI infection. The tracking tool indicated Criteria Met as Yes. However, the columns Symptom(s) and Diagnostic Performed were blank. This potential infection was treated with antibiotics; however, there was no evidence any recognized set of criteria was used to determine the presence of infection before the antibiotic was initiated. On 10/8/21, at 10:08 a.m. the director of nursing (DON) stated the facility used LOEBS to determine if criteria were met before initiating an antibiotic. During a follow-up interview on 10/8/21, at 2:51 p.m. DON confirmed information on the tracking tool was missing for R160, R26, R158, and R50, and because no symptoms were indicated, there was no evidence any recognized set of criteria was used to determine the presence of infection before the antibiotic was initiated. Additionally, DON stated, I missed putting in the symptoms; I know it should be in there. (continued on next page)

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	10/12/2021

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Antibiotic Stewardship policy revised 12/20/19, indicated the purpose of the antibiotic stewardship program was to promote appropriate use of antibiotics for quality of care, successful resident outcomes and reduction of potential adverse consequences related to antibiotic use. Additionally, the policy indicated an antibiotic would be ordered based upon McGeers (LOEBS) criteria, and the Infection Preventionist would track antibiotic use and monitor adherence to evidence-based criteria.

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	10/12/2021

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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645 Based on interview and document review, the facility failed to test staff for COVID-19 according to county transmission rate, and outbreak status as directed by the Center for Disease Control (CDC). The facility was in COVID-19 outbreak status since 9/17/21 which resulted in four staff (NA-D, NA-E, PT-A, DA-A) testing positive for COVID-19. Further, the facility failed to restrict 1 of 1 staff (DA-A) to return to work whom had COVID-19 symptoms 3 days earlier, pending the results of COVID-19 testing. This practice resulted in an immediate jeopardy (IJ) situation which had the likelihood to cause serious illness or death for all 67 residents residing in the facility. The immediate jeopardy began on 9/17/21, when the facility was notified a staff member tested positive for COVID-19. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 10/7/21, at 5:57 p.m. The immediate jeopardy was removed on 10/12/21, at 10:30 a.m. but noncompliance remained at the lower scope and severity level of F, which indicated widespread scope, and no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: During entrance conference on 10/4/21, at 11:48 a.m. administrator and DON (Director of Nursing) stated she was the Infection Preventionist, the facility census was 67 residents, and the facility was currently testing staff twice a week because of high community transmission rate. Additionally, the DON stated there had been no active or suspected COVID-19 cases in the building for the last two weeks. The CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes updated 9/10/21, indicated a single new case of SARS-CoV-2 infection in any health care personnel (HCP) or a facility-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak, and the facility should perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but not earlier than 2 days after the exposure, if known) and, if negative, again 5-7 days later. If no additional cases are identified during the broad-based testing, no further testing is indicated after 14 days. However, if additional cases are identified, testing should continue every 3-7 days until there are no new cases for 14 days. The document further indicated unvaccinated HCP should continue routine testing based on the CDC Reports of COVID-19 Community Transmission Levels, and in nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have viral testing twice a week. Additionally, anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible; and symptomatic HCP, regardless of vaccination status, should be restricted from work pending evaluation for SARS-CoV-2 infection. According to the CDC Reports of COVID-19 Community Transmission Levels per CDC Data Tracker for Minnesota, [NAME] County was at a High Level of Community Transmission between 8/11/21 to 10/8/21. The facility provided an untitled document, printed 10/4/21, with the handwritten text 83% COVID Vax (vaccination) on the top of the document. The document was a list of resident names and their COVID-19 vaccination record for each resident. (continued on next page)

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	10/12/2021

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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility provided an untitled document, dated as of 9/20/21, with the hand written text 49% COVID Vax at the top of the document. The document identified a list of staff names, cell phone number, job title, and COVID-19 vaccination status. The DON provided in the morning on 10/5/21, several stacks of rubber-banded, untitled forms. She identified these were the facility testing forms. Each untitled form indicated the staff name, gender, date of birth, home address, contact phone number, symptoms, pregnancy status, date, time, and COVID testing results. The DON also provided in the morning on 10/5/21 an untitled, undated document with a list of staff names. The DON stated the document was, a listing of COVID positive staff for 2021. The list contained 13 staff names and the date each tested positive for COVID-19. The positive staff ranged from January to August 2021, with the last staff identified being positive was on 8/23/21. The DON identified on 10/6/21, at 1:35 p.m. the stacks of rubber-banded documents was their tracking method for COVID-19 testing of staff. Additionally, DON reported she did not have a system in place to ensure unvaccinated staff were completing COVID testing as identified by county transmission rate or that all staff were tested as required when the facility was in outbreak status. The DON was unable to determine which staff completed testing or if they tested at all. The facility's List of COVID Positive Staff for 2021 indicated the previously identified COVID-19 infection had been 8/23/21, 23 days before NA-D's positive result on 9/17/21. Review of the rubber banded documents and COVID testing (POC testing results) identified the following: NA-D NA-D's POC Testing Result Report identified she was COVID positive on 9/16/21. On 10/7/21, at 9:21 a.m. DON stated NA-D received a polymers chain reaction (PCR) test on 9/15/21, NA-D worked on 9/16/21, and the facility became aware on 9/17/21 NA-D was positive. DON further stated NA-D was asymptomatic and worked on 9/15/21, 9/16/21, and was removed from the schedule on 9/17/21 until 9/30/21. The facility's vaccination document, identified NA-D was fully vaccinated. The DON stated, because NA-D was positive the facility started testing residents and staff twice a week for outbreak testing starting on 9/17/21. NA-E DON stated on 10/7/21, at 9:21 a.m. NA-E received a COVID-19 test outside the facility on 9/22/21, 6 days after NA-D tested positive. DON stated, NA-E was asymptomatic when she last worked at the facility 9/16/21 and had not worked since, and then became symptomatic and tested positive on 9/22/21. DON further stated NA-E was removed from the schedule until 10/6/21. The 9/20/21 staff vaccination form, identified NA-E was fully vaccinated. The POC Test Result form, printed on 10/7/21 indicated that NA-E was last tested on [DATE], even though she was not required to be tested because she was fully vaccinated per CDC recommendations. PT-A (continued on next page)

