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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CGZW

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 **02/19/2015** (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 **104** (L18)

13.Total Certified Beds **104** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	104			
(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 :
Douglas Stevens, HFE NE II 03/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/07/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 9, 2015

Ms. Erin Hilligan, Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, Minnesota 55337

RE: Project Number S5213025

Dear Ms. Hilligan:

On February 19, 2015, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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

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
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 31, 2015, 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 19, 2015 (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 19, 2015 (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.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 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 _____	02/19/2015

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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident bathing preferences were honored for 1 of 2 residents (R208) reviewed for choices. Findings include: R208 was asked about bathing preferences in an interview on 2/17/15, at 2:58 p.m. The resident answered, "I get once a week--I would like more	F 246	F 246 Resident 208 care plan was updated on 2/23/15 and then again on 3/13/15 to reflect her choice of bathing preference. Her choice may change due to her cognition. " All residents are interviewed quarterly on their choices related to bathing via our electronic survey (Truthpoint). One 2/10/15 the resident strongly agreed her	3/31/15

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

Electronically Signed | 03/17/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 often. I would rather have a tub bath than a shower." In a follow up interview with R208 on 2/19/15, at 1:38 p.m. the resident reported, "I don't like the shower." R208's care plan dated 11/29/14, directed staff to give the resident a tub bath. The plan noted the resident had some confusion.R208's admission Minimum Data Set (MDS) dated 12/6/14, indicated the resident had diagnoses including bipolar disorder, had impaired cognitive skills for daily decision making, and required assistance from staff for bathing. On 2/18/15, at 1:31 p.m. a registered nurse (RN)-B stated, "We try to accommodate the resident for bathing by our [facility] schedule." A nursing assistant (NA)-F was interviewed on 2/19/15, at 1:56 p.m. and explained, "For bathing we go by what the care plan says or if resident says something and we accommodate them." A licensed practical nurse (LPN)-B then stated at 2:05 p.m. "I know [R208] takes a shower because I work with her and when I do her skin checks on Friday PMs [evenings] she is in the shower room." Following the interview with LPN-B, the director of nursing stated she expected residents' care plans to be followed by staff and that the plans be updated as needed.	F 246	bathing preferences was followed. " All nursing staff have been inserviced on providing resident choices at bathing time. " Residents are asked with Admission Assessment so their care plan is updated per their preference. The Nurse Manager will be responsible to assure choice is offered. " DON along with Nurse Managers will interview 5 residents per month for 3 months or until after 100% compliance with bathing choice being followed. After compliance is achieved we will monitor choices via our quarterly electronic customer survey (Truthpoint). Results will be monitored at monthly QA and by our quarterly Customer Satisfaction tool.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		3/31/15

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F 279	Continued From page 2 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan interventions to minimize the risk of injury for 1 of 2 residents (R219) reviewed for non-pressure related skin problems. Findings include: R219 was observed on 2/17/15, at 2:41 p.m. Large purple bruises were noted on the tops of the resident's hands, as well as a skin tear on the left hand. On 2/18/15, at 10:10 p.m. a nursing note read, "Scabbed skin tears near knuckles...Entire top of hand covered with bruise...." Additionally, bruises were noted on the left outer forearm and measurements were included. R219's care plan dated 1/17/15, however, lacked identification of the bruises and skin tears with related goals and	F 279	F 279 Resident 219 care plan was updated on 2/18/15 to address skin tears (resident passed away 3/8/15). Education provided to all NA□s and licensed staff on consistent skin integrity template. 2 chart audits per week on residents with new skin concerns will be completed for 1 month until 100% compliance with skin integrity template. Nurse Managers and DON will be responsible for ongoing compliance. Results of audits will be reported to QA monthly until 100% compliance with the usage of skin integrity template.	

