### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 6EX1

Facility ID: 00756

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245213 2.STATE VENDOR OR MEDICAID NO. (L2) 834243100 3. NAME AND ADDRESS OF FACILITY (L3) EBENEZER RIDGES GERIATRIC CARE CENTER (L4) 13820 COMMUNITY DRIVE (L5) BURNSVILLE, MN (L6) 55337 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)			4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other	
(L9) 6. DATE OF SURVEY <b>03/29/2017</b> (L	01 Hospital  02 SNF/NF/Dual  10) 03 SNF/NF/Distinct  04 SNF	05 HHA 09 ESRD 06 PRTF 10 NF 07 X-Ray 11 ICF/III 08 OPT/SP 12 RHC	13 PTIP 22 CLIA 14 CORF	8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)  06/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 114 (L 13.Total Certified Beds 114 (L	Compliance 1. As  18)  B. Not in Com		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code  * Code:  A	6. Scope of Services Limit 7. Medical Director
114	O SNF ICF	IID (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE  Gayle Lantto, Unit Supervisor	Date : 0:	18. STATE SURVEY AGENCY APPROVAL Date:  Anne Peterson, Enforcement Specialist 08/07/2017 (L20)		
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Participate     2. Facility is not Eligible	20. COMI	BY HCFA REGIONA PLIANCE WITH CIVIL SHTS ACT:	21. 1. Statement of Finan 2. Ownership/Control 3. Both of the Above	cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
OF PARTICIPATION BEGIN 12/01/1976  (L24) (L41)  25. LTC EXTENSION DATE: 27. ALTE A. Su	GREEMENT 24.  NNING DATE  RNATIVE SANCTIONS spension of Admissions: cind Suspension Date:	LTC AGREEMENT ENDING DATE  (L25)  (L44)	26. TERMINATION ACTION:  VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/C. 03001	(L45) ARRIER NO. (L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32. DETERMINATION O. <b>04/27/2017</b>	OF APPROVAL DATE	DETERMINATION ADDR	OVAL



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245213 May 17, 2017

Ms. Courtney Vanvooren, Administrator Ebenezer Ridges Geriatric Care Center 13820 Community Drive Burnsville, MN 55337

Dear Ms. Vanvooren:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 28, 2017 the above facility is certified for:

114 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 114 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 17, 2017

Ms. Courtney Vanvooren, Administrator Ebenezer Ridges Geriatric Care Center 13820 Community Drive Burnsville, MN 55337

RE: Project Number S5213028

Dear Ms. Vanvooren:

On March 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 16, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On March 29, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 28, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 16, 2017, effective March 28, 2017 and therefore remedies outlined in our letter to you dated March 1, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION  A. Building			DATE OF REV	'ISIT
	B. Wing		Y2	3/29/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
EBENEZER RIDGES GERIATRIC CARE CENTER 13820		13820 COMMUNITY DRIVE			
		BURNSVILLE, MN 55337			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	<b>DATE</b> Y5	ITEM Y4	<b>DATE</b> Y5	ITEM Y4	<b>DATE</b> Y5
ID Prefix F0248	Correction	ID Prefix F0279	Correction	on ID Prefix	Correction
Reg. # 483.24(c)(1)	Completed	Reg. # 483.20	(d);483.21(b)(1) Complet	ed Reg. #	Completed
LSC	03/28/2017	LSC	03/28/201	7 LSC	
ID Prefix	Correction	ID Prefix	Correction	on ID Prefix	Correction
Reg. #	Completed	Reg. #	Complet	ed Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	on ID Prefix	Correction
Reg. #	Completed	Reg. #	Complet	ed Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	on ID Prefix	Correction
Reg. #	Completed	Reg. #	Complet	ed Reg.#	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	on ID Prefix	Correction
Reg. #	Completed	Reg. #	Complet	ed Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) GL/mm	<b>DATE</b> 05/17/2017	SIGNATURE OF SURVEYO		<b>DATE</b> 03/29/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY 2/16/2017	COMPLETED ON		R ANY UNCORRECTED DEFI CTED DEFICIENCIES (CMS-2		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6EX1 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00756 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) EBENEZER RIDGES GERIATRIC CARE CENTER (L1)1. Initial 2. Recertification (L4) 13820 COMMUNITY DRIVE 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55337 834243100 (L2)(L5) BURNSVILLE, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 02/16/2017 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 16 HOSPICE 06/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): \_\_\_\_ 2. Technical Personnel То (b): Program Requirements Scope of Services Limit Compliance Based On: \_\_\_ 3. 24 Hour RN Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 114 (L18) \_\_\_ 5. Life Safety Code \_\_\_ 9. Beds/Room 13. Total Certified Beds 114 (L17) **X** B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)\* Code: 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18/19 SNF 19 SNF ICF IID (L15)18 SNF 1861 (e) (1) or 1861 (j) (1): 114 (L37) (1.38)(L39) (L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Lisa Hakanson, HFE NEII 04/17/2017 Mark Meath, Enforcement Specialist 04/27/2017 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: X 1. Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 12/01/1976 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change 00-Active (L44)(L27)B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 1, 2017

