Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 27, 2024

Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, MN 55337

RE: CCN: 245213
Cycle Start Date: November 21, 2024

Dear Administrator:

On November 21, 2024, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 February 21, 2025 (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 May 21, 2025 (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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245213	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER RIDGES GERIATRIC CARE CENTER	13820 COMMUNITY DRIVE BURNSVILLE, MN 55337

(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
E 000	Initial Comments On 11/18/24 to 11/21/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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.	E 000		
F 000	INITIAL COMMENTS On 11/18/24 to 11/21/24, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H52131402C (MN105344) H52131403C (MN101317) H52131404C (MN106912) H52131405C (MN102026) and (MN102081) H52131406C (MN105826) H52131543C (MN108373) H52131402C (MN106912) 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	F 000		

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

Electronically Signed | 12/05/2024

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.

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F 000	Continued From page 1 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.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		12/16/24

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F 561	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate bathing/shower preferences for 1 of 1 residents (R159) reviewed for choices. Findings include: R159's admissions Minimum Data Set (MDS) dated 11/10/24 identified admission to facility on 11/4/24, had impaired cognition, required substantial to maximal assistance for showering, toileting, lower body dressing, and personal hygiene. Review of transitional care unit (TCU) care sheet identified all residents by room number, name, primary diagnoses, and day of the week with "AM" or "PM" next to it. R159 identified "Fri PM" associated with it. R159's care plan dated 11/4/24 identified, "Care Plan: I will have my preferences followed." During interview with R159 and family member (FM)-B on 11/18/24 at 3:14 p.m., R159 stated facility never offered or asked preferences on day and time of showers. R159 and FM-B stated he was informed that the showers and bath schedules were "assigned per room number". R159 stated, "I prefer to shower in the morning because I get too tired to participate in showering [in] the evenings after I work with physical therapy. FM-B stated, "[R159] likes mornings better than evenings" for showers. During interview with nursing assistant (NA)-A on 11/19/24 at 12:49 a.m., NA-A stated she worked	F 561	F000 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 the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. 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. F561 1. Corrective Action: R159's bathing preferences were reviewed and discussed with the resident. R159's shower times have been adjusted accordingly. 2. Corrective Action as it Applies to Other Residents: The policies for Bathing and Admission Assessment have been reviewed and revised to assess and allow for patient preferences for timing and type of bath. All nursing staff will be re-educated on the policies and assessment changes. 3. Date of Completion: 12/16/24. 4. Responsible Party for Monitoring: The RN Unit Managers and Director of Nursing will monitor for ongoing correction and report findings to the Quality Assurance and Performance Improvement (QAPI) Committee to assure ongoing compliance.	

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F 561	Continued From page 3 full-time on the TCU where R159 resided. NA-A stated the expectation of nursing assistants at start of their shifts was to look at the resident's care plan in computer system and review the paper care sheets on each unit to see what shower days and times are assigned. NA-A pointed to the paper care sheet and stated, "Showers are assigned per room. He[R159] is Friday PMs". NA-A stated, "[nursing assistants] always go by the sheet here". During interview with NA-B on 11/19/24 at 1:06 p.m., NA-B stated he worked full-time on the TCU and "I look at the care sheets which say what room and shower days [are assigned]. Shower days and times [are] with the room and not preference of the resident". During interview with registered nurse (RN)-A on 11/19/24 at 1:25 p.m., RN-A stated expectation of nursing assistants to "look at the care sheet first" to identify shower days and times. RN-A indicated shower day assignments are scheduled per room. During interview with director of nursing (DON) on 11/21/24 at 9:47 a.m., DON stated, the baths and showers are divided out by room number on the TCU." DON stated, "[assigned shower days] are not reflective of [R159] preferences. It makes sense he would like a shower in the morning before therapy instead of later in the day after he is tired out from working with therapy. We should not be assigning shower days per room." Requested policy on choices and preferences and did not receive.	F 561		
F 641 SS=D	Accuracy of Assessments	F 641		12/16/24

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F 641	Continued From page 4 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect upper body impairment for 1 of 2 residents (R162) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, identified the purpose of the RAI process was to help ensure holistic care was provided. According to the RAI/MDS, the definition of functional limitation in range of motion is, "limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living or places the resident at risk of injury." Coding instructions for GG0115A Functional Limitation in Range of Motion question, the Upper Extremity (Shoulder, Elbow, Wrist, Hand) include: "Code 0, no impairment: if resident has full functional range of motion on the right and left side of upper/lower extremities. Code 1, impairment on one side: if resident has an upper-and/or lower-extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury. Code 2, impairment on both sides: if resident has an upper-and/or lower extremity impairment on both sides that interferes with daily functioning or	F 641	F641 1. Corrective Action: R162's Minimum Data Set (MDS) has been modified to correct the erroneous coding for Range of Motion. 2. Corrective Action as it Applies to Other Residents: All resident MDS assessments were audited to assure accurate Range of Motion coding. All staff responsible for MDS coding and Therapy department staff will be re-educated regarding proper documentation of limitations in range of motion. 3. Date of Completion: 12/16/24. 4. Responsible Party for Monitoring: The MDS Director will monitor for ongoing accuracy and report findings to the QAPI Committee to assure ongoing compliance.	