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F 279	Continued From page 3 interventions. A registered nurse (RN)-B was interviewed on 2/19/15, at 9:06 a.m. RN-B verified that although the bruises and skin tear was noted on an incident report, it had not been added to the resident's care plan. The facility's 12/14, Individualized Care Plan policy indicated, "The interdisciplinary team develops a comprehensive, individualized care plan based on interdisciplinary team assessments...."	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly identify and monitor skin conditions for 1 of 2 residents (R219) reviewed for non-pressure related skin conditions. Findings include: R219 was observed on 2/17/15, at 2:41 p.m. and large purple bruises were noted on the tops of the resident's hands, as well as a skin tear on the left	F 309	F 309 Resident 219 had new body audits completed 2/18/15, 2/26/15, 2/27/15. Weekly body audits are completed on bath day. Skin integrity concerns are noted in □skin integrity template. All nursing staff have been educated on skin documentation □ including weekly body audits and skin template.	3/31/15

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F 309	Continued From page 4 hand. The Treatment Administration Record (TAR) included initial showing a weekly body audit had been completed on 2/2, 2/9/and 2/16/15. A nursing note dated 2/17/15, at 7:00 a.m. indicated R219 fell out of bed, but no injuries were sustained, including bruising. The current care plan did not identify bruising or skin tears with related goals and interventions. On 2/18/15, at 10:10 p.m. a nursing note read, "Scabbed skin tears near knuckles...Entire top of hand covered with bruise...." Additionally, bruises were noted on the left outer forearm and measurements were included. A nursing assistant (NA)-B was interviewed on 2/18/15, at 4:16 p.m. She reported she had been assigned to work with R219 1:1 on the evening shift for the past week because of frequent falls. The resident often wanted to go home and drive his car. She said the resident wanted to get out of bed about every half hour and "is really fast" and "very hard to redirect." A registered nurse (RN)-B was interviewed on 2/19/15, at 9:06 a.m. RN-B explained that although the bruises and skin tear was noted in the nursing notes, it was not added to the resident's care plan. Her expectation when an injury was discovered, that staff would start a daily wound checklist. The surveyor then requested evidence of weekly skin audits that had been initialed as completed, but the audits were not provided. A licensed practical nurse (LPN)-A said on	F 309	Nurse Managers and DON will review 3 bath days per week to audit for compliance with weekly body audits and follow-up documentation for 1 quarter or until 100% compliant. Nurse Managers and DON will be responsible for ongoing compliance and results will be monitored at monthly QA.	

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F 309	Continued From page 5 2/19/15, at 11:46 a.m. that the Tubi Grips (for hand protection) were initiated by the nurse practitioner "this morning." In addition, Steri-strips (wound tape to adhere skin edges together) were applied "last evening" by RN-F to both hands. The interventions, however, were intiated at least two days following the injury. The director of nursing stated on 2/19/15, at 9:30 a.m. she expected a wound protocol sheet upon discovery of an injury. A 7/14 policy Wound Documentation directed staff to "Upon discovery of new wound(s), initiate the facility Wound Documentation Checklist and complete within 24 hours...Complete Weekly Wound Assessment (using Wound Care Protocol) for each wound including: a. Date or origin/identification; b. Wound etiology/type; c. Site, size...; d. Treatment...g. Notification of wound changes."	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315		3/31/15