Ms. Courtney VanVooren, Administrator Ebenezer Ridges Geriatric Care Center 13820 Community Drive Burnsville, Minnesota 55337

RE: Project Number S5213028

Dear Ms. VanVooren:

On February 16, 2017, a standard 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Ebenezer Ridges Geriatric Care Center March 1, 2017 Page 2

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

### DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794 Fax: (651) 215-9697

### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 28, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

### ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A

Ebenezer Ridges Geriatric Care Center March 1, 2017 Page 4

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

### 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 May 16, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

Ebenezer Ridges Geriatric Care Center March 1, 2017 Page 5

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 16, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

### INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245213	B. WING		<del></del>	02/	16/2017
	PROVIDER OR SUPPLIER  ER RIDGES GERIATE	RIC CARE CENTER		13	REET ADDRESS, CITY, STATE, ZIP CODE 820 COMMUNITY DRIVE JRNSVILLE, MN 55337		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated.  Upon receipt of an on-site revisit of your electron your electron that the bottom of the form.	of correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required a first page of the CMS-2567 ic submission of the POC will cion of compliance.  acceptable electronic POC, an our facility may be conducted to	F 0	000			
F 248 SS=D	regulations has bee your verification. 483.24(c)(1) ACTIVINTERESTS/NEED (c) Activities. (1) The facility mus comprehensive assiste preferences of program to support activities, both facil individual activities designed to meet the physical, mental, are each resident, encound interaction in the This REQUIREMED by: Based on observation.	t provide, based on the ressment and care plan and each resident, an ongoing residents in their choice of ty-sponsored group and and independent activities, ne interests of and support the nd psychosocial well-being of buraging both independence ne community.	F 2	448	Correction Action for identified		3/28/17
AROBATOP	review, the facility f based on an individ residents (R244, R2 Findings include:	ailed to provide activities ualized care plan for 2 of 3 234) reviewed for activities.	NATURE		residents: -Activities Assessments for residents R244 and R234 were reviewed and revised as of 2/20/2017, Care Plans reviewed and revised as of 2/23/201 include resident preferences for acti	7 to	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/10/2017

