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.
(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**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/29/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **114** (L18)

13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 05/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 08/07/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/27/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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

MDH
Minnesota Department of Health

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245213		3/29/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER RIDGES GERIATRIC CARE CENTER	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	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0248 Reg. # 483.24(c)(1) LSC	Correction Completed 03/28/2017	ID Prefix F0279 Reg. # 483.20(d);483.21(b)(1) LSC	Correction Completed 03/28/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GL/mm	05/17/2017	15507	03/29/2017
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/16/2017

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

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.
(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**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/16/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **114** (L18)
13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEII 04/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/27/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - 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;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

Informal Dispute Resolution - 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

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.

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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 _____	02/16/2017

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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This 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. Findings include:	F 248	1. Correction Action for identified residents: -Activities Assessments for residents R244 and R234 were reviewed and revised as of 2/20/2017, Care Plans reviewed and revised as of 2/23/2017 to include resident preferences for activities.	3/28/17

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

Electronically Signed | 03/10/2017

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245213	A. BUILDING _____ B. WING _____	02/16/2017

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
F 248	Continued From page 1 R244 was lying on his bed in a darkened room on 2/14/17, at 9:00 a.m. R244 was observed again at 12:30 p.m. having lunch when he was in his room napping. R244 was not observed out of his room on 2/14/17, except for the noon meal. On 2/15/17, at 8:20 a.m. R244 was in bed with his eyes closed At 9:30 a.m. R244 was assisted to use the bathroom. At 9:56 a.m. R244 was dressed and napping on his bed in a darkened room. An activity of visits from young children was scheduled for the morning of 2/15/17, but R244 did not attend. At 2:42 p.m. R244 was napping in his room. R244 was not observed attending an activity other than meals on 2/15/17. On 2/16/17, at 9:24 a.m. R244 was sitting at the dining room table after breakfast. When asked what he was he had planned for the day, R244 responded, "sleep." R244 was taken by staff to the television (TV) area where he sat on the sofa. R244's 12/9/16, admission Minimum Data Set (MDS) indicated the resident was cognitively impaired. R244 reported he considered music, news, pets, being in groups, getting outside and pursuing favorite activities as being very important. He was dependent on staff to move him from place to place. 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	F 248	2. Corrective Action as it applies to other residents: -Other resident activities preferences reviewed and revised as of 2/23/2017. -Staff educated on providing activities that meet individual interests and needs for each resident. 3. Date of Completion 3/28/2017 4. Reoccurrence will be prevented by: -Random weekly audits of 2 resident's activities attendance logs to be reviewed weekly for 90 days to assure resident's needs/interests of activities are being met. -The results of these audits will be shared with the QAPI committee for input on system improvement opportunities and the need to increase, decrease, or continue the audits. 5. The correction will be monitored by the administrator or designee	

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 _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 2 music, and working on puzzles. The admission care plan completed on paper and filed in R244's medical record was blank for the section of therapeutic recreation. The record lacked personalized goals and interventions to help R244 engage in preferred daily activities. The director of active living (DAL) was interviewed on 2/15/17, at 3:16 p.m. and explained the facility's activity assessment and care planning process. Upon admission, a resident's Minimum Data Set (MDS) assessment and active living assessment would be completed. The active living coordinators would interview the resident and/or family as needed to gather further information on past and current activity preferences. The assessments would be documented in the electronic health record. The initial care plan would be completed on paper after completion of the MDS and active living assessment and interview(s). Updates would be made on the paper copy until the first quarterly assessment. At that time, a more comprehensive care plan would be documented in the electronic health record. Additional information from the care conference meeting would be added and activity goals would be reviewed. R244's paper care plan was reviewed with the DAL. The DAL was surprised to see the care plan had not been developed. The DAL said the expectation was for the coordinators to complete the initial care plan, and she would enter the care plan into the electronic record at the first quarterly review. The DAL was again interviewed on 2/16/17, at 8:57 a.m. and 2/17, activity attendance record for R244 was reviewed. The record revealed R244 had watched TV, and passively attended an	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 3	F 248		

activity on 2/4/17, and on 2/2/17, it was noted the resident was sleeping. From 2/4/17 to 2/16/17, there was no documentation R244 had been offered or attended activities. The DAL said R244 liked to lie down after meals and it was hard to awaken him. She explained he was hard of hearing and had some cognitive losses that made communication difficult. R244 did seem to enjoy observing social activities. The DAL explained she had been looking into ensuring the resident was up more frequently, and to try using a pocket talker to aid in communication. The DAL verified R244 could have used additional activity opportunities.