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F 641	Continued From page 5 places the resident at risk of injury." Examples of coding instructions include: 1. "The resident can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. They are able to perform grooming activities (e.g., brush their teeth, comb their hair) with their right upper extremity and are also able to pivot to their wheelchair with the assistance of one person. They are, however, unable to voluntarily move their left side (limited arm, hand, and leg motions), as they have a flaccid left hemiparesis from a prior stroke. Coding: GG0115A would be coded 1, upper-extremity impairment on one side." R162's admissions Minimum Data Set (MDS) dated 11/7/24, identified R162 with admission to facility's transitional care unit (TCU) on 11/1/24, with moderately impaired cognition, and required partial to moderate assistance with upper body dressing and personal hygiene and required substantial to maximal assistance with showers or bathes and lower body dressing. The MDS section GG0115: Functional Limitation in Range of Motion identified R162 with, "No impairment of upper and lower extremity". In addition, R162 with diagnoses of a stroke, cancer, and hypertension (high blood pressure). R162's initial visit notes from physician dated 11/4/24, "[R162] originally presented with left upper extremity weakness." And "not able to move her left arm." During observation and interview on 11/18/24 at 3:42 p.m., R162 was observed seated in a recliner watching television in her room. R162	F 641		

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F 641	Continued From page 6 was observed with her left arm in shoulder sling with left arm immobilized. R162 stated, "I have this [pointing to sling] because I had a stroke." R162 stated it was important for the sling to be on so her left arm would not "flop" down as she had "no control or feeling" in it. R162 stated that she admitted to the facility with the sling and that staff at the facility were applying it and removing it daily. Review of R162 care plan, orders, and nursing assistant care sheet and Kardex failed to mention an assessment for use about the sling, including purpose for it, who was responsible for applying and removing it, and when it should be done. During interview with rehabilitation supervisor (RS) on 11/20/24 at 9:38 a.m., stated, R162 "came in after stroke and diagnoses with metastatic [wide spread] brain and lung cancer." RS stated R162 had "Left arm weakness was fully flaccid [paralyzed as a result of interrupted communication within the nervous system]". RS stated the assessment for use of a sling was a therapy department responsibility and was unable to determine if R162 was assessed for use of the sling. RS stated the process was for therapy to assess use and appropriateness of a sling and a nursing communication form would be filled out by therapy and given to nursing department who would upload the information in resident's care plan and Kardex. RS stated the expectation was staff would not apply or remove the sling without orders and recommendations from the therapy department. During interview with nursing assistant (NA)-B on 11/20/24 at 10:00 a.m., NA-B stated, "Yes [R162] had a sling on her left arm. She could not use the	F 641		

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F 641	Continued From page 7 arm at all. No nothing in care plan or our Kardex for us to do anything with the sling." And "[R162] had therapy every day so I think they took care of it." During interview with TCU nurse manager registered nurse (RN)-A on 11/20/24 at 10:40 a.m., RN-A stated, "[R162] had splint on her for support and arm [sic] she cannot control it." RN-B stated there were no instructions to use, apply or remove the sling. "It is important for the staff to know what they need to look out for and why. In this instance it was not done." During interview with the director of Resident Assessment Instrument (RAI)/MDS (DR) on 11/20/24 at 11:13 a.m., DR reviewed R162's admission MDS information and stated, "looks like no impairment was noted for the upper and lower extremities". DR stated, 'if patient has no use of arm and it is not their previous norm then this was coded incorrectly". During interview with RN-A on 11/20/24 at 11:32 a.m., RN-A looked at R162's admission MDS and stated, "not correct because of left arm in sling. It should have been coded accurately." During interview with director of nursing (DON) on 11/21/24 at 9:58 a.m., DON stated, "[R162] had impairment of arm. The MDS response was inaccurate and should not have been coded as, 'No impairment'". Facility policy titled MDS/CARE PLAN PROCESS/RESIDENT ASSESSMENT updated 11/11/24 identified Use the Minimum Data set forms and CAA's (Care Area Assessment) collect data and supplemental forms as needed to	F 641		

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F 641	Continued From page 8 complete a comprehensive, review of the resident's status." And "MDS coordinator does MDS coding and prioritizing."	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure care conferences were conducted upon admission for 1 of 2 residents	F 657	F657 1. Corrective Action: R103 has had a care conference completed with the IDT	12/16/24

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EBENEZER RIDGES GERIATRIC CARE CENTER	13820 COMMUNITY DRIVE BURNSVILLE, MN 55337