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 _____	02/19/2015

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 315	Continued From page 6 Based on observation, interview and document review, the facility failed to reassess a comprehensive care plan for decline in urinary incontinence for 1 of 1 resident (R155) reviewed for urinary incontinence. Finding include: R155's family member (FM)-A was interviewed on 2/19/15, at 12:28 p.m. and reported when the nursing assistants (NAs) took R155 to the toilet, he had already voided in his incontinence brief. FM-A explained that the problem was the staff not understanding the resident's had gestures indicating the need for the toilet. R155 pointed to his stomach meaning he needed the toilet, which staff understood the gesture as meaning he had pain. R155 verified FM-A's report by nodding his head as it was explained to the surveyor. R155's MDS dated 11/8/14, identified occasional urinary incontinence, however, a subsequent MDS dated 1/29/15, revealed a decline in urinary incontinence to frequently incontinent, as well as severe cognitive impairment and dependence on staff for activities of daily living including transferring and toileting. Nursing notes from 11/8/14 to 1/29/15, lacked documentation that R155's urinary incontinence status had changed from occasionally to frequently incontinent, or that there was a need to reassess why the resident declined. R155's care plan dated 2/6/15, identified R155 had a diagnoses of cerebrovascular accident, right hemiplegia (stroke with paralysis of half of the body) and global aphasia (difficulty speaking and understanding words). The plan directed	F 315	F 315 Resident 155 □ Bowel & Bladder assessment was completed on 3/10-3/15/15. R155 care plan was updated with is ADL requests and communication on 3/16/15. Nurse Managers and DON will conduct 3 audits per unit on bowel & bladder assessments for 1 quarter until 100% compliance. All licensed nursing staff were educated on bowel & bladder documentation. Nurse Managers and DON will be responsible for ongoing compliance and results will be shared at monthly QA.	

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F 315	Continued From page 7 staff to toilet him upon rising, after meals, and at bedtime. The MDS coordinator was interviewed on 2/18/15 at 3:30 p.m. and verified that she had completed the MDS assessments. She was unsure why R155 experienced a change from occasional incontinent to frequently incontinent. She also said she would have been responsible for changing the care plan to meet the resident's needs. When asked what interventions had been tried when the resident declined in status, the coordinator stated, "It's on his care plan." The following day the coordinator said she had talked to staff and passed on the information regarding FM-A's comment about staff misunderstanding his need for toileting. The MDS coordinator said the miscommunication was the reason the resident had declined in toileting ability, therefore she had added asking the resident if he needed to use the toilet to his care plan. On 2/18/15, R155's care plan had been revised and noted the resident had difficulty communicating. When he pointed to his abdomen, he needed to use the toilet. Interventions included asking R155 if he needed to use the toilet.	F 315		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		3/31/15

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	245213	A. BUILDING _____ B. WING _____	02/19/2015

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F 356	Continued From page 8 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post information on the daily nurse staff posting as required. This had the potential to affect the 99 residents residing in the facility at the time of the survey as well as visitors. Findings include: During the initial tour of the facility on 2/17/15, at 11:50 a.m. the Ebenezer Ridges Care Center staff posting was observed on the counter at the front desk. Although the daily posting included category of staff, actual hours worked and staffing	F 356	F 356 Staffing information is available for the public. The information includes the facility name, date, total number of staff by position and the daily census. The receptionist will update the daily posting. The receptionists have been inserviced. 25% of days in a quarter will be reviewed and submitted to QA for review until 100% compliant. The Administrator is responsible for	

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	245213	A. BUILDING _____ B. WING _____	02/19/2015

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F 356	Continued From page 9 totals on all shifts, it did not include the daily census. The posting lacked the census on subsequent days of the survey on 2/18 and 2/19/15, as well. The health unit coordinator (HUC) then stated that although she ensured the posting was available, she had not been directed to include the daily facility census. On 2/19/15, at 10:50 a.m. the director of human resources explained the the facility did not include the daily census on the staff posting or anywhere in else the faclility. The faciltiy did not have a policy regarding the posting, but the director stated that "starting today" they would include the census information. At approximately 12:00 p.m. the staff posting included a hand-written addition that read, "Today's Census: 102."	F 356	ongoing compliance.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure items were stored in refrigerators/freezers in a sanitary manner. This potentially affected 52 residents residing on the third floor.	F 371	F 371 Freezers and refrigerators are to only store resident food. Medical ice packs are to be stored in the medical refrigerator/freezer.	3/31/15

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	245213	A. BUILDING _____ B. WING _____	02/19/2015