R234 was observed on 2/15/17, at 9:16 a.m. dozing in his wheelchair at the dining room table. At 9:21 a.m. staff escorted him out of the dining room and informed him there was a church service that morning. At 9:51 a.m. R234 was napping in his recliner in his room. There was an activity of visits from children, however, R234 did not participate. R234 also did not attend the church service.

The admission active living assessment note, dated 11/17/16, indicated R234 did not pursue independent leisure activities present in his room, was missing people in his life, had a past history of enjoying hunting and fishing, played the piano, enjoyed jazz and classical piano, played cards and table games. R234 stated during the assessment interview he would enjoy pet visits, was interested in intergenerational activities, and enjoyed watching sports on TV and being outdoors. The plan was to gather more information from R234's family, provide assistance with independent leisure and bring outdoor magazines to R234.

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F 248	Continued From page 4	F 248		

R234's 11/15/16, admission MDS indicated the resident was cognitively impaired. The resident reported activity pursuits were somewhat important to him. He required staffs' assistance to move from place to place.

The admission care plan completed on paper and filed in R234's medical record was blank for the section of therapeutic recreation. The record lacked personalized goals and interventions to help R234 engage in desired activities during the day. When the care plan was reviewed with the DAL on on 2/15/17, at 3:16 p.m. she was surprised to see the care plan had not been developed for R234.

On 2/16/17 8:57 a.m. the 2/17, activity attendance record for R234 were reviewed with the DAL. The record for 2/1/17 through 2/7/17,showed R234 had watched TV four times, participated in a sing along twice, a movie, and passively attended an activity and received a snack once. From 2/8/17 to 2/15/17, R234 had attended an intergenerational activity, a music entertainment and a snack cart.

The DAL explained R234 often watched TV in the common area, had a recliner in his room which he enjoyed and liked to nap. The DAL explained R234 was on hospice care, but the hospice staff would not necessarily tell them if R234 had been engaged in an activity other than receiving personal care. If the activity staff observed R234 in an activity they marked it on the attendance record.

The facility's 1/17, individualized care plans policy indicated an individualized plan of care would be

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F 248	Continued From page 5 developed using the comprehensive assessments to accurately reflect the resident's activity and other identified needs. .	F 248		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 279		3/28/17

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F 279	Continued From page 6 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop individualized approaches to activities for 2 of 3 residents (R244, R234) reviewed for activities. Findings include: R244's 12/9/16, admission Minimum Data Set (MDS) indicated the resident was cognitively impaired. R244 reported he considered music, news, pets, being in groups, getting outside and	F 279	1. Corrective Action for identified residents: -Activities Assessments for residents R244 and R234 reviewed and revised as of 2/20/2017, Care Plans reviewed and revised as of 2/23/2017 to include resident preferences for activities. 2. Corrective Action as it applies to other residents:	

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F 279	Continued From page 7 pursuing favorite activities as being very important. He was dependent on staff to move him from place to place. R244's initial therapeutic recreation assessment dated 12/9/16, indicated he 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. The admission care plan completed on paper and filed in R244's medical record was blank for the section of therapeutic recreation. The record lacked personalized goals and interventions to help R244 engage in preferred daily activities. R234's 11/15/16, admission MDS indicated the resident was cognitively impaired. The resident reported activity pursuits were somewhat important to him. He required staffs' assistance to move from place to place. R234's admission active living assessment note, dated 11/17/16, indicated the resident did not pursue independent leisure activities present in his room, was missing people in his life, had a past history of enjoying hunting and fishing, played the piano, enjoyed jazz and classical piano, played cards and table games. R234 stated during the assessment interview he would enjoy pet visits, was interested in intergenerational activities, and enjoyed watching sports on TV and being outdoors. The plan was to gather more information from R234's family,	F 279	-The Policy and Procedure for Individualized Care Plans was reviewed and remains current. -Other resident activities care plans have been reviewed and updated as necessary. -Activities staff re-educated on Policy and Procedure for Individualized Care Plans. 3. Date of Completion 3/28/2017 4. Reoccurrence will be prevented by: -Random weekly audits of 2 resident's activities care plans to be reviewed weekly for 90 days to assure changes in activities preferences are reflected and up to date on care plan. -The results of these audits will be shared with the QAPI committee for input on system improvement opportunities and the need to increase, decrease, or discontinue the audits. 5. The correction will be monitored by administrator or designee	