**Electronically Signed** 

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245213	B. WING		02/	16/2017	
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	•		
EDENE7	ER RIDGES GERIATI	DIC CADE CENTED		13820 COMMUNITY DRIVE			
CDENEZ	EN NIDGES GENIALI	NIC CARE CENTER		BURNSVILLE, MN 55337			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 248	Continued From pa	age 1	F 2	48			
	R244 was lying on 2/14/17, at 9:00 a.r at 12:30 p.m. havir room napping. R24 room on 2/14/17, et 0n 2/15/17, at 8:20 his eyes closed At to use the bathroor dressed and nappir room. An activity of was scheduled for R244 did not attendapping in his room attending an activition on 2/16/17, at 9:24 dining room table a what he was he had responded, "sleep, the television (TV)  R244's 12/9/16, and (MDS) indicated the impaired. R244 regulated the respondent in the was him from place to pursuing favorite a important. He was him from place to pursue leisure in conference note da R244's daughter respondent in the church. R244 to pursue leisure in conference note da R244's daughter respondent in the church. R244 to pursue leisure in conference note da R244's daughter respondent in the church in the c	his bed in a darkened room on m. R244 was observed again ing lunch when he was in his 44 was not observed out of his except for the noon meal.  O a.m. R244 was in bed with 9:30 a.m. R244 was assisted in a darkened in a darkene		2. Corrective Action as it residents: -Other resident activities previewed and revised as ostaff educated on providing meet individual interests a each resident.  3. Date of Completion 3/4  4. Reoccurrence will be parandom weekly audits of activities attendance logs weekly for 90 days to assumeds/interests of activitie. The results of these audit with the QAPI committee from the need to increase, decreased to increase the administrator or designs.  5. The correction will be the administrator or designs.	preferences of 2/23/2017. In a activities that and needs for 28/2017 prevented by: 2 resident's to be reviewed are resident's are being met. Its will be shared for input on preventies and rease, or monitored by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245213	B. WING			02/	16/2017
	PROVIDER OR SUPPLIER			13	TREET ADDRESS, CITY, STATE, ZIP CODE 8820 COMMUNITY DRIVE URNSVILLE, MN 55337	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	music, and working The admission car filed in R244's med section of theraped lacked personalize help R244 engage The director of act interviewed on 2/19 explained the facilit care planning proc resident's Minimun and active living as completed. The act interview the reside gather further infor activity preferences documented in the initial care plan wo after completion of assessment and in made on the paper assessment. At th care plan would be health record. Add care conference m activity goals would care plan was reviewas surprised to so developed. The DA the coordinators to and she would ente electronic record a  The DAL was agai 8:57 a.m. and 2/17 R244 was reviewe		F 2	248			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245213	B. WING		02	2/16/2017	
	PROVIDER OR SUPPLIER  ER RIDGES GERIATE	RIC CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 13820 COMMUNITY DRIVE BURNSVILLE, MN 55337			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 248	activity on 2/4/17, a resident was sleepi there was no docur offered or attended liked to lie down aft awaken him. She e hearing and had so communication diffi observing social ac she had been looki was up more freque talker to aid in com R244 could have us opportunities.  R234 was observed dozing in his wheeled the service that mornin napping in his reclinactivity of visits from not participate. R23church service.  The admission activity of visits from not participate. R23church service.  The admission activity of visits from not participate. R23church service.  The admission activity of visits from not participate. R23church service.  The admission activity of visits from not participate. R23church service.  The admission activity of visits from not participate. R23church service.	and on 2/2/17, it was noted the ng. From 2/4/17 to 2/16/17, mentation R244 had been activities. The DAL said R244 er meals and it was hard to explained he was hard of the cognitive losses that made icult. R244 did seem to enjoy tivities. The DAL explained ng into ensuring the resident ently, and to try using a pocket munication. The DAL verified sed additional activity.  If on 2/15/17, at 9:16 a.m. chair at the dining room table, scorted him out of the dining him there was a church g. At 9:51 a.m. R234 was her in his room. There was an an children, however, R234 did as also did not attend the explained activities present in his room, as icated R234 did not pursue activities present in his room, assical piano, played the piano, assical piano, played the piano, assical piano, played cards R234 stated during the ew he would enjoy pet visits, tergenerational activities, and ports on TV and being was to gather more 234's family, provide ependent leisure and bring	F 2	48			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUC		(X3) DATE SURVEY COMPLETED			
		245213	B. WING				<b>02</b> /	16/2017
	PROVIDER OR SUPPLIER  ER RIDGES GERIATE	RIC CARE CENTER		13820 COMMI	ESS, CITY, STATE, ZIP CO UNITY DRIVE .E, MN 55337	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF COR CH CORRECTIVE ACTION S-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 248	resident was cognit reported activity purimportant to him. Himove from place to The admission care filed in R234's med section of therapeulacked personalized help R234 engage day. When the care DAL on on 2/15/17, surprised to see the developed for R234 we record for 2/1/17 th had watched TV for along twice, a movi activity and receive to 2/15/17, R234 had intergenerational activity and re	dmission MDS indicated the rively impaired. The resident results were somewhat e required staffs' assistance to place.  The plan completed on paper and ical record was blank for the tic recreation. The record digoals and interventions to in desired activities during the e plan was reviewed with the at 3:16 p.m. she was e care plan had not been the plan was reviewed with the at 3:17, activity attendance re reviewed with the DAL. The rough 2/7/17, showed R234 ar times, participated in a sing e, and passively attended and discovered as the record of the recor	F 2	48				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245213	B. WING			02/16/2017	
	PROVIDER OR SUPPLIER  ER RIDGES GERIATE	RIC CARE CENTER		13	TREET ADDRESS, CITY, STATE, ZIP CODE 3820 COMMUNITY DRIVE SURNSVILLE, MN 55337		
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F 248	Continued From pa developed using the assessments to acceptately and other id	e comprehensive curately reflect the resident's	F 2	248			
F 279 SS=D	483.20(d);483.21(b COMPREHENSIVE		F 2	279			3/28/17
	assessments comp months in the resid results of the asses	nust maintain all resident bleted within the previous 15 ent's active record and use the esments to develop, review dent's comprehensive care					
	483.21 (b) Comprehensive	Care Plans					