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	10/12/2021

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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	PT-A's POC Test Results report, printed 10/7/21, indicated PT-A tested positive for COVID-19 on 10/1/21, and tested negative for COVID-19 on 9/29/21. The facility Labor Details Report printed 10/7/21 indicated PT-A worked on 9/18, 9/23 and 9/24/21. The facility provided no evidence PT-A was tested twice a week between 9/17/21 and 9/28/21 while the facility was in outbreak status. During interview on 10/7/21, at 9:21 a.m. the DON stated PT-A became symptomatic and did not work but was tested on [DATE]. PT-A was removed from the schedule after testing positive. Her return date was undetermined. The DON stated at 5:12 p.m. that PT-A had not been tested for COVID-19 between 9/17/21 and 9/28/21 and acknowledged PT-A should not have worked on 9/18, 9/23, and 9/24/21 without first being tested , as the facility was in outbreak status. DA-A: The DON stated on 10/7/21, at 9:21 a.m. that dietary aide (DA)-A arrived at work at 7:00 a.m. on 10/3/21 and was sent home at 7:15 a.m. after notifying her supervisor that she had a headache. DA-A was not tested for COVID-19 even though DA-A had COVID symptoms. DA-A returned to the facility on [DATE], at 2:00 p.m. and did not have any COVID symptoms. On 10/6/21, at 3:30 p.m. the DON identified DA-A has not completed any testing for the day, and had DA-A complete a test. DA-A tested positive for COVID-19. DA-A had worked for 90 minutes on 10/6/21 before she was tested . Review of a facility provided form, untitled, dated 10/6/21, indicated DA-A's name, gender, date of birth, home address, contact phone number, pregnancy status, symptoms none, dated 10/6/21 at 3:30 p.m. results positive, and the DON's initials were written on the form. The facility provided document, untitled, dated as of 9/20/21, indicated DA-A was not vaccinated for COVID-19. Review of DA-A's POC Test Results report, printed 10/7/21, indicated DA-A tested negative for COVID-19 on 9/24/21, 9/14/21, 9/8/21, 9/4/21, 9/3/21, 9/2/21, 8/30/21, 8/27/21, and 8/26/21. DA-A did not test biweekly as identified by the county transmission rate for routine testing. DA-A only tested weekly during this time. In addition, the facility provided no evidence DA-A completed outbreak testing between 9/17/21 to 9/24/21, and 9/25/21 to 10/6/21. Further, there was no indication DA-A completed testing before she worked with residents and other staff. Review of Talahi Nursing and Rehab Center Schedule, dated 9/1-9/30/21, and 10/1-10/7/21, indicated DA-A consistently worked 4-5 days a week from 9/2-10/6/21. After review of facility provided testing paperwork, there was no indication the facility implemented outbreak status testing guidelines as identified by the CDC. There was no indication the facility had completed staff testing twice a week, testing immediately (but not earlier than 2 days after the exposure, if known) and, if negative, again 5-7 days later, until there were 14 days where no staff have tested positive for COVID. (continued on next page)

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	10/12/2021

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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/7/21, at 9:21 a.m. the DON stated PCR tests were done on Tuesdays, POC tests were done on Fridays, and outbreak testing lasted until the facility had 14 days without any new positive cases. In addition, DON stated if staff missed scheduled testing dates, they were expected to complete a POC test the first date they returned to work before going on the floor stating, I encourage everyone to get tested . The DON confirmed a tracking system was not in place to monitor for staff COVID-19 testing compliance. During interview on 10/7/21, at 5:12 p.m. the DON confirmed DA-A was unvaccinated and removed from the schedule after testing positive for COVID-19 with an undetermined return date. The DON further confirmed DA-A had not completed routing testing twice a week between 9/5/21 and 9/16/21. In addition, the DON stated DA-A was not tested for COVID-19 between 9/24/21 and 10/5/21 while the facility was in outbreak status. The DON acknowledged DA-A should not have worked 10/1/21 and 10/2/21. The facility's COVID-19 Testing Plan policy revised 9/13/21, indicated the facility would test all unvaccinated staff at the frequency prescribed by the CDC based on community transmission level. The policy further indicated outbreak means there is a new COVID-19 infection in any staff, or any nursing home-onset COVID-19 resident infection. In response to an outbreak, all residents and staff would be tested regardless of vaccination status and serial testing would be completed every 3-7 days until there were no new positive cases for 14 days. In addition, the policy indicated staff with COVID-19 signs or symptoms would be tested regardless of vaccination status, and the staff member would not report to work while waiting for test results. The IJ was removed on 10/12/21, at 10:30 a.m. when it was verified through interview and document review the facility policies were reviewed and an addendum dated 10/8/21, was added to reflect protocol for outbreak testing, routine testing of unvaccinated staff, and staff that do not comply with testing requirements. The facility developed a testing plan which included daily review of staff schedules to validate testing compliance. Education to all staff was provided on updated COVID-19 testing protocols prior to scheduled shifts. Regional Director of Clinical Services provided the DON with additional education, and will continue to provide oversight, education, and support. Completion of testing and training will be tracked, analyzed, and acted upon to ensure compliance.