(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
F 657	Continued From page 9 (R103) reviewed for care conferences. Findings include: R103's admission Minimum Data Set (MDS) assessment, dated 11/4/24, indicated R103 had intact cognition with no hallucinations or delusions with an admission date of 10/29/24. Diagnoses included: displaced bicondylar fracture of left tibia (fracture in left lower leg), muscle weakness, other abnormalities of gait and mobility, left foot drop (dragging of front of foot when walking and/or inability to raise toes or the foot from the ankle), and infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts (an infection caused related to implanted devices from surgery). R103's care plan, printed 11/18/24, indicated R103 discharge planning: [R103] was living at home .... where she is planning to return home at discharge with an intervention of "arrange for in home services as ordered," with an initiation date of 11/18/24. R103's progress notes, dated 10/29/24 to 11/21/24, were reviewed. Progress notes lacked evidence of R103 having a care conference since admission on 10/29/24. Furthermore, lacked documentation of a planning of a care conference. On 11/18/24 at 3:12 p.m., R103 indicated she has not had a care conference since admission. R103 indicated there has been no meeting of any kind to talk about discharge or the plan around this. R103 stated she asked the nurse practitioner at the facility last week about having a care conference as they are thinking she might	F 657	team on 11/22/24. 2. Corrective Action as it Applies to Other Residents: All resident care conference schedules were reviewed to assure a conference was conducted within at least 21 days of admission and quarterly thereafter. All Social Work staff were re-educated on the expectations of timely care conference completion. 3. Date of Completion: 12/16/24. 4. Responsible Party for Monitoring: The Social Work Director will monitor for ongoing correction and report findings to the QAPI Committee to assure ongoing compliance.	

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F 657	Continued From page 10 discharge in a couple of weeks but has not heard anything about any sort of meeting or care conference. R103's provider note, dated 11/18/24, was reviewed. The provider note did not mention a care conference and potential discharge plan or date. On 11/20/24 at 10:19 a.m., nurse manager on third floor registered nurse (RN)-D verified R103 has not had a care conference since admission to the facility on 10/29/24 [22 days ago]. R103 indicated that social worker sets up the care conferences for residents. RN-D indicated they talked about R103 in "rounds" yesterday and will going to do a care conference soon as R103 has a home assessment set up on 11/22/24. RN-D stated they think the social worker wanted to wait until closer to dischage for a care conference. On 11/21/24 at 9:33 a.m., social worker (SW)-A verified that she is the social worker for R103. SW-A verified that when a resident is admitted to the facility, specifically transitional care unit (TCU), they try to do a care conference within the first week or two of admission. SW-A stated it is expected that a care conference is done no later than 21 days after admission. SW-A verified R103's care conference is "probably beyond 21 days" and verified R103 has not had a care conference since arriving at the facility. SW-A verified R103's admission was 10/29/24 which was more than 21 days ago. SW-A stated R103's care conference was "missed." On 11/21/24 at 10:18 a.m., director of nursing (DON) stated the expectation is that a care conference is held no later than 21 days after	F 657		

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F 657	Continued From page 11 admission. A facility policy titled Care Conference Process, revised 10/18, indicated "a care conference is held for every resident receiving care within our facilities upon admission, quarterly, with significant change and as needed." Furthermore indicating "care conference for an individual resident is held within 21 days of an admission."	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., showers) was completed for 4 of 5 residents (R89, R103, R159, R162) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R89 R89's admissions Minimum Data Set (MDS) dated 11/1/24, identified R89 with admission to facility's transitional care unit (TCU) on 10/26/24, had severe cognitive impairment, required substantial to maximal assistance with showers, upper and lower body dressing, and personal hygiene. In addition, R89 was documented with an indwelling catheter (drain urine from the bladder) and had diagnoses of left arm fracture,	F 677	F677 1. Corrective Action: Baths were completed for R89, R103, R159 and R162 by nursing staff and resident charting schedules in Point of Care were audited to assure complete and accurate bathing documentation. 2. Corrective Action as it Applies to Other Residents: Resident charting schedules in Point of Care for all new admissions going forward will be audited to assure proper bathing task scheduling and follow up charting is completed. Resident baths on all units will be audited to assure they have been completed in a timely manner. All staff will be educated on the Bathing and Assessment policies to ensure reeducation regarding assistance with ADL care requirements. 3. Date of Completion: 12/16/24.	12/16/24