	comprehensive per each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial n comprehensive ass	t develop and implement a reson-centered care plan for sistent with the resident rights $O(c)(2)$ and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the ressment. The comprehensive cribe the following -					
	or maintain the resi physical, mental, ar	t are to be furnished to attain dent's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and					
	under §483.24, §48 provided due to the	at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (	(X3) DATE SURVEY COMPLETED		
		245213	B. WING		02/16/2017		
	PROVIDER OR SUPPLIER  ER RIDGES GERIATI	RIC CARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 13820 COMMUNITY DRIVE BURNSVILLE, MN 55337			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION		
F 279	rehabilitative service provide as a result recommendations. findings of the PAS rationale in the residential resident's represent (A) The resident's represent (A) The resident's redesired outcomes.  (B) The resident's redesired outcomes.  (B) The resident's redesired outcomes.  (B) The resident's redesired outcomes.  (C) Discharge plan plan, as appropriate requirements set for section.  This REQUIREMED by:  Based on observare review, the facility fapproaches to active (R244, R234) review.  Findings include:  R244's 12/9/16, add	descrices or specialized sees the nursing facility will of PASARR  If a facility disagrees with the SARR, it must indicate its ident's medical record.  with the resident and the ntative (s)- goals for admission and  preference and potential for acilities must document nt's desire to return to the sessed and any referrals to sees and/or other appropriate rose.  s in the comprehensive care e, in accordance with the orth in paragraph (c) of this  NT is not met as evidenced tion, interview and document failed to develop individualized vities for 2 of 3 residents	F 279	Corrective Action for identified residents:     Activities Assessments for resident R244 and R234 reviewed and revise of 2/20/2017, Care Plans reviewed a revised as of 2/23/2017 to include resident preferences for activities.	ed as		
	impaired. R244 rep	ported he considered music, n groups, getting outside and		2. Corrective Action as it applies to residents:	other		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		245213	B. WING		02/1	6/2017	
	PROVIDER OR SUPPLIER	RIC CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  13820 COMMUNITY DRIVE  BURNSVILLE, MN 55337				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 279	pursuing favorite a important. He was him from place to provide a factor of the state of the sta	ctivities as being very dependent on staff to move place.  peutic recreation assessment cated he was a retired farmer and games, puzzles, he accordion, and was active required assistance from staff atterests. A Life Focus care ated, 12/21/16, indicated exported he enjoyed watching hows and movies, listening to gon puzzles.  e plan completed on paper and dical record was blank for the atic recreation. The record ed goals and interventions to in preferred daily activities.  dmission MDS indicated the tively impaired. The resident arsuits were somewhat the required staffs' assistance to be place.  active living assessment note, dicated the resident did not not leisure activities present in sing people in his life, had a bying hunting and fishing, enjoyed jazz and classical and table games. R234 ssessment interview he would	F 279	-The Policy and Procedure for Individualized Care Plans was re and remains currentOther resident activities care plateen reviewed and updated as management of Individualized Care.  3. Date of Completion 3/28/2014  4. Reoccurrence will be preventant of Procedure for Individualized Care.  3. Date of Completion 3/28/2014  4. Reoccurrence will be preventant of Procedure for Individualized Care.  4. Reoccurrence will be preventant of Procedure for Individualized Care.  5. The results of these audits will be with the QAPI committee for input system improvement opportunities the need to increase, decrease, discontinue the audits.  5. The correction will be monital administrator or designee	ans have necessary. Policy and e Plans. 17 Inted by: dent's red anges in ed and up to e shared ut on es and or		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245213	B. WING		02	/16/2017		
	PROVIDER OR SUPPLIER  ER RIDGES GERIATE	RIC CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  13820 COMMUNITY DRIVE  BURNSVILLE, MN 55337					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 279	provide assistance bring outdoor maga. The admission care filed in R234's med section of therapeu lacked personalized help R234 engage day. When the care DAL on on 2/15/17, surprised to see the developed for R234. The director of activinterviewed on 2/15 explained the faciliticare planning proceresident's MDS and would be completed coordinators would family as needed to past and current and assessments would electronic health rewould be completed the MDS and active interview(s). Update paper copy until the At that time, a more would be document record. Additional in conference meeting goals would be reviewed with surprised to see the developed. The DA the coordinators to and she would entertice.	with independent leisure and azines to R234.  e plan completed on paper and ical record was blank for the tic recreation. The record d goals and interventions to in desired activities during the e plan was reviewed with the at 3:16 p.m. she was e care plan had not been d.  ye living (DAL) was 5/17, at 3:16 p.m. and y's activity assessment and ess. Upon admission, a d active living assessment	F 2	79				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245213	B. WING		02	/16/2017
	PROVIDER OR SUPPLIER  ER RIDGES GERIATE	RIC CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  13820 COMMUNITY DRIVE  BURNSVILLE, MN 55337			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	8:57 a.m. the DAL safter meals and it wexplained he was honey and it was activities. The DAL looking into ensuring frequently, and to train communication. The have used additional companion of the watched TV in recliner in his room nap. The DAL explorare, but the hospic tell them if R234 has other than receiving staff observed R23 on the attendance of the train the standance of the train the standance of the facility's 1/17, indicated an individ developed using the	in interviewed on 2/16/17, at said R244 liked to lie down was hard to awaken him. She ard of hearing and had some at made communication eem to enjoy observing social explained she had been up the resident was up more by using a pocket talker to aid The DAL verified R244 could all activity opportunities.  The DAL explained R234 in the common area, had a which he enjoyed and liked to ained R234 was on hospice be staff would not necessarily ad been engaged in an activity of personal care. If the activity a first in an activity they marked it record.  Individualized care plans policy utilized plan of care would be ecomprehensive curately reflect the resident's	F 2	79		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

