DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 1, 2026

Administrator
Ebenezer Integrated Care & Rehab
45 WEST 10TH STREET
SAINT PAUL, MN 55102

RE: CCN: 245587
Cycle Start Date: April 1, 2026

Dear Administrator:

On May 29, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered

April 13, 2026

Administrator
Ebenezer Integrated Care & Rehab
45 WEST 10TH STREET
SAINT PAUL, MN 55102

RE: CCN:245587

Cycle Start Date: April 1, 2026

Dear Administrator:

On April 1, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 1, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 1, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Integrated Care & Rehab	**45 WEST 10TH STREET , SAINT PAUL, Minnesota, 55102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 3/30/26 through 4/1/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/22/2026
F0000	INITIAL COMMENTS On 3/30/26 through 4/1/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55879703C (MN00112707), H5587702C (MN00112868), H55879700C (2742122), H5579941C (2969153) NO deficiencies were cited. The complaint H58879701C (2624718) with citation at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/22/2026
F0684 SS = D	Quality of Care CFR(s): 483.25	F0684	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in	05/22/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

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F0684 SS = D	Continued from page 1 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure fasting blood glucose (BG) testing was performed before a meal for 1 of 2 residents (R28) observed who required insulin (medication used to lower blood glucose) based on a sliding scale. Findings include: R28's quarterly Minimum Data Set (MDS) dated 3/9/26, indicated R28 was cognitively intact, dependent on staff for most activities of daily living (ADLs), required insulin injections every day of the seven-day lookback period and had a diagnosis of diabetes mellitus (disease that leads to elevated blood glucose). R28's care plan revised 3/12/26, indicated R28 had diabetes mellitus type 2 and instructed staff to monitor blood sugars per provider order and as needed. R28's provider order dated 11/21/25, instructed, "Monitor BG-Levels QID AC and HS [four times a day before meals and at bedtime]." R28's provider order dated 11/24/25, instructed, "Insulin Aspart Pen-injector 100 units/milliliter (ML) inject as per sliding scale: if BG 0-139 = 0 units; 140-189=1 unit; 190-239=2units; 240-289=3units; 290-339=4units; 340-439=5units; 440+=7units, subcutaneously with meals" for diabetes. During observation on 3/31/26 at 8:28 a.m., licensed practical nurse (LPN)-B entered R28's room to administer morning medications. R28 was sitting up in bed with his bedside table over the bed and a breakfast tray on the table. R28's breakfast included scrambled	F0684	Continued from page 1 the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. Corrective Action: Resident R28 was assessed following the identified concern. No adverse outcomes were noted. The licensed nurse involved was re-educated on proper timing of blood glucose monitoring prior to meals and correct administration of sliding scale insulin. Corrective Action as it applies to other residents: All residents receiving blood glucose monitoring and/or sliding scale insulin were audited. No additional concerns were identified. All licensed nursing staff were re-educated on blood glucose monitoring timing. The Blood Sugar Monitoring policy was reviewed and revised. Date of Completion: May 22, 2026 Reoccurrence will be prevented by: Random observational audits of blood glucose monitoring will be completed. 5 audits/week for 1 week, then 3 audits/week for 2 weeks, then 1 audit/week for 2 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: Director of Nursing or designee	