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F 677	Continued From page 12 non-Alzheimer's dementia, depression, and urinary retention. Furthermore, the MDS stated R89 and family participated in the assessment and goal setting process. During initial screening on 11/18/24 at 12:15 a.m., surveyor provided with undated TCU nursing assistant care sheet. During interview with nursing assistant (NA)-A on 11/19/24 at 12:49 a.m., NA-A stated she had worked full-time on the TCU since, "January [2024]". NA-A stated the expectation of nursing assistants at start of their shifts was to look at the resident's care plan in the computer system and review the paper care sheets on each unit to see what shower days and times are assigned. NA-A pointed to the paper care sheet and stated, "Showers are assigned per room. NA-A stated, "[nursing assistants] always go by the sheet here". NA-A stated nursing assistants document in the "Task[s]" section of the electronic medical record (EMR) for assigned tasks. Review R89's of undated nursing assistant care sheet indicated R89's assigned bathing day and time was Saturday evenings. Per bathing task in the electronic medical record (EMR) indicating a shower was missed or not documented on 11/9/24. R89's progress note dated 10/26/24 to 11/20/24, failed to identify R89 refused a shower on 11/9/24. During interview with R89 on 11/21/24 at 8:21 a.m., R89 stated, "my daughter [FM-A] is helping with the arrangements [for discharge]. I get confused. I like to get washed up. It makes me	F 677	4. Responsible Party for Monitoring: The RN Unit Managers and Director of Nursing will monitor for correction and report findings to the QAPI Committee to assure ongoing compliance.	

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F 677	Continued From page 13	F 677		

feel normal and less gross. It is important to me to have my hair washed. I cannot remember the last time I had it washed. It does feel like its ben a least a week since it was washed."

During interview with family member (FM)-A on 11/21/24 at 8:38 a.m., FM-A stated she recalled being present for R89's admissions assessment. FM-A stated, "Mom [R89] likes showers in the morning but I am quite sure she was never asked if she preferred a specific day or time of the day for the shower. I think [R89] missed a shower while she was there. They [staff] said they were going to do it but I believe they forgot. [R89] is a lot of work to get in and out of the shower so I am sure it was forgotten, or they did not have enough staff to do it. She had one last week, I think." And, "Yes, she likes her hair washed. Makes her feel good, like it does for all of us. A wet washcloth is not the same as a shower. I feel disgusting if I don't have a shower and I am quite sure she would not like missing a good shower or bath. She used to shower every day."

During interview with registered nurse (RN)-A on 11/19/24 at 1:25 p.m., RN-A stated the expectation of nursing assistants was to "look at the care sheet first" to identify shower days and times. RN-A indicated shower day assignments are scheduled per room.

R159

R159's admissions MDS dated 11/10/24, identified R159 with admission to facility's TCU on 11/4/24, R159 had impaired cognition, and required substantial to maximum assistance with showers or baths, toileting, lower body dressing, and personal hygiene. Also, R159 was

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F 677	Continued From page 14 documented with diagnoses of fracture to right hip, and arthritis. In addition, section F0400 of the MDS titled Interview for Daily Preferences. C. How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Answer coded was, "1. Very important." During interview with NA-B on 11/19/24 at 1:06 p.m., NA-B stated he worked at facility on TCU for sixteen years and noted that R159 was to receive showers on Fridays in the evening per the nursing aide care sheet. NA-B stated the expectation of staff was to document showers including refusals in the EMR under "Tasks". NA-B verified R159's EMR lacked documentation of showers or refusals from R159. During interview with NA-A on 11/19/24 at 12:49 a.m., NA-A stated she had worked full-time on the TCU since, "January [2024]". NA-A stated the expectation of nursing assistants is to look in resident's care plan, Kardex and (undated) care sheet to determine what assistance is required for each resident. NA-A stated the expectation of nursing assistants was to document in the "Task[s]" section of the electronic medical record EMR for assigned tasks, subsequently, NA-A reviewed R159's care sheet and noted "shower day is Fridays in the evening" and stated the EMR lacked documentation of showers or refusals from R159. During interview with TCU nursing manager, registered nurse (RN)-A on 11/19/24 at 1:06 p.m., RN-A stated the expectation of nursing assistants was to look at the resident's care plan, Kardex and (undated) paper care sheet to determine the assistance needed and shower days and times. RN-A looked at R159's EMR and verified no	F 677		

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F 677	Continued From page 15	F 677		

documentation of showers or refusals since he was admitted 11/4/24. RN-A stated, "It was not being documented of being offered, refused, ecetera and it should be. RN-A stated, "I expect documentation in a progress note if he refuses a shower. It horrifies me that he hasn't had shower since he was admitted. It is important that our residents get a shower and cleaned up."

R162

R162's admission MDS dated 11/7/24, identified R162 with admission to facility's TCU on 11/1/24, with moderately impaired cognition, and required partial to moderate assistance with upper body dressing and personal hygiene and required substantial to maximal assistance with showers or bathes and lower body dressing. In addition, R162 was documented with diagnoses of a stroke, cancer, and hypertension (high blood pressure).

During interview with R162 on 11/18/24 at 3:42 p.m., R162 stated, "I prefer a shower if they [staff] could do it. I don't recall if I was asked."

R162's undated care sheet identified R162's showers were assigned for Friday mornings. R162's Tasks tab in EMR identified documentation of having a shower on 11/15/24, missing 11/1/24 and 11/8/24.