5213026

Printed: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES A. BUILDING 01 - MAIN BUILDING 01 COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245213 B. WING 02/22/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

EBENEZER RIDGES GERIATRIC CARE CENTE **13820 COMMUNITY DRIVE** 

(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 000	INITIAL COMMENTS	K 000		
	FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Ebenezer Ridges Care Center was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.			
	Ebenezer Ridges Geriatric Care Center is a 3-story building with a partial basement. The building was built at 3 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 2015 Transitional Care Unit addition, is a 1 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 3 buildings will be surveyed as one building. The property is going through a major remodel at this time. They have just started phase II of 10 phases. They were given some lattitude due to the construction process. They were advised to ensure that all exits remain clear and unobstructed.			7
	The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms		:1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

Printed: 02/28/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA /IBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED		
		245213		B. WING		02/22	02/22/2017	
	PROVIDER OR SUPPLIER	TRIC CARE CENTE	13820 0	DDRESS, CITY, STATE, ZIP CODE  COMMUNITY DRIVE				
			BURNS	VILLE, MN	N 55337			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 000		•		K 000				
	in all resident room	is.						
	The facility has a licensed capacity of 114 beds and had a census of 109 at the time of the survey.							
	The requirement a MET.	t 42 CFR, Subpart 48	33.70(a) is,					
			-					
			9.		a.			
					,			
			× 1		18 a			
-							*	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 1, 2017

Ms. Courtney VanVooren, Administrator Ebenezer Ridges Geriatric Care Center 13820 Community Drive Burnsville, Minnesota 55337

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5213028

Dear Ms. VanVooren:

The above facility was surveyed on February 13, 2017 through February 16, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Ebenezer Ridges Geriatric Care Center March 1, 2017 Page 2