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F 371	Continued From page 10 Findings include: The third floor kitchenette was observed on 2/17/15, at 12:18 p.m. with the director of nutrition (DN). The freezer contained french toast and ice cream for the residents, as well as two ice packs, one white and one blue. The DN reported no knowledge as to the use of the ice packs. Later, at 12:46 p.m. the DN stated she would inform the health unit coordinators (HUCS) that the ice packs should not have been stored with resident food, and needed to be removed. HUC-A then explained that staff sometimes their lunch bags in the refrigerators where resident food was stored. HUC-A said the blue pack had been on a resident's back, and the resident had since discharged. HUC-A reported, "I threw the blue pack." The following day the DN stated on 2/18/15, at 12:10 p.m. "Yesterday I wrote a condensed policy for what we do down here for the kitchenettes. " She said she had given the new policy to the director of nursing and staff responsible for supervising the HUCS. The DN stated on 2/19/15, at 8:38 a.m. the white ice pack had come from the pharmacy. The DN further stated she had put laminated sheets on front of each of the freezers to say "No ice packs in freezer." A 2/15 Refrigerator/Freezers on the Floors policy indicated, "Sanitary techniques will be maintained in perishable food storage in order to safeguard the health of those dependent on the service."	F 371	The Director of Medical Records will assure compliance with 3 checks per week. HUC□s will check and record refrigerator/freezer temperatures Monday □Friday and House Charge to check on weekends and holidays for 1 month until 100% compliant. Results will be reported and monitored through monthly QA. All staff were inserviced on proper food storage in resident refrigerators.	

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F 463	Continued From page 11	F 463		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to call lights were functioning and/or were within reach for 2 of 35 residents (R20, R129) whose call lights were observed. Findings include: R20's call light was tested during an initial tour on 2/17/15, at 11:35 a.m. R20 was able to push the call light button, however, the it did not then light up in the resident's room nor in the hallway to notify nursing staff. A nursing assistant (NA)-A was then notified that R20's call light was not working. NA-A pushed the call light button, unplugged and re-plugged in the call light, but the light still did not work properly. NA-A verified it was not working and called a maintenance staff to report the problem. A maintenance staff person then replaced the light and it was observed in working order. R20's admission Minimum Data Set (MDS) dated 1/21/15, indicated the resident was cognitively intact and able to communicate needs clearly. R20's admission care plan dated 2/16/15, directed staff to place the call light within the resident's reach when in the room.	F 463	F 463 R 20□s light was replaced on 2/17/15 and is working. R 129 light was replaced on 2/19/15 and is working. All staff have been inserviced on assuring call lights are within reach of a resident. Maintenance will conduct spot audits for 10 lights per week for one quarter to assure they are working until 100% compliance and then continue quarterly maintenance checks per current preventative maintenance system. Maintenance Director is responsible for ongoing compliance and results of the audit will be reported at monthly QA until compliance is achieved.	3/31/15

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	245213	A. BUILDING _____ B. WING _____	02/19/2015

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F 463	Continued From page 12 On 2/17/15, at 2:33 p.m. R129's call light (pancake type) was observed hanging on the bed rail near the floor and behind R129 who was seated in his wheelchair. When the call light was tested, it did not activate. A registered nurse (RN)-C verified the call light was out of the resident's reach and was not functioning, and maintenance staff would be notified. RN-C stated, "I would normally give R129 his call light and put it here on his abdomen under his left hand." RN-C said he would notify. At 2:40 p.m. a maintenance staff (M)-A requested M-B obtain a new call light and the light was replaced and was working at 2:43 p.m. R129's quarterly Minimum Data Set (MDS) dated 12/4/14, indicated the resident had cognitive impairment, and was totally dependent on staff for cares. On 2/19/15, at 8:55 a.m. the maintenance director explained that if a call light was not working, staff sent a work order on the computer marked urgent, or they called or paged maintenance staff. The call system was supposed to alert the nurses' station of any call light problems and the affected room number. More frequent checks had been performed in the past, but now were completed quarterly. The maintenance director showed documentation that both R20's and R129's call light had been working on 1/15, during quarterly room checks, and no work orders had been received regarding non-functioning call lights for either resident. The maintenance director added, "Unfortunately with the call light pads and the cords, they are a mechanical device that can break."	F 463		