R159 progress notes dating from 11/4/24 to 11/19/24, failed to document a shower was offered or declined on 11/1/24 and 11/8/24.

During interview with RN-A on 11/20/24 at 10:40 a.m., RN-A stated, "She [R162] should have been given a shower." Additionally stating "we [facility]

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F 677	Continued From page 16 have noticed that some [residents] have missed the showers and we are not documenting it." During interview with director of nursing (DON) on 11/21/24 at 9:52 a.m., DON verified "showers are not being charted. Showers were missed. Showers are important to everyone, and they should not have been missed." Facility policy titled BATH, SHOWER updated 2/24 identify, "23. Document bath/shower in the EHR (electronic health record). " R103 R103's admission Minimum Data Set (MDS) assessment, dated 11/4/24, indicated R103 had intact cognition with no hallucinations or delusions with an admission date of 10/29/24. Diagnoses included: displaced bicondylar fracture of left tibia (fracture in left lower leg), muscle weakness, other abnormalities of gait and mobility, left foot drop (dragging of front of foot when walking and/or inability to raise toes or the foot from the ankle), and infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts (an infection caused related to implanted devices from surgery). In addition, R103 was dependent on staff for showers/bathing and transfers, and required maximal assistance from staff for dressing, personal hygiene and mobility. R103's care plan, printed 11/18/24, indicated R103 has "an ADL [activity of daily living] self-care performance deficit" with the following intervention:	F 677		

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F 677	Continued From page 17 -"BATHING/SHOWERING: Assistance by (2) staff with bathing/showering. Staff to provide nail care as needed. If diabetic, nail care to be done by nurse. Report need of nail care to nurse. -"PERSONAL HYGIENE: assist of 2 staffs." R103's Kardex, printed 11/20/24, indicated R103's bathing was Saturday PM (evening). Further, indicated "assistance by (2) staff with bathing/showering .... prefers to have a bath." R103's task log, printed 11/20/24, indicated R103's bathing was completed with "total dependence" with "one person physical assist." The document lacked evidence for an entry on 11/16/24, which would be the next scheduled bathing/showering day per schedule. R103's progress notes, dated 10/29/24 to 11/21/24, were reviewed. Progress notes lacked evidence of R103 refusing showers or staff assistance with ADLs. Furthermore, lacked documentation of staff offering an additional showers/bed bath/partial bath since last documented bath/shower on 11/9/24. R103's November Administration Record, printed 11/18/24, indicated an order for: -"Complete weekly/bath and pain sheet assessment in PCC [electronic health record - EHR]. If any new alterations in skin integrity, follow the skin alterations and wounds checklist. Bath declined, skin audit must still be completed. Every evening shift every Saturday." It was documented the assessment was completed for 11/2/24, 11/9/24, and 11/16/24. During an interview on 11/18/24 at 3:12 p.m., R103 stated that her shower/bath day was	F 677		

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F 677	Continued From page 18 scheduled to be on Saturdays. She stated that she not offered and did not get a bath or shower this past Saturday (11/16/24) and the last shower/bath she had was on 11/9/24. R103 was displeased that she was not offered a shower in 9 days. R103 indicated her preference was to have a shower/bath daily, understood that this was likely not possible but going 9 days without a shower was not acceptable. R103 stated she had told staff that she would like more than one shower/bath a week. R103 indicated she was told that they offer one shower/bath a week. On 11/20/24 at 9:20 a.m., registered nurse (RN)-C stated that upon admission, residents are assessed to determine if they want one or two showers a week, in the morning or evening, and that is added to the care plan. RN-C stated that if a shower or bath is missed, for any reason, the nursing assistant is expected to notify the nurse and the shower is to be attempted again another day. RN-C indicated the skin assessment, which is documented on the administration record, is completed by the nurse on the scheduled shower day, whether the shower is completed or not. RN-C indicated that a progress note is entered when a resident refuses a shower and when a shower is attempted or offered again. On 11/20/24 at 10:07 a.m., nurse manager on the 3rd floor RN-D verified that residents are expected to be showered at least once a week and can get an additional shower if requested. RN-D verified the nurse should document in the progress notes when a shower is refused or not given. RN-D reviewed R103's EHR, verified the weekly skin assessment was completed on 11/16/24 and verified R103 did not receive a shower on 11/16/24. RN-D verified R103's last	F 677		

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F 677	Continued From page 19 shower was 11/9/24 which was 11 days ago, at time of interview. RN-D verified R103 needed assistance with showering/bathing and would not be able to complete this task independently. RN-D stated the expectation is that residents are showered or bathed at least weekly. RN-D indicated they would follow up with R103 regarding her showers. A facility policy titled Bath Shower, revised 2/24, indicated the purpose of the policy was "that a resident feels cleansed and refreshed per resident's wishes after bathing," and indicated baths/showers to be documented in EHR.	F 677		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		12/16/24