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F 279	Continued From page 8 provide assistance with independent leisure and bring outdoor magazines to R234. The admission care plan completed on paper and filed in R234's medical record was blank for the section of therapeutic recreation. The record lacked personalized goals and interventions to help R234 engage in desired activities during the day. When the care plan was reviewed with the DAL on on 2/15/17, at 3:16 p.m. she was surprised to see the care plan had not been developed for R234. The director of active living (DAL) was interviewed on 2/15/17, at 3:16 p.m. and explained the facility's activity assessment and care planning process. Upon admission, a resident's MDS and active living assessment would be completed. The active living coordinators would interview the resident and/or family as needed to gather further information on past and current activity preferences. The assessments would be documented in the electronic health record. The initial care plan would be completed on paper after completion of the MDS and active living assessment and interview(s). Updates would be made on the paper copy until the first quarterly assessment. At that time, a more comprehensive care plan would be documented in the electronic health record. Additional information from the care conference meeting would be added and activity goals would be reviewed. R244's paper care plan was reviewed with the DAL. The DAL was surprised to see the care plan had not been developed. The DAL said the expectation was for the coordinators to complete the initial care plan, and she would enter the care plan into the electronic record at the first quarterly review.	F 279		

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F 279	Continued From page 9 The DAL was again interviewed on 2/16/17, at 8:57 a.m. the DAL said R244 liked to lie down after meals and it was hard to awaken him. She explained he was hard of hearing and had some cognitive losses that made communication difficult. R244 did seem to enjoy observing social activities. The DAL explained she had been looking into ensuring the resident was up more frequently, and to try using a pocket talker to aid in communication. The DAL verified R244 could have used additional activity opportunities. On 2/16/17 8:57 a.m. the DAL explained R234 often watched TV in the common area, had a recliner in his room which he enjoyed and liked to nap. The DAL explained R234 was on hospice care, but the hospice staff would not necessarily tell them if R234 had been engaged in an activity other than receiving personal care. If the activity staff observed R234 in an activity they marked it on the attendance record. The facility's 1/17, individualized care plans policy indicated an individualized plan of care would be developed using the comprehensive assessments to accurately reflect the resident's activity and other identified needs.	F 279		

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 _____	**02/22/2017**

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

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K 000	INITIAL COMMENTS 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. 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	K 000		

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

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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	245213	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/22/2017**

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K 000	Continued From page 1 in all resident rooms. The facility has a licensed capacity of 114 beds and had a census of 109 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MDH
Minnesota Department of Health

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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00756	A. BUILDING: _____ B. WING _____	02/16/2017

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	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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00756	A. BUILDING: _____ B. WING _____	02/16/2017

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On February 13, 14, 15, and 16, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop individualized approaches to activities for 2 of 3 residents (R244, R234) reviewed for activities. Findings include: R244's 12/9/16, admission Minimum Data Set (MDS) indicated the resident was cognitively impaired. R244 reported he considered music, news, pets, being in groups, getting outside and pursuing favorite activities as being very important. He was dependent on staff to move	2 555	Corrected	3/28/17