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F 463	Continued From page 13 On 2/19/15, at 9:48 a.m. the director of nursing stated, "I expect call lights to be functioning at all times. It's a safety issue." During an environmental tour on 2/19/15, at 10:00 a.m. R20's call light worked when activated. R20 reported, however, "The other day my call light was not working, but had been working 15-20 minutes before that." At 10:05 a.m. R129's call light worked when activated. A 1/09 Call Light Response policy was "To assure call system is in proper working order...Check all call lights daily and report any defective call lights to environmental services immediately. Be sure call lights are placed within resident reach at all times, never on the floor or bedside stand."	F 463		

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	245213	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/18/2015**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. 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 Geriatric Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/2015

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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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Ebenezer Ridges Geriatric Care Center is a 3-story building with a partial basement. The building was built at 2 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. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification.

The facility has a capacity of 104 beds and had a census of 102 beds at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide reliable lighting for all components of the means of egress as required by 2000 NFPA 101, Section 19..2.9.1, 7.8, and 7.9. The deficient practice could affect 40 out of 102 residents. Findings include: On facility tour between 10:30 AM and 1:30 PM on 02/18/2015, observation revealed, that the Green wing exit discharge does not have a two bulb fixture on the exterior of building. NOTE: Check ALL exterior lights for this deficiency This deficient practice was confirmed by the Facility Maintenance Director (BE) at the time of discovery.	K 045	The Green Wing exit lights were replaced. All exterior lights were inspected and found in working order. The Director of Plant Operations is responsible for assuring on-going compliance.	3/31/15
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		3/31/15

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K 062	Continued From page 3 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7 and 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect all 15 out of 102 residents. Findings include: On facility tour between 10:30 AM and 1:30 PM on 02/18/2015, observation revealed that the spare sprinkler head box - does not contain (2) spare sprinkler heads of each type. This deficient practice was confirmed by the Facility Maintenance Director (BE) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062	The spare sprinkler head box now contains 2 spare sprinkler heads of each type. The Director of Plant Operations is responsible for assuring on-going compliance.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 9, 2015

Ms. Erin Hilligan, Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, Minnesota 55337

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5213025

Dear Ms. Hilligan:

The above facility was surveyed on February 17, 2015 through February 19, 2015 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, Compliance Monitoring 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 me.

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.

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 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 _____	02/19/2015

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		

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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 January 26th, 27th, 28th and 29th 2015 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan interventions to minimize the risk of injury for 1 of 2 residents (R219) reviewed for non-pressure related skin problems. Findings include: R219 was observed on 2/17/15, at 2:41 p.m. Large purple bruises were noted on the tops of the resident's hands, as well as a skin tear on the left hand. On 2/18/15, at 10:10 p.m. a nursing note read, "Scabbed skin tears near knuckles...Entire top of hand covered with bruise...." Additionally, bruises were noted on the left outer forearm and	2 560	Acknowledged	3/31/15

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2 560	Continued From page 3 measurements were included. R219's care plan dated 1/17/15, however, lacked identification of the bruises and skin tears with related goals and interventions. A registered nurse (RN)-B was interviewed on 2/19/15, at 9:06 a.m. RN-B verified that although the bruises and skin tear was noted on an incident report, it had not been added to the resident's care plan. The facility's 12/14, Individualized Care Plan policy indicated, "The interdisciplinary team develops a comprehensive, individualized care plan based on interdisciplinary team assessments...." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure care plans are developed when problems are identified. Staff could be educated regarding care plan development. Audits could be conducted to ensure problems are identified on care plans, and the results of the audits brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		3/31/15