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact **Gayle Lantto at: (651) 201-3794 or email: gayle.lantto@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00756	B. WING		02/1	6/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER RIDGES GERIATE	RIC CARE CENTE	MMUNITY D LLE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000 Initial Comments			2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <a href="http://www.health.">http://www.health.</a>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/10/17 **Electronically Signed** 

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00756	B. WING		02/1	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
EBENEZ	ER RIDGES GERIATE	RIC CARE CENTE	MMUNITY D LLE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE	
2 000	Department of Hea you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department of this Department provider and the foliasued. Please indepartment of the State Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. To assigned the minnesota Department of the State Licensing federal software. The assigned tag in column entitled "Illustrature/rule out of the State of the Stat	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  It, 15, and 16, 2017, surveyors is staff, visited the above lowing correction orders are locate in your electronic plan of have reviewed these orders, is when they will be completed. The order of Health is documenting and numbers have been located at a state statutes/rules for the order of Deficiencies" column to Comply" portion of the location of the state statute in violation of the state statute in the ent of Deficiencies" column to Comply" portion of the location of the state statute in violation i	2 000			

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00756	B. WING		02/1	6/2017
	PROVIDER OR SUPPLIER	IIC CARE CENTE 13820 CC	DRESS, CITY, S DMMUNITY D LLE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From page 2		2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 555	MN Rule 4658.0405 Plan of Care; Devel	5 Subp. 1 Comprehensive opment	2 555			3/28/17
	Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.					
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to develop individualized rities for 2 of 3 residents wed for activities.		Corrected		
	Findings include:					
	(MDS) indicated the impaired. R244 rep news, pets, being ir pursuing favorite ac	mission Minimum Data Set e resident was cognitively orted he considered music, n groups, getting outside and ctivities as being very dependent on staff to move				

Minnesota Department of Health

STATE FORM 6899 6EX111 If continuation sheet 3 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00756	B. WING		02/1	6/2017
	PROVIDER OR SUPPLIER	RIC CARE CENTE 13820 CO	DRESS, CITY, S MMUNITY D LLE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 555	him from place to p R244's initial therap dated 12/9/16, indid who enjoyed cards television, played tr in his church. R244 to pursue leisure in conference note da R244's daughter re football, old time sh music, and working The admission care filed in R244's med section of therapeu lacked personalize help R244 engage R234's 11/15/16, ac resident was cognit reported activity pur important to him. H move from place to  R234's admission a dated 11/17/16, ind pursue independen his room, was miss past history of enjoy played the piano, el piano, played cards stated during the as enjoy pet visits, was intergenerational ac sports on TV and b to gather more info	peutic recreation assessment cated he was a retired farmer and games, puzzles, he accordion, and was active required assistance from staff terests. A Life Focus care ted, 12/21/16, indicated ported he enjoyed watching lows and movies, listening to no puzzles.  The plan completed on paper and ical record was blank for the tic recreation. The record d goals and interventions to in preferred daily activities.  In the plan completed on paper and ical record was blank for the tic recreation. The record d goals and interventions to in preferred daily activities.  In the plan completed on paper and ical record was blank for the tic recreation. The record d goals and interventions to in preferred daily activities.  In the plan completed on paper and ical record was blank for the tic recreation. The resident results were somewhat e required staffs' assistance to place.  The plan completed on paper and ical record was blank for the tic recreation. The resident resident daily in plane in the plan was applied to the plan was remation from R234's family, with independent leisure and ical retrieve in the plan was remation from R234's family, with independent leisure and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		00756	B. WING		02/1	6/2017
	PROVIDER OR SUPPLIER	RIC CARE CENTE 13820 CO	DRESS, CITY, S MMUNITY D LLE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 555	The admission care filed in R234's med section of therapeu lacked personalized help R234 engage day. When the care DAL on on 2/15/17, surprised to see the developed for R234.  The director of activity interviewed on 2/15 explained the facility care planning processident's MDS and would be completed coordinators would family as needed to past and current act assessments would electronic health rewould be completed the MDS and active interview(s). Updat paper copy until the At that time, a more would be document record. Additional in conference meeting goals would be reviwas reviewed with the surprised to see the developed. The DA the coordinators to and she would enterelectronic record at The DAL was again 8:57 a.m. the DAL signal.	e plan completed on paper and ical record was blank for the tic recreation. The record d goals and interventions to in desired activities during the e plan was reviewed with the at 3:16 p.m. she was e care plan had not been d.  I we living (DAL) was 1/17, at 3:16 p.m. and 1/19 activity assessment and 1/19 active living assessment	2 555			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00756	B. WING		02/1	6/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER RIDGES GERIATE	RIC CARE CENTE	MMUNITY D LLE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
2 555	cognitive losses that difficult. R244 did sactivities. The DAL looking into ensuring frequently, and to train communication. have used additional offer watched TV in recliner in his room nap. The DAL exploare, but the hospic tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance of the tell them if R234 has other than receiving staff observed R23 on the attendance o	ard of hearing and had some at made communication eem to enjoy observing social explained she had been go the resident was up more ry using a pocket talker to aid The DAL verified R244 could al activity opportunities.  The DAL explained R234 in the common area, had a which he enjoyed and liked to ained R234 was on hospice be staff would not necessarily ad been engaged in an activity go personal care. If the activity a fin an activity they marked it record.  Individualized care plans policy utilized plan of care would be ecomprehensive curately reflect the resident's	2 555			
21435	(21) days.  MN Rule 4658.0900 Recreation Program	O Subp. 1 Activity and n; General	21435			3/28/17