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2 555	Continued From page 3 him from place to place. R244's initial therapeutic recreation assessment dated 12/9/16, indicated he 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. The admission care plan completed on paper and filed in R244's medical record was blank for the section of therapeutic recreation. The record lacked personalized goals and interventions to help R244 engage in preferred daily activities. R234's 11/15/16, admission MDS indicated the resident was cognitively impaired. The resident reported activity pursuits were somewhat important to him. He required staffs' assistance to move from place to place. R234's admission active living assessment note, dated 11/17/16, indicated the resident did not pursue independent leisure activities present in his room, was missing people in his life, had a past history of enjoying hunting and fishing, played the piano, enjoyed jazz and classical piano, played cards and table games. R234 stated during the assessment interview he would enjoy pet visits, was interested in intergenerational activities, and enjoyed watching sports on TV and being outdoors. The plan was to gather more information from R234's family, provide assistance with independent leisure and bring outdoor magazines to R234.	2 555		

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2 555	Continued From page 4 The admission care plan completed on paper and filed in R234's medical record was blank for the section of therapeutic recreation. The record lacked personalized goals and interventions to help R234 engage in desired activities during the day. When the care plan was reviewed with the DAL on on 2/15/17, at 3:16 p.m. she was surprised to see the care plan had not been developed for R234. The director of active living (DAL) was interviewed on 2/15/17, at 3:16 p.m. and explained the facility's activity assessment and care planning process. Upon admission, a resident's MDS and active living assessment would be completed. The active living coordinators would interview the resident and/or family as needed to gather further information on past and current activity preferences. The assessments would be documented in the electronic health record. The initial care plan would be completed on paper after completion of the MDS and active living assessment and interview(s). Updates would be made on the paper copy until the first quarterly assessment. At that time, a more comprehensive care plan would be documented in the electronic health record. Additional information from the care conference meeting would be added and activity goals would be reviewed. R244's paper care plan was reviewed with the DAL. The DAL was surprised to see the care plan had not been developed. The DAL said the expectation was for the coordinators to complete the initial care plan, and she would enter the care plan into the electronic record at the first quarterly review. The DAL was again interviewed on 2/16/17, at 8:57 a.m. the DAL said R244 liked to lie down after meals and it was hard to awaken him. She	2 555		

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2 555	Continued From page 5 explained he was hard of hearing and had some cognitive losses that made communication difficult. R244 did seem to enjoy observing social activities. The DAL explained she had been looking into ensuring the resident was up more frequently, and to try using a pocket talker to aid in communication. The DAL verified R244 could have used additional activity opportunities. On 2/16/17 8:57 a.m. the DAL explained R234 often watched TV in the common area, had a recliner in his room which he enjoyed and liked to nap. The DAL explained R234 was on hospice care, but the hospice staff would not necessarily tell them if R234 had been engaged in an activity other than receiving personal care. If the activity staff observed R234 in an activity they marked it on the attendance record. The facility's 1/17, individualized care plans policy indicated an individualized plan of care would be developed using the comprehensive assessments to accurately reflect the resident's activity and other identified needs. SUGGESTED METHOD OF CORRECTION: The DAL or designee could review policies and procedures related to developing care plan interventions that ensured meaningful activities and measurable goals for residents. Staff could be trained as appropriate. Audits could be conducted and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General	21435		3/28/17

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21435	Continued From page 6 Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. 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. Findings include: R244 was lying on his bed in a darkened room on 2/14/17, at 9:00 a.m. R244 was observed again at 12:30 p.m. having lunch when he was in his room napping. R244 was not observed out of his room on 2/14/17, except for the noon meal. On 2/15/17, at 8:20 a.m. R244 was in bed with his eyes closed At 9:30 a.m. R244 was assisted to use the bathroom. At 9:56 a.m. R244 was dressed and napping on his bed in a darkened room. An activity of visits from young children was scheduled for the morning of 2/15/17, but R244 did not attend. At 2:42 p.m. R244 was napping in his room. R244 was not observed attending an activity other than meals on 2/15/17.	21435	Corrected	

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21435	Continued From page 7 On 2/16/17, at 9:24 a.m. R244 was sitting at the dining room table after breakfast. When asked what he was he had planned for the day, R244 responded, "sleep." R244 was taken by staff to the television (TV) area where he sat on the sofa. R244's 12/9/16, admission Minimum Data Set (MDS) indicated the resident was cognitively impaired. R244 reported he considered music, news, pets, being in groups, getting outside and pursuing favorite activities as being very important. He was dependent on staff to move him from place to place. 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. The admission care plan completed on paper and filed in R244's medical record was blank for the section of therapeutic recreation. The record lacked personalized goals and interventions to help R244 engage in preferred daily activities. The director of active living (DAL) was interviewed on 2/15/17, at 3:16 p.m. and explained the facility's activity assessment and care planning process. Upon admission, a resident's Minimum Data Set (MDS) assessment and active living assessment would be completed. The active living coordinators would interview the resident and/or family as needed to	21435		