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F0684 SS = D	Continued from page 2 eggs, blueberry muffin, cereal, milk and juice. R28 had eaten approximately ninety percent of the scrambled eggs and had taken some of each of the beverages. LPN-B told R28 to go ahead and finish his eggs and then she handed him a cup containing his oral medications, which he took and swallowed. LPN-B then prepped the BG meter and pricked R28's finger and obtained a sample of blood to test for the level of blood sugar in his blood. R28's BG was 175. LPN-B reviewed R28's orders and stated he needed 1 unit of insulin as indicated by the ordered sliding scale and proceeded to inject the insulin. During interview on 3/31/26 at 8:45 a.m., R28 stated his BG should be checked prior to eating meals since the amount of one of the insulins he received was based on the BG result and a sliding scale. During interview on 3/31/26 at 8:49 p.m., LPN-B stated R28's BG should have been tested by 7:30 a.m., to ensure it was before breakfast. LPN-B stated testing prior to a meal would have provided a more accurate fasting BG. During interview on 4/1/26 at 7:14 a.m., registered nurse (RN)-C stated insulin administered per sliding scale should be based on a fasting BG (before a meal) in order to ensure an accurate amount of insulin was provided. During interview on 4/1/26 at 10:42 a.m., RN-A stated staff were expected to be checking BG before meals to get an accurate fasting BG result. RN-A stated a BG taken after a resident already started eating or completed a meal, could provide an inaccurate level and the amount of insulin provided based on the result and per sliding scale could be incorrect. During interview on 4/1/26 at 1:21 p.m., director of nursing (DON) stated expectation for fasting BG to be taken prior to a meal and that a BG taken during or after a meal could potentially indicate a wrong dose of insulin administered per sliding scale. Facility policy Blood Sugar Monitoring dated 4/25, instructed staff to monitor resident BG levels per provider order.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices	F0689	Corrective Action: R46 fall interventions were	05/22/2026

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F0689 SS = D	Continued from page 3 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure active interventions were implemented to reduce the risk of falls for 1 of 2 residents (R46) who had repeated falls and was reviewed for accidents. Findings include: R46's quarterly Minimum Data Set (MDS) dated 2/19/26, identified severely impaired cognition and no behaviors. A walker and wheelchair were used, and substantial/maximal assist was required for transfers, ambulation, toileting, lower body dressing, and bed mobility. R46 had a diagnosis of vascular dementia (nontraumatic brain dysfunction). One fall occurred since the last assessment with two or more injuries. R46's annual Care Area Assessment (CAA) dated 6/2/25, identified falls triggered due to falls since previous MDS. R46 had two falls without injury due to poor balance, poor judgement, and wearing inappropriate footwear. Fall risk score was 12 and indicated high risk for falls. Dementia with severe cognitive impairment contributed to poor safety awareness and decision-making. He demonstrated shuffling gait and poor balance. Staff supervised his activity, provided reminders and redirection, and ensured he was wearing appropriate footwear. Additional contributing factors were incontinence and heart failure. R46 was at risk for further loss with all areas due to advancing disease process. Interventions were in place and the plan was to continue assisting with cares for R46 at present level. Reference care plan for goals and interventions. R46's Fall Risk assessment dated 3/30/26, identified he was at high risk for falls.	F0689	Continued from page 3 reassessed, and care plan was updated. Staff involved were re-educated on adherence to care plan interventions and fall prevention strategies. Corrective Action as it applies to other residents: All residents with high fall risk were audited to ensure interventions were in place and being followed. Nursing staff were re-educated on reviewing the Kardex/care plan and following fall interventions as written. The Fall Risk, Post Fall Investigation, Follow Up, and Care policy was reviewed and remains current. Date of Completion: May 22, 2026 Reoccurrence will be prevented by: Random observational audits of high fall risk residents and implementation of fall interventions will be completed. 5 audits for 1 week, then 3 audits/week for 2 weeks, then 1 audit/week for the following 2 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: Director of Nursing or designee	