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F 758	Continued From page 20 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure as-needed (PRN) antipsychotic medications were limited to 14 days of use or re-evaluated by the medical provider to ensure necessity and reduce the risk of complication for 1 of 5 residents (R6) reviewed for unnecessary medication use. Findings include: R6's significant change Minimum Data Set (MDS) dated 9/26/24, indicated R6 had moderately	F 758	F758 1. Corrective Action: R6 expired after survey exit; her as-needed (PRN) haloperidol orders were reviewed and stop dates reassessed by hospice prior to her passing away. 2. Corrective Action as it Applies to Other Residents: All PRN antipsychotic orders were reviewed to assure a 14-day stop date and medical re-evaluation of necessity. All nursing staff were re-educated on the requirements for PRN	

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(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
F 758	Continued From page 21 impaired cognition and was receiving hospice services. R6 was dependent on staff for toileting, personal hygiene, and bed mobility. The MDS indicated R6 was diagnosed with dementia, anxiety, and depression. R6's Verbal Orders report dated 10/23/24, indicated a hospice provider (MD)-A had ordered two milligrams (mg) haloperidol (an antipsychotic medication) three times a day as needed (PRN) starting on 10/23/24. The report had a column titled "Date Discontinued" that was left blank and the order did not include an end date. R6's order summary report dated 10/23/24, indicated R6 had an order for two milligrams (mg) haloperidol three times a day as needed (PRN) starting on 10/23/24 for agitation or nausea ordered by nurse practitioner (NP)-A. The report included a section titled "End Date" that did not include a date for this order. R6's Medication Administration Record (MAR) dated 10/23/24 through 11/19/24, indicated R6 had received the PRN haloperidol with the order date 10/23/24 over ten times during the period. During an interview on 11/20/24 at 10:47 a.m., registered nurse (RN)-E, the unit nurse manager, stated she had reviewed R6's medical record and confirmed R6's PRN haloperidol order had been active for longer than fourteen days and a provider had not re-evaluated her during that time and renewed the order if needed. During an interview on 11/20/24 at 11:23 a.m., NP-A stated she was R6's primary care provider but R6 also received hospice care and the Haldol was managed by them. NP-A stated she would	F 758	antipsychotic medication orders with respect to this regulatory requirement. 3. Date of Completion: 12/16/24. 4. Responsible Party for Monitoring: The Consultant Pharmacist and Director of Nursing or Designee will monitor for correction and report findings to the QAPI Committee to assure ongoing compliance.	

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	245213	A. BUILDING _____ B. WING _____	C 11/21/2024

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F 758	Continued From page 22 have expected the hospice provider to order PRN haloperidol for a maximum of 14 days and then reevaluate R6 for the appropriateness of continued haloperidol use prior to reordering it. NP-A stated she had not reassessed R6 for the appropriateness of this medication as it was ordered by hospice. During an interview on 11/20/24 at 11:35 a.m., RN-F, R6's hospice nurse, confirmed the hospice provider had not re-evaluated R6 after 14 days of PRN haloperidol use and had not ordered an end date for the medication. RN-F stated she had reviewed R6's hospice medical record and confirmed the order had not been renewed after 14 days of use. During an interview on 11/21/24 at 8:30 a.m., the director of nursing (DON) stated R6's medical record had been reviewed and facility staff did not find that R6's PRN haloperidol had an ordered stop date or had been renewed by a provider after 14 days. The facility Psychopharmacologic Drug Use policy dated 7/8/24, indicated PRN psychotropic medications should be limited to 14 days unless the prescribing practitioner believes it was appropriate to extend past 14 days and documented the rationale in the medical record and indicated the duration. The policy did not include additional instruction for PRN antipsychotic medication use	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		12/16/24

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F 880	Continued From page 23 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 24 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented or followed for 2 of 2 residents (R46 and R21) reviewed for EBP. Findings include: The CDC article titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24, indicated MDRO transmission in skilled nursing facilities was common and contributed to substantial	F 880	F880 1. Corrective Action: R46 and R21's enhanced barrier precautions (EBP) were reviewed and affected caregiver staff re-educated on proper personal protective equipment (PPE) usage to assure proper infection control during care and services. 2. Corrective Action as it Applies to Other Residents: Resident EBP signage and PPE donning/doffing will be audited on all floors to assure appropriate PPE is worn during cares. All nursing and contracted service provider (i.e. podiatry, hearing and vision, dental) staff were	