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2 830	Continued From page 4 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly identify and monitor skin conditions for 1 of 2 residents (R219) reviewed for non-pressure related skin conditions. Findings include: R219 was observed on 2/17/15, at 2:41 p.m. and large purple bruises were noted on the tops of the resident's hands, as well as a skin tear on the left hand. The Treatment Administration Record (TAR) included initial showing a weekly body audit had been completed on 2/2, 2/9/and 2/16/15. A nursing note dated 2/17/15, at 7:00 a.m. indicated R219 fell out of bed, but no injuries were sustained, including bruising. The current care plan did not identify bruising or skin tears with related goals and interventions. On 2/18/15, at 10:10 p.m. a nursing note read, "Scabbed skin tears near knuckles...Entire top of hand covered with bruise...." Additionally, bruises were noted on the left outer forearm and measurements were included. A nursing assistant (NA)-B was interviewed on	2 830	Acknowledged	

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2 830	Continued From page 5 2/18/15, at 4:16 p.m. She reported she had been assigned to work with R219 1:1 on the evening shift for the past week because of frequent falls. The resident often wanted to go home and drive his car. She said the resident wanted to get out of bed about every half hour and "is really fast" and "very hard to redirect." A registered nurse (RN)-B was interviewed on 2/19/15, at 9:06 a.m. RN-B explained that although the bruises and skin tear was noted in the nursing notes, it was not added to the resident's care plan. Her expectation when an injury was discovered, that staff would start a daily wound checklist. The surveyor then requested evidence of weekly skin audits that had been initialed as completed, but the audits were not provided. A licensed practical nurse (LPN)-A said on 2/19/15, at 11:46 a.m. that the Tubi Grips (for hand protection) were initiated by the nurse practitioner "this morning." In addition, Steri-strips (wound tape to adhere skin edges together) were applied "last evening" by RN-F to both hands. The interventions, however, were intiated at least two days following the injury. The director of nursing stated on 2/19/15, at 9:30 a.m. she expected a wound protocol sheet upon discovery of an injury. A 7/14 policy Wound Documentation directed staff to "Upon discovery of new wound(s), initiate the facility Wound Documentation Checklist and complete within 24 hours...Complete Weekly Wound Assessment (using Wound Care Protocol) for each wound including: a. Date or origin/identification; b. Wound etiology/type; c. Site, size...; d. Treatment...g. Notification of	2 830		

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2 830	Continued From page 6 wound changes." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to skin assessments, monitoring and care, and could provide staff education related to the care of resident related to skin care. The director of nursing or designee could complete audits to ensure appropriate care is provided and the results of the audits be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by:	2 910		3/31/15

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2 910	Continued From page 7 Based on observation, interview and document review, the facility failed to reassess a comprehensive care plan for decline in urinary incontinence for 1 of 1 resident (R155) reviewed for urinary incontinence. Finding include: R155's family member (FM)-A was interviewed on 2/19/15, at 12:28 p.m. and reported when the nursing assistants (NAs) took R155 to the toilet, he had already voided in his incontinence brief. FM-A explained that the problem was the staff not understanding the resident's had gestures indicating the need for the toilet. R155 pointed to his stomach meaning he needed the toilet, which staff understood the gesture as meaning he had pain. R155 verified FM-A's report by nodding his head as it was explained to the surveyor. R155's MDS dated 11/8/14, identified occasional urinary incontinence, however, a subsequent MDS dated 1/29/15, revealed a decline in urinary incontinence to frequently incontinent, as well as severe cognitive impairment and dependence on staff for activities of daily living including transferring and toileting. Nursing notes from 11/8/14 to 1/29/15, lacked documentation that R155's urinary incontinence status had changed from occasionally to frequently incontinent, or that there was a need to reassess why the resident declined. R155's care plan dated 2/6/15, identified R155 had a diagnoses of cerebrovascular accident, right hemiplegia (stroke with paralysis of half of the body) and global aphasia (difficulty speaking and understanding words). The plan directed staff to toilet him upon rising, after meals, and at	2 910	Acknowledged	