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F0689 SS = D	Continued from page 4 R46's falls care plan dated 3/31/26, identified he was at risk for falls related to cognitive impairment, deconditioning, gait and balance instability, crisscross gait pattern, incontinence, incomplete bladder emptying, history of falls, and history of low blood pressure. Interventions effective 2/18/26, were to remove R45's feet from the footrests and place wheelchair footrests in upright position when not propelling. R46's progress notes dated 1/18/26 through 3/31/26, identified three falls from his wheelchair.On 1/18/26 at 8:27 p.m., R46 was found on the floor in TV lobby at 6:15 p.m., with no injury. R46 said he tried to get up to use the bathroom. The nursing assistant last checked on R46 10 minutes before the fall and denied toileting R46 after the evening meal. The root cause analysis included was standing up unassisted to try and use the bathroom without locking wheelchair brakes, and misjudgment of ability. The NA last checked on him 10 min ago and R46 was not toileted after the meal. Immediate interventions included frequent checks and to encourage R46 to ask for help before transferring.The Post Fall IDT note dated 1/19/26 at 11:41 a.m., identified new Interventions included cue resident after every meal to go to the bathroom and offer assistance, and a request was sent to therapy to evaluate for strengthening.On 2/17/26 at 9:51 p.m., R46 had an unwitnessed fall to the floor from his wheelchair in the dining room at 7:15 p.m., and sustained a laceration to the left upper eyelid. R46 was toileted around dinner, and the root cause analysis included misjudgment of ability. Immediate interventions included staff to constantly check on R46.The Post Fall IDT note dated 2/18/26 at 10:07 a.m., identified R46's wheelchair footrests were in the down position, and R46 likely tripped when attempting to stand and walk from his wheelchair. A new intervention was placed for wheelchair footrests in upright position when not propelling R46 to destinations.On 3/3/26 at 4:15 p.m., R46 was witnessed by staff standing up in the dining room, his body leaned to the left, the wheelchair tipped over and he fell to the floor. The root cause analysis included misjudgment of ability and cognitive impairments. Lapses in memory about R46's physical limitations resulted in attempts to transfer/ambulate without assist. R46 had actual repeated falls due to weakness, deconditioning, poor balance, poor insight into deficit, and antiarrhythmic medication use. Immediate interventions included increased rounding and staff presence, especially before and after dinner time which were high risk times.The IDT Follow Up Incident progress note dated	F0689		

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F0689 SS = D	Continued from page 5 3/4/26 at 10:22 a.m., identified occupational therapy would assess additional wheelchair safety. The note did not identify if the footrests were positioned up according to the care plan.During an observation on 3/30/26 at 1:52 p.m., R46 was observed to be lying face down on the floor next to his bed. R46's bed was in a low position, and his call light was on the bed and not activated. Surveyor went to alert staff and nursing assistant (NA)-A and NA-B alerted the nurse and both NAs came down to R46's room to check on him. At 1:54 p.m., licensed practical nurse (LPN)-A arrived at the room, saw he was waking up, and left to get the vital signs machine. At 1:55 p.m., R46 got up onto his knees and got back into bed independently, despite NA-A and NA-B advising him to be still until LPN-A returns to assess for any injuries. At 1:57 p.m., LPN-A re-entered the room with the vital signs machine. LPN-A stated R46 could not communicate well so staff had to look for non-verbal signs. LPN-A assessed range of motion, skin condition, and vital signs which were within normal limits. LPN-A stated R46 had been up most of the morning and was assisted into bed shortly before he fell out of bed. During an interview on 3/30/26 at 4:39 p.m., R46's family member (FM)-A stated she had concerns about R46 having repeated falls. During a continuous observation on 4/1/26 starting at 7:45 a.m. to 10:15 a.m., R46 was seated at the dining room table alone. Licensed practical nurse (LPN)-A was at the medication cart approximately 10 feet away. R46's feet were placed on the wheelchair footrests which were not in an upright position, which conflicted with the care plan intervention to place wheelchair footrests in upright position when not propelling. At 8:14 a.m., R46's breakfast tray was placed in front of him and began eating and drinking independently. One other resident was at the table along with a nursing assistant. R46's feet were still on the footrests which were not in an upright position. At 8:45 a.m., R46 finished with breakfast and was brought to the commons by nursing assistant (NA)-B to watch TV. R46's feet remained on the footrests while propelling and after being stopped near the television. NA-B was intermittently close to R46 but escorted residents to other places and intervened with other residents. R46 was awake and alert with his feet on the footrests which were not in the upright position. At 9:19 a.m., NA-B left the unit and LPN-A remained at her medication cart about 10 feet away from R46.	F0689		