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F 880	Continued From page 25 resident morbidity. EBP is an infection control intervention to reduce transmission of MDROs by using gowns and gloves during "high contact resident care activities" that provide opportunities for transfer of MDROs to staff hands and clothing that lead to indirect transfer of MDROs from resident to resident. The article indicated high-contact activities include changing linens, bathing, dressing, transferring, changing briefs, feeding tube care, etc. The article indicated EBP should be implemented (when contact precautions did not apply) for residents with wounds or indwelling medical devices (central lines, urinary catheter, feeding tube) regardless of MDRO colonization status. R46's quarterly Minimum Data Set (MDS) dated 9/19/24, indicated R46 had severely impaired cognition, was diagnosed with a stroke, and required total assistance with all care activities. The MDS indicated R46 received his nutrition through a feeding tube. R46's order summary report dated 11/4/24, indicated R46 had an enteral feeding tube. R46's progress note dated 11/19/24 at 12:21 p.m., indicated the staff development director/ registered nurse (SDD) had instructed podiatry per the "nurse manager" that R46 would like podiatry services in his room in bed but the SDD advised podiatry staff that they would not need to utilize EBP. The SDD explained to podiatry staff that "working on his feet would not prevent a splash risk" so they would not need to don or doff PPE for this encounter. During an observation on 11/19/24 at 11:42 a.m., licensed practical nurse (LPN)-B was observed in	F 880	re-educated on EBP and PPE requirements. 3. Date of Completion: 12/16/24. 4. Responsible Party for Monitoring: The Infection Preventionist will audit for proper EBP signage and PPE usage during personal cares and report findings to the QAPI Committee to assure ongoing compliance.	

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F 880	Continued From page 26 R46's room with gloves on but no gown. LPN-B was observed to lean into R46's bed, pull back his covers, and reposition R46's legs. LPN-B was then observed to continue leaning against R46's bed to adjust the pillows between R46's legs before removing his gloves and leaving the room. During an interview on 11/21/24 at 8:04 a.m., the SDD stated she completed EBP education for nursing staff. The SDD stated staff should utilize EBP when there was a "splash risk" but if an activity did have a splash risk such as transferring a resident or completing foot care EBP would not be needed. During an interview on 11/21/24 at 9:34 a.m. with the director of nursing (DON) and the infection preventionist (IP), the IP stated the SDD completed all staff infection prevention education. The IP stated it was important for staff to read the CDC infection control signs that outline when PPE was needed for residents on EBP. The IP stated she would expect nursing staff to utilize EBP when they were transferring a resident per the CDC sign. The DON stated when care was being given to a resident in bed and involved staff-to-resident contact, she would expect nursing staff to utilize PPE, given the possible burden of MDROs in the resident ' s room. The facility's EBP policy dated 11/8/24, indicated EBP was needed for residents with chronic wounds and indwelling medical devices such as feeding tubes. The policy indicated that glove and gown use should be utilized for dressing, bathing, transferring, providing hygiene, changing linens, assisting with toileting, etc.	F 880		

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F 880	Continued From page 27 R21's quarterly Minimum Data Set (MDS) dated 8/8/24, indicated R21 had moderate cognitive impairment, was diagnosed with severe vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), left side hemiplegia (paralysis of the left side of the body), and a pressure area (pressure areas are injuries to the skin and the tissue below the skin that are due to extended pressure on the skin). The MDS also indicated R21 required substantial assistance with mobility, and total assistance with toileting and hygiene. R21's Clinical Diagnosis report printed 11/21/24, documented R21 was on enhanced barrier precautions related to a wound. R21's Order Summary report dated 11/21/24, indicated orders for wound care to right posterior thigh. The order directed nurses to "1. Clean right posterior thigh with unscented soap [Cetaphil/dove]. 2. Apply small amount of VASHE [a wound cleanser solution] on gauze, lay into wound bed, let it sit for 10 minutes, remove gauze, do not rinse. 3. Gently pack with VASHE moistened plain packing strip to fill depth of wound, ensure to leave a tail for easy removal. Do not overpack. 4. Cover with Mepilex dressing [Mepilex Ag is a soft and conformable dressing that absorbs exudate and inactivates wound pathogens]. Change every- day shift and as needed if soiled/saturated/dislodged." During observation on 11/20/24 at 10:22 a.m.,	F 880		

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F 880	Continued From page 28 nursing assistant (NA)-C was observed providing personal cares to R21 without wearing a gown. R21 was in bed, turned on her right side facing the wall and NA-C was adjusting R21's brief. NAR's legs were touching the bed linen and NA-C was wearing gloves. NA-C finished adjusting R21's pants and left the room to find another NA to help him transfer R21 with a mechanical lift. NA-C came back to the room followed by NA-D who was pushing the mechanical lift. Before entering R21's room, NA-C and NA-D put on gloves, but did not wear gowns and transferred R21 from her bed to her wheelchair. During interview on 11/20/24 at 10:27 a.m., NA-D confirmed she didn't use a gown when she assisted R21 during transfer. When asked regarding the EBP sign posted to the right side of R21's room, NA-D started reading it aloud. After she finished reading the sign NA-D said, "I was supposed to clean my hands before I entered the room, wear gloves and a gown." NA-D stated she didn't know what EBP meant, but she could find out by asking the nurse. During interview on 11/20/24 at 10:41 a.m., NA-C stated he didn't wear a gown while changing R21's brief and added "I wore gloves." When directed to the EBP sign next to R21's door, NA-C asked, "do I have to use a gown all the time?" NA-C proceeded to read the sign and stated, "we [staff] need to follow precautions to prevent further disease and infections to go around." During interview on 11/20/24 at 10:47 a.m., LPN-A, who was caring for R21 stated, it is concerning when staff don't follow EBP precautions due to the potential of spreading pathogens and diseases. LPN-A added the	F 880		