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00756	B. WING		02/1	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER RIDGES GERIATE	RIC CARE CENTE	MMUNITY D LLE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	age 6	21435			
	home must provide recreation program based on each indistrengths, and need meet the physical, well-being of each comprehensive rescomprehensive pla 4658.0400 and 46 provided opportunity	al requirements. A nursing an organized activity and an organized activity and an organized activity and an organized activity and an organized ending and must be designed to mental, and psychological resident, as determined by the sident assessment and an of care required in parts 58.0405. Residents must be ties to participate in the opment of the activity and an organized ending activity and activity activity and activity activity and activity and activity activity and activity activi				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities based on an individualized care plan for 2 of 3 residents (R244, R234) reviewed for activities.			Corrected		
	2/14/17, at 9:00 a.n at 12:30 p.m. havin room napping. R24 room on 2/14/17, et 8:20 his eyes closed At 9 to use the bathroor dressed and napping room. An activity of was scheduled for R244 did not attend napping in his room	his bed in a darkened room on m. R244 was observed again ag lunch when he was in his 4 was not observed out of his xcept for the noon meal.  I a.m. R244 was in bed with 9:30 a.m. R244 was assisted m. At 9:56 a.m. R244 was ag on his bed in a darkened if visits from young children the morning of 2/15/17, but d. At 2:42 p.m. R244 was m. R244 was not observed y other than meals on 2/15/17.				