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F0689 SS = D	Continued from page 6 At 9:22 a.m., LPN-A walked by R46 and had not corrected the position of his footrests. At 9:24 a.m., NA-B re-entered the dining room which was approximately 15 feet away from R46 and LPN-A left the area. R46 remained in his wheelchair with his feet in the footrests that were not in the upright position. At 9:33 a.m., NA-A took R46's shoes off, put on gripper socks on both of his feet, and then put his shoes back on while his feet remained on the footrest, then NA-A left the area. R46 remained in the commons area with intermittent staff in the area but no staff right next to him to intervene quickly if he attempted to self-transfer. Staff in the area had not corrected the position of the footrests. At 10:00 a.m., NA-A brought R46 from the commons area back to his room. Once in R46's room NA-A flipped up R46's footrests and angled them off to the side away from the front of the wheelchair and assisted R46 to transfer into bed using a gait belt and one staff assist. When NA-A was asked how she knew which fall interventions R46 had in place, she stated interventions showed up on their charting iPad, and the nurse would update them on new interventions. NA-A acknowledged she put R46's gripper socks on while the footrests were not in an upright position but R46 was not propelling. At 10:10 a.m., after NA-A left R46's room, NA-A was asked to show surveyor a list of R46's fall interventions from their iPad to verify if all interventions were visible on the NA's charting iPad. NA-A would not answer. R46's Kardex (list of cares) was shown to NA-A with the fall intervention of keeping feet off the footrests unless propelling in wheelchair. NA-A would not answer and deferred surveyor to LPN-A who was also in the hallway. LPN-A reviewed the Kardex and stated that fall intervention to keep feet off footrests unless propelling was in place because when R46 would stand up, he would trip over the footrests and had falls in the past related to this issue. LPN-A stated R46 had been calmer the last couple of days and that might by why R46's footrests remained in place with his feet on top, even though he was not propelling. NA-A then stated yes that was the reason why his footrests remained in use. During an interview on 4/1/26 at 10:15 a.m., (RN)-A stated fall interventions listed on the Kardex and care plan should be followed as written for safety reasons. All nursing staff had access to the interventions. RN-A	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Integrated Care & Rehab	**45 WEST 10TH STREET , SAINT PAUL, Minnesota, 55102**

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F0689 SS = D	Continued from page 7 stated R46 had a fall in the past from tripping over his footrests and since the intervention of keeping the footrests up was implemented, he has not had falls from tripping over the footrests. RN-A stated R46's vascular dementia was challenging because he could not process the dangers of self-transferring. During an interview on 4/1/26 at 2:28 p.m., the director of nursing (DON) stated staff should review the care plan or Kardex at the start of their shift. Fall risk interventions should be implemented as written for safety. Following a fall, the interdisciplinary team (IDT) would review any resident falls and see if the care planned interventions were in place. If documentation was lacking, the IDT would follow up with the staff working during the fall. During a follow up interview on 4/1/26 at 2:58 p.m., The DON stated keeping R46's feet off the footrests unless propelling was still an active intervention that should have been implemented. The facility's Fall Risk, Post Fall Investigation, Follow Up, and Care policy dated 1/26, identified Universal fall precautions are used for all patients based on individual patient needs. Interventions should be selected based on individual patient needs. Document interventions in the medical record. Falls risk and interventions should be noted on the plan of care.	F0689		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	F0791	Corrective Action: R1 was assessed for dental needs, and a dental appointment was scheduled. Assistance was provided with appointment coordination and transportation as needed. Corrective Action as it applies to other residents: All residents requiring assistance with dental services were audited. Licensed Nursing staff, Health unit coordinators and Social Services staff were re-educated on assisting residents with obtaining routine and emergency dental services, including scheduling and follow-up. The dental services policy was reviewed and remains current. Date of Completion: May 22, 2026 Reoccurrence will be prevented by: Random chart audits of residents requiring dental services will be completed to ensure appointments are scheduled timely and needs are met. 1 audit per week for 4 weeks, then 2 audits per month for 1 month. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations.	05/22/2026

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F0791 SS = D	Continued from page 8 §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to assist in obtaining routine dental services for 1 of 1 resident (R1) reviewed for dental services. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/5/26, indicated R1 was cognitively intact, dependent on staff for oral hygiene, and did not exhibit rejection of care behavior. R1’s diagnoses included hemiplegia and hemiparesis (weakness and paralysis affecting one side of the body). R1's care plan revised on 3/4/26, identified R1 had a self-care performance deficit and required substantial to dependent assistance with personal hygiene and oral care.	F0791	Continued from page 8 The Correction will be monitored by: Social Services Director or designee	