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F 880	Continued From page 29 expectation was for all staff to follow the infection precautions as indicated by the signs posted adjacent to the resident's rooms.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on November 20, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Ebenezer Ridges Geriatric Care Center, 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 19 Existing 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	K 000		

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

Electronically Signed | 12/05/2024

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Ebenezer Ridges Geriatric Care Center is a 3-story building with a partial basement. The building was built at three different times. The original building was built in 1976 and was determined to be of Type II(222) construction. The 1994 Chapel addition is a 1-story and was determined to be of Type II(222) construction. The	K 000		

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K 000	Continued From page 2 2015 Transitional Care Unit addition is a one-story building with an underground parking garage. In 2015, an addition was constructed to the east side of the building that was determined to be of Type II(222) construction. Because the original building and the 1994 addition meet the construction type allowed for existing buildings, the three buildings will be surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 114 beds and had a census of 110 at the time of the survey.	K 000		
K 293 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 7.10.1.5.1. These deficient findings could have an	K 293	K293 1. Corrective Action: 7 exit signs will be placed on the 3rd floor unit, 7 exit signs will be placed on the 2nd floor unit, and 1	12/16/24

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K 293	Continued From page 3 widespread impact on the residents within the facility. Findings include: On 11/20/2024, between 11:30 AM and 2:30 PM, it was revealed by observation that there was no exit signs in the following areas: 1. On the 3rd floor, in the Gardens area, there were 4 intersections where there were no exit signs. 2. On the 2nd floor, by the Nurses Station, there was no exit sign to show the direction of travel. 3. On the TCu, at the Nurses Station, there was no exit sign to show the direction of travel. An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.	K 293	exit sign will be placed on the TCU unit. 2. Date of Completion: 12/16/24. 3. Responsible Party for Monitoring: As the exit signs were installed permanently, no monitoring of compliance is necessary to assure compliance.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING 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 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 311	K311	12/16/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER RIDGES GERIATRIC CARE CENTER	**13820 COMMUNITY DRIVE BURNSVILLE, MN 55337**

(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
K 311	Continued From page 4 facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 11/20/2024, between 11:30 AM and 2:30 PM, observations and staff interview revealed that there was a ceiling tile missing in the kitchen. This condition would delay the activation of the fire alarm and sprinkler system in the event of an emergency. An interview with the Director of Environmental Services and the Administrator verified this deficient finding at the time of discovery.	K 311	1. Corrective Action: Missing ceiling tiles were placed in the third-floor kitchenette in accordance with the requirements of K311. 2. Corrective Action as it Applies to Systems: The building ops team was educated on the requirements of K311. 3. Date of Completion: 12/16/2024 4. Responsible Party for Monitoring: The Director of Environmental Services will monitor for Compliance with K311 and report any findings to the QAPI Committee for 3 months following the date of the survey	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		12/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245213	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/20/2024**

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K 321	Continued From page 5 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.6.3.1, 8.4.3.2, and 8.4.4.1. This deficient finding could have a wide impact on the residents within the facility. Findings include: On 11/20/2024 between 11:30 AM and 2:30 PM, it was revealed by observation that the 3rd floor storage room door did not have a closure on it to allow the door to self close and positivly latch. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 321	K321 1. Corrective Action: The 3rd floor storage room door was equipped with closure in accordance with K321. 2. Date of Completion: 12/16/2024 3. Responsible Part for Monitoring: As the closure mechanism was installed on the door permanently, no monitoring is necessary to assure compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		12/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245213	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/20/2024**

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K 353	Continued From page 6 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. This deficient finding could a widespread impact on the residents within the facility. Findings include: On 11/20/2024 between 11:30 AM and 2:30 PM, it was revealed by observation that storage materials had been placed within 18" of the sprinkler system in the mechanical/sprinkler room on the 1st floor. An interview with the Director of Environmental	K 353	K353 1. Corrective Action: The materials were removed from 18 inches within the ceiling immediately. 2. Corrective Actions as it Applies to Systems: The Building Ops team was re-educated on the requirements of K353 as the room in question was on accessible by building ops staff. 3. Date of Completion: 12/16/2024 4. Responsible Part for Monitoring: The Director of Environmental Services will monitor for Compliance with K353 and report any findings to the QAPI Committee for 3 months following the date of the survey.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245213	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/20/2024**

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K 353	Continued From page 7 Services and Administrator verified this deficient finding at the time of discovery.	K 353		