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STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING:	A. BUILDING:		
		00756	B. WING	· · · · · · · · · · · · · · · · · · ·	02/1	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER RIDGES GERIATE	RIC CARE CENTE	OMMUNITY D ILLE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Continued From pa	age 7	21435			
	dining room table a what he was he had responded, "sleep." the television (TV)  R244's 12/9/16, ad (MDS) indicated the impaired. R244 repriews, pets, being in pursuing favorite ad important. He was him from place to p					
	The initial therapeutic recreation assessment dated 12/9/16, indicated R244 was a retired farmer who enjoyed cards and games, puzzles, television, played the accordion, and was active in his church. R244 required assistance from staff to pursue leisure interests. A Life Focus care conference note dated, 12/21/16, indicated R244's daughter reported he enjoyed watching football, old time shows and movies, listening to music, and working on puzzles.					
	filed in R244's med section of therapeu lacked personalize	e plan completed on paper and lical record was blank for the utic recreation. The record ed goals and interventions to in preferred daily activities.	i i			
	interviewed on 2/15 explained the facilit care planning proceed resident's Minimum and active living as completed. The active	ve living (DAL) was 5/17, at 3:16 p.m. and ty's activity assessment and ess. Upon admission, an Data Set (MDS) assessment issessment would be tive living coordinators would ent and/or family as needed to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00756	B. WING	B. WING		02/16/2017	
	PROVIDER OR SUPPLIER	NC CARE CENTE 13820 CC	DDRESS, CITY, S DMMUNITY DI ILLE, MN 553				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
21435	gather further informactivity preferences documented in the initial care plan wou after completion of assessment and informactivity goals would care plan would be health record. Addit care conference meactivity goals would care plan was review was surprised to see developed. The DA the coordinators to and she would enterelectronic record at The DAL was again 8:57 a.m. and 2/17, R244 was reviewed had watched TV, a activity on 2/4/17, a resident was sleepithere was no docur offered or attended liked to lie down aft awaken him. She ehearing and had so communication difficulties observing social activity on aid in com R244 could have us opportunities.	mation on past and current. The assessments would be electronic health record. The ald be completed on paper the MDS and active living terview(s). Updates would be copy until the first quarterly at time, a more comprehensive documented in the electronic tional information from the eeting would be added and be reviewed. R244's paper wed with the DAL. The DAL the the care plan had not been L said the expectation was for complete the initial care plan, at the care plan into the the first quarterly review.  In interviewed on 2/16/17, at activity attendance record for It. The record revealed R244 and passively attended an and on 2/2/17, it was noted the ng. From 2/4/17 to 2/16/17, mentation R244 had been activities. The DAL said R244 er meals and it was hard to explained he was hard of me cognitive losses that made foult. R244 did seem to enjoy tivities. The DAL explained ng into ensuring the resident ently, and to try using a pocket munication. The DAL verified sed additional activity					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		00756	B. WING		02/1	6/2017					
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE						
21435	At 9:21 a.m. staff ex room and informed service that morning napping in his reclir activity of visits from not participate. R23 church service.  The admission activity dated 11/17/16, individe independent leisure was missing people of enjoying hunting enjoyed jazz and claim dable games. Rassessment interview was interested in in enjoyed watching soutdoors. The plan information from R2 assistance with independent was cognit reported activity purimportant to him. Himove from place to the properties of the resident was cognit reported activity purimportant to him. Himove from place to the properties of the reported activity activity purimportant to him. Himove from place to the properties of the reported activity purimportant to him. Himove from place to the properties of the reported activity purimportant to him. Himove from place to the properties of the reported activity purimportant to him. Himove from place to the properties of the reported activity purimportant to him. Himove from place to the properties of the reported activity purimportant to him. Himove from place to the properties of the reported activity purimportant to him. Himove from place to the properties of the reported activity purimportant to him. Himove from place to the properties of the reported activity purimportant to him. Himove from place to the properties of the prop	scorted him out of the dining him there was a church g. At 9:51 a.m. R234 was her in his room. There was an a children, however, R234 did 4 also did not attend the ve living assessment note, icated R234 did not pursue a activities present in his room, and fishing, played the piano, assical piano, played cards 1234 stated during the lew he would enjoy pet visits, tergenerational activities, and ports on TV and being was to gather more 234's family, provide ependent leisure and bring to R234.  Idmission MDS indicated the ively impaired. The resident results were somewhat e required staffs' assistance to place.  In plan completed on paper and ical record was blank for the tic recreation. The record a goals and interventions to an desired activities during the et a 3:16 p.m. she was a care plan had not been									

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
			A. BOILDIIVO.									
		00756	B. WING		02/1	6/2017						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
EBENEZER RIDGES GERIATRIC CARE CENTE  13820 COMMUNITY DRIVE BURNSVILLE, MN 55337												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE						
21435	record for 2/1/17 th had watched TV for along twice, a movi activity and receive to 2/15/17, R234 had intergenerational activity and a snack cart.  The DAL explained common area, had he enjoyed and like R234 was on hospi would not necessar engaged in an activity personal care. If the in an activity they make the facility's 1/17, i indicated an individed eveloped using the assessments to act activity and other ides SUGGESTED MET DAL or designee comprocedures related individualized, mea Staff could be conducted quality committee.	re reviewed with the DAL. The rough 2/7/17,showed R234 or times, participated in a sing e, and passively attended and a snack once. From 2/8/17 and attended an etivity, a music entertainment.  R234 often watched TV in the a recliner in his room which and to nap. The DAL explained are care, but the hospice staffirily tell them if R234 had been with other than receiving a activity staff observed R234 harked it on the attendance andividualized care plans policy unalized plan of care would be a comprehensive curately reflect the resident's lentified needs.  THOD OF CORRECTION: The buld review policies and	21435									

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