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F0791 SS = D	Continued from page 9 R1's Oral/Dental Assessment (ODA) dated 9/23/25, indicated R1did not have any oral concerns, but was considering partials for his edentulous (lacking teeth) upper and lower premolars. R28's ODA indicated R28 had not seen a dentist in over two years and neither R28 nor a responsible party declined offer for routine dental appointment. R1's ODA dated 12/22/25, indicted R28 had no dental concerns, but had not seen a dentist in over two years and neither R28 nor a responsible party declined offer for routine dental appointment. R1's medical record lacked evidence of a dental appointment or any reference to an offer for dental referral. During interview on 3/30/26 at 12:43 p.m., R1 stated had not seen a dentist in at least a year and a half and had not been offered to see a dentist since admission. During interview on 3/31/26 at 12:35 p.m., registered nurse (RN)-B stated the MDS nurse would schedule the quarterly oral assessment, and the assigned nurse or charge nurse would complete the assessment as identified on the treatment administration record (TAR). If it was identified that the resident needed a dental referral due to oral issues or lack of routine dental evaluation, they would notify the provider to have a dental referral placed. RN-B further stated if the resident had a dental appointment while a resident, there would be documentation in the electronic medical record (EMR) indicating a summary of the appointment. RN-B stated if documentation could not be located, she would consult the health unit coordinator (HUC) who could determine if a referral had been made and/or an appointment scheduled or completed. RN-B stated regardless of a resident's dental status, if a resident had not seen a dentist in over two years and they did not decline an appointment; a referral should be made. During interview on 4/1/26 at 9:49 a.m., family member (FM)-B stated could not remember the last time R28 had seen a dentist and could not recall any discussion with the facility regarding offering dental services. FM-B further stated would expect R28 to be offered routine	F0791		

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F0791 SS = D	Continued from page 10 dental care and neither she nor R28 would decline those services. During interview on 4/1/26 at 10:13 p.m., HUC stated if a resident wanted to see a dentist, and did not have their own dental clinic, she would arrange for an appointment and transportation when she received a referral from their provider. HUC looked in R28's EMR and confirmed R28 did not have a dental appointment scheduled and had not seen a dentist since his admission. During interview on 4/1/26 at 10:42 a.m., RN-A stated if a resident was assessed and found to need or desire to see a dentist, the nurse would request a referral from the provider, and the facility would get a consent and make the arrangements. RN-A further stated R18 should have been offered a dental referral regardless of his dental status and that routine dental care could prevent oral issues in the future. During interview on 4/1/26 at 1:21 p.m., director of nursing (DON) stated dental referral should be recommended and arranged per resident preference. DON expected staff to address R28's lack of dental visits and offer to arrange a dental appointment. Facility policy Consultant Visit Policy – Audiology, Optometry, Podiatry, and Dental Services dated 6/25, identified the facility was responsible for scheduling and coordinating dental consultations for residents. The policy further indicated, "Within 90 days of admission, staff will refer the resident for an initial dental examination, unless the resident has had a dental exam within six months before admission. After the initial exam, staff will offer an annual dental exam within one year of the previous exam."	F0791		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on March 31, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Ebenezer Integrated Care & Rehab, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		04/15/2026

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 reverse for further 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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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: M Health Fairview is an 5-story building with a basement. The original building was built in 2008 and was determined to be of Type I (332) construction. A complete fire sprinkler system protects the building. The facility has a fire alarm system with entire corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0311 SS = E Bldg. 03	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1 hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7.	K0311	Corrective Action: Fairview Maintenance staff installed fire barrier protective substance in all identified openings to prevent the spread of smoke and fire. Systemic Changes: The Fairview Maintenance Department will conduct annual inspections of all utility closets to ensure that wall and ceiling penetrations are properly sealed with approved fire caulking materials. Monitoring Plan: A logbook will be maintained in the Administrator’s	04/15/2026

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K0311 SS = E Bldg. 03	Continued from page 2 18.3.1 through 18.3.1.5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 18.3.1.1 through 18.3.1.5). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 3/31/2026, at 12:15 PM, observations and staff interview revealed 3 floor penetrations in room 5117. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0311	Continued from page 2 office documenting inspection dates and findings. The EVS Supervisor and/or Site Administrator will review the logbook regularly to ensure ongoing compliance. Completion Date: April 15, 2026 *Pictures/proof to be sent to Fire Marshal via email 4/21/26*	