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2 910	Continued From page 8 bedtime. The MDS coordinator was interviewed on 2/18/15 at 3:30 p.m. and verified that she had completed the MDS assessments. She was unsure why R155 experienced a change from occasional incontinent to frequently incontinent. She also said she would have been responsible for changing the care plan to meet the resident's needs. When asked what interventions had been tried when the resident declined in status, the coordinator stated, "It's on his care plan." The following day the coordinator said she had talked to staff and passed on the information regarding FM-A's comment about staff misunderstanding his need for toileting. The MDS coordinator said the miscommunication was the reason the resident had declined in toileting ability, therefore she had added asking the resident if he needed to use the toilet to his care plan. On 2/18/15, R155's care plan had been revised and noted the resident had difficulty communicating. When he pointed to his abdomen, he needed to use the toilet. Interventions included asking R155 if he needed to use the toilet. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to incontinence care, assessments, monitoring and care, and could provide staff education related to the care of resident related to incontinence care. The director of nursing or designee could complete audits to ensure appropriate care is provided and the results of the audits be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one	2 910		

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2 910	Continued From page 9 (21) days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure items were stored in refrigerators/freezers in a sanitary manner. This potentially affected 52 residents residing on the third floor. Findings include: The third floor kitchenette was observed on 2/17/15, at 12:18 p.m. with the director of nutrition (DN). The freezer contained french toast and ice cream for the residents, as well as two ice packs, one white and one blue. The DN reported no knowledge as to the use of the ice packs. Later, at 12:46 p.m. the DN stated she would inform the health unit coordinators (HUCS) that the ice packs should not have been stored with resident food, and needed to be removed. HUC-A then explained that staff sometimes their lunch bags in the refrigerators where resident food was stored. HUC-A said the blue pack had been on a resident's back, and the resident had since discharged. HUC-A reported, "I threw the blue pack."	21015	Acknowledged	3/31/15

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21015	Continued From page 10 The following day the DN stated on 2/18/15, at 12:10 p.m. "Yesterday I wrote a condensed policy for what we do down here for the kitchenettes. " She said she had given the new policy to the director of nursing and staff responsible for supervising the HUCS. The DN stated on 2/19/15, at 8:38 a.m. the white ice pack had come from the pharmacy. The DN further stated she had put laminated sheets on front of each of the freezers to say "No ice packs in freezer." A 2/15 Refrigerator/Freezers on the Floors policy indicated, "Sanitary techniques will be maintained in perishable food storage in order to safeguard the health of those dependent on the service." SUGGESTED METHOD OF CORRECTION: The dietary director or designee could ensure staff is trained in current policies regarding food storage in the kitchenettes. Staff could be trained personal lunches may not be stored with resident food. The director of nursing could ensure an appropriate place to store ice packs. Audits could be conducted to ensure staff are following the policies and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21015		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means	21810		3/31/15

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21810	Continued From page 11 care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure resident bathing preferences were honored for 1 of 2 residents (R208) reviewed for choices. Findings include: R208 was asked about bathing preferences in an interview on 2/17/15, at 2:58 p.m. The resident answered, "I get once a week--I would like more often. I would rather have a tub bath than a shower." In a follow up interview with R208 on 2/19/15, at 1:38 p.m. the resident reported, "I don't like the shower." R208's care plan dated 11/29/14, directed staff to give the resident a tub bath. The plan noted the resident had some confusion.R208's admission Minimum Data Set (MDS) dated 12/6/14, indicated the resident had diagnoses including bipolar disorder, had impaired cognitive skills for daily decision making, and required assistance from staff for bathing. On 2/18/15, at 1:31 p.m. a registered nurse (RN)-B stated, "We try to accommodate the resident for bathing by our [facility] schedule." A nursing assistant (NA)- F was interviewed on 2/19/15, at 1:56 p.m. and explained, "For bathing we go by what the care plan says or if resident	21810	Acknowledged	