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21435	Continued From page 8	21435		

gather further information on past and current activity preferences. The assessments would be documented in the electronic health record. The initial care plan would be completed on paper after completion of the MDS and active living assessment and interview(s). Updates would be made on the paper copy until the first quarterly assessment. At that time, a more comprehensive care plan would be documented in the electronic health record. Additional information from the care conference meeting would be added and activity goals would be reviewed. R244's paper care plan was reviewed with the DAL. The DAL was surprised to see the care plan had not been developed. The DAL said the expectation was for the coordinators to complete the initial care plan, and she would enter the care plan into the electronic record at the first quarterly review.

The DAL was again interviewed on 2/16/17, at 8:57 a.m. and 2/17, activity attendance record for R244 was reviewed. The record revealed R244 had watched TV, and passively attended an activity on 2/4/17, and on 2/2/17, it was noted the resident was sleeping. From 2/4/17 to 2/16/17, there was no documentation R244 had been offered or attended activities. The DAL said R244 liked to lie down after meals and it was hard to awaken him. She explained he was hard of hearing and had some cognitive losses that made communication difficult. R244 did seem to enjoy observing social activities. The DAL explained she had been looking into ensuring the resident was up more frequently, and to try using a pocket talker to aid in communication. The DAL verified R244 could have used additional activity opportunities.

R234 was observed on 2/15/17, at 9:16 a.m. dozing in his wheelchair at the dining room table.

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21435	Continued From page 9 At 9:21 a.m. staff escorted him out of the dining room and informed him there was a church service that morning. At 9:51 a.m. R234 was napping in his recliner in his room. There was an activity of visits from children, however, R234 did not participate. R234 also did not attend the church service. The admission active living assessment note, dated 11/17/16, indicated R234 did not pursue independent leisure activities present in his room, was missing people in his life, had a past history of enjoying hunting and fishing, played the piano, enjoyed jazz and classical piano, played cards and table games. R234 stated during the assessment interview he would enjoy pet visits, was interested in intergenerational activities, and enjoyed watching sports on TV and being outdoors. The plan was to gather more information from R234's family, provide assistance with independent leisure and bring outdoor magazines to R234. R234's 11/15/16, admission MDS indicated the resident was cognitively impaired. The resident reported activity pursuits were somewhat important to him. He required staffs' assistance to move from place to place. The admission care plan completed on paper and filed in R234's medical record was blank for the section of therapeutic recreation. The record lacked personalized goals and interventions to help R234 engage in desired activities during the day. When the care plan was reviewed with the DAL on on 2/15/17, at 3:16 p.m. she was surprised to see the care plan had not been developed for R234. On 2/16/17 8:57 a.m. the 2/17, activity attendance	21435		

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21435	Continued From page 10 record for R234 were reviewed with the DAL. The record for 2/1/17 through 2/7/17,showed R234 had watched TV four times, participated in a sing along twice, a movie, and passively attended an activity and received a snack once. From 2/8/17 to 2/15/17, R234 had attended an intergenerational activity, a music entertainment and a snack cart. The DAL explained R234 often watched TV in the common area, had a recliner in his room which he enjoyed and liked to nap. The DAL explained R234 was on hospice care, but the hospice staff would not necessarily tell them if R234 had been engaged in an activity other than receiving personal care. If the activity staff observed R234 in an activity they marked it on the attendance record. The facility's 1/17, individualized care plans policy indicated an individualized plan of care would be developed using the comprehensive assessments to accurately reflect the resident's activity and other identified needs. SUGGESTED METHOD OF CORRECTION: The DAL or designee could review policies and procedures related to the provision of individualized, meaningful activities for residents. Staff could be trained as appropriate. Audits could be conducted and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		