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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
21810	Continued From page 12 says something and we accommodate them." A licensed practical nurse (LPN)-B then stated at 2:05 p.m. "I know [R208] takes a shower because I work with her and when I do her skin checks on Friday PMs [evenings] she is in the shower room." Following the interview with LPN-B, the director of nursing stated she expected residents' care plans to be followed by staff and that the plans be updated as needed. SUGGESTED METHOD OF CORRECTION: The social worker with the director of nursing could ensure resident preferences are honored related to bathing. Residents could be asked preferences upon admission and at care conferences. The care plans and NA assignment sheets could specify the resident's preferences. Residents could be randomly selected for audits to ensure preferences are being honored. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen days (14) days.	21810		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station.	23010		3/31/15

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 _____	02/19/2015

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23010	Continued From page 13 A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to call lights were functioning and/or were within reach for 2 of 35 residents (R20, R129) whose call lights were observed. Findings include: R20's call light was tested during an initial tour on 2/17/15, at 11:35 a.m. R20 was able to push the call light button, however, the it did not then light up in the resident's room nor in the hallway to notify nursing staff. A nursing assistant (NA)-A was then notified that R20's call light was not working. NA-A pushed the call light button, unplugged and re-plugged in the call light, but the light still did not work properly. NA-A verified it was not working and called a maintenance staff to report the problem. A maintenance staff person then replaced the light and it was observed in working order. R20's admission Minimum Data Set (MDS) dated 1/21/15, indicated the resident was cognitively intact and able to communicate needs clearly.	23010	Acknowledged	

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23010	Continued From page 14 R20's admission care plan dated 2/16/15, directed staff to place the call light within the resident's reach when in the room. On 2/17/15, at 2:33 p.m. R129's call light (pancake type) was observed hanging on the bed rail near the floor and behind R129 who was seated in his wheelchair. When the call light was tested, it did not activate. A registered nurse (RN)-C verified the call light was out of the resident's reach and was not functioning, and maintenance staff would be notified. RN-C stated, "I would normally give R129 his call light and put it here on his abdomen under his left hand." RN-C said he would notify. At 2:40 p.m. a maintenance staff (M)-A requested M-B obtain a new call light and the light was replaced and was working at 2:43 p.m. R129's quarterly Minimum Data Set (MDS) dated 12/4/14, indicated the resident had cognitive impairment, and was totally dependent on staff for cares. On 2/19/15, at 8:55 a.m. the maintenance director explained that if a call light was not working, staff sent a work order on the computer marked urgent, or they called or paged maintenance staff. The call system was supposed to alert the nurses' station of any call light problems and the affected room number. More frequent checks had been performed in the past, but now were completed quarterly. The maintenance director showed documentation that both R20's and R129's call light had been working on 1/15, during quarterly room checks, and no work orders had been received regarding non-functioning call lights for either resident. The maintenance director added, "Unfortunately with the call light pads and the cords, they are a	23010		

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23010	Continued From page 15 mechanical device that can break." On 2/19/15, at 9:48 a.m. the director of nursing stated, "I expect call lights to be functioning at all times. It's a safety issue." During an environmental tour on 2/19/15, at 10:00 a.m. R20's call light worked when activated. R20 reported, however, "The other day my call light was not working, but had been working 15-20 minutes before that." At 10:05 a.m. R129's call light worked when activated. A 1/09 Call Light Response policy was "To assure call system is in proper working order...Check all call lights daily and report any defective call lights to environmental services immediately. Be sure call lights are placed within resident reach at all times, never on the floor or bedside stand." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure staff are trained in the policy regarding call lights being placed within residents' reach and in reporting the issue immediately. Maintenance staff could increase frequency of call light checks and ensure staff are using the system for immediate reporting. The results of the audits could be brought to the quality committee for their review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	23010		