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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: H7NV

Facility ID: 00191

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245587**
2.STATE VENDOR OR MEDICAID NO.
(L2) **810542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EBENEZER CARE CENTER**
(L4) **2545 PORTLAND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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) **05/01/2012**

6. DATE OF SURVEY 02/13/14 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (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 **127** (L18)

13.Total Certified Beds **127** (L17)

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34	93		
(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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 02/19/14 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/18/2014 (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
06/01/1991
(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.
00320
(L31)

30. REMARKS
Posted 03/28/14 CO

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/11/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5587

On 02/13/14, a second Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the12/05/13 standard survey, effective 02/11/14.

Refer to the CMS 2567B for both health and life safety code survey findings. Effective 02/11/14, the facility is certified for 50 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5587

March 18, 2014

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

Dear Mr. Prevost:

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 February 11, 2014, the above facility is certified for:

127 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 127 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. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 6, 2014

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5587023

Dear Mr. Prevost:

On January 31, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 5, 2014. (42 CFR 488.422)

On January 31, 2014, this department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 5, 2014. (42 CFR 488.417 (b))

In addition, we notified you in our letter of January 31, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 5, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on December 5, 2013, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on January 9, 2014. The most serious deficiencies at the time of the revisit were found 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 February 13, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 9, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 30, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 9, 2014, as of February 13, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 11, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of January 31, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 5, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 5, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 5, 2014, is to be rescinded.

In our letter of January 9, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 5, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 11, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

AH Form Approved
2/19/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00191	A. Building B. Wing	2/13/2014

Name of Facility	Street Address, City, State, Zip Code
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. : LSC	Correction Completed 02/13/2014	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By GD/AK	Date: 02/19/2014	Signature of Surveyor: 30951	Date: 02/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/5/2013		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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245587	A. Building B. Wing	2/13/2014

Name of Facility	Street Address, City, State, Zip Code
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **02/11/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/11/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **02/11/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **02/11/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	02/19/2014	30951	02/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/5/2013			

AH Form Approved
2/19/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00191	A. Building B. Wing	2/13/2014

Name of Facility	Street Address, City, State, Zip Code
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **30970** Reg. # **MN Rule 4655.6400 Subp. :** LSC	Correction Completed **02/13/2014**	ID Prefix **30975** Reg. # **MN Rule 4655.6400 Subp. :** LSC	Correction Completed **02/13/2014**	ID Prefix **31810** Reg. # **MN Rule 144.651 Subd. 6** LSC	Correction Completed **02/13/2014**
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** GD/AK	**Date:** 02/19/2014	**Signature of Surveyor:** 30951	**Date:** 02/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 12/5/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 6, 2014

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

Re: Enclosed Reinspection Results - Project Number S5587023

Dear Mr. Prevost:

On February 13, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 5, 2013, with orders received by you on December 21, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H7NV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00191

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245587**

2.STATE VENDOR OR MEDICAID NO.
(L2) **810542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EBENEZER CARE CENTER**
(L4) **2545 PORTLAND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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) **05/01/2012**

6. DATE OF SURVEY 01/09/14 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (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 **127** (L18)

13.Total Certified Beds **127** (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
	34	93		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date : 02/12/14
Ann Hyrkas, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/18/2014 (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
06/01/1991
(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.
00320
(L31)

30. REMARKS
Posted 03/28/2014 CO> H7NV

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/11/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5587

On 01/09/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on 01/13/14, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility has not achieved substantial compliance pursuant to the 12/05/13 standard survey. Refer to the CMS 2567Bs for health and life safety code survey findings.

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR BOARDING CARE HOMES

Certified #7011 2000 0002 5143 4523

March 4, 2014

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

Re: Project Number S5587023

Dear Mr. Prevost:

On January 9, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 5, 2013 with orders received by you on December 21, 2013.

State licensing orders issued pursuant to the last survey completed on December 5, 2013 and found corrected at the time of the January 9, 2014 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on December 5, 2013, found not corrected at the time of this January 9, 2014 revisit and subject to penalty assessment are as follows:

- **30970--S/S:--MN Rule 4655.6400 Subp. 2E--Adequate Care; Assist With Oral Hygiene—$250.00**
- **30975--S/S:--MN Rule 4655.6400 Subp. 2F--Adequate Care; Care Of Hands. Feet, Nails— $250.00**
- **31810--S/S:--MN Rule 144.651 Subd. 6--Patients & Residents Of Hcf Bill Of Rights— $250.00**

The details of the violations noted at the time of this revisit completed on January 9, 2014 (listed above), are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144.653, you are assessed for the amount of **$750.00.** Fines shall be paid by check made payable to the Commissioner of Finance, Treasury

Division and sent to the Department of Health, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900 within 15 days of the receipt of this notice.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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 with any questions related to this letter.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Gloria Derfus, Metro Team C Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8019

January 31, 2014

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5587023

Dear Mr. Prevost:

On December 17, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 5, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 9, 2014, the Minnesota Department of Health and on January 13, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 5, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 30, 2013. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 5, 2013. The deficiencies not corrected are as follows:

F0242 -- S/S: D -- 483.15(b) -- Self-Determination - Right To Make Choices
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0311 -- S/S: D -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls

In addition, at the time of this revisit, we identified the following deficiency:

F0312 -- S/S: D -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective February 5, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 5, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 5, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 5, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Ebenezer Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective March 5, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3792
Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 June 5, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245587	A. Building / B. Wing **01 - MAIN BUILDING 01**	1/13/2014

Name of Facility	Street Address, City, State, Zip Code
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **12/19/2013**	ID Prefix	Correction Completed **12/19/2013**	ID Prefix	Correction Completed **12/19/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0012		LSC K0038		LSC K0040	
ID Prefix	Correction Completed **12/19/2013**	ID Prefix	Correction Completed **12/19/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0045		LSC K0144		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 01/29/2014	**Signature of Surveyor:** 28120	**Date:** 01/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/10/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245587	A. Building 02 - BLDG TWO B. Wing	1/13/2014

Name of Facility	Street Address, City, State, Zip Code
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0045	12/19/2013	ID Prefix Reg. # NFPA 101 LSC K0144	12/19/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 01/29/2014	**Signature of Surveyor:** 28120	**Date:** 01/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 12/10/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00191	A. Building B. Wing	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **30601** Reg. # **MN St. Statute 144.56 Sub** LSC	Correction Completed **12/30/2013**	ID Prefix **30615** Reg. # **MN Rule 4655.3200 Subp. 3** LSC	Correction Completed **12/30/2013**	ID Prefix **31145** Reg. # **MN Rule 4655.7830 Subp. 4** LSC	Correction Completed **12/30/2013**
ID Prefix **31240** Reg. # **MN Rule 4655.8520 E** LSC	Correction Completed **12/30/2013**	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** GD/AK	**Date:** 01/28/2014	**Signature of Surveyor:** 31768	**Date:** 01/09/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/5/2013	_____	**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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245587	A. Building B. Wing	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/09/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **01/09/2014**	ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **01/09/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/09/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/09/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	01/28/2014	31768	01/09/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/5/2013			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00191	A. Building B. Wing	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21095** Reg. # **MN Rule 4658.0650 Subp.** LSC	Correction Completed **12/30/2013**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **12/30/2013**	ID Prefix **21415** Reg. # **MN Rule 4658.0815 Subp.** LSC	Correction Completed **12/30/2013**
ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp.** LSC	Correction Completed **12/30/2013**	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** GD/AK	**Date:** 01/28/2014	**Signature of Surveyor:** 31768	**Date:** 01/09/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/5/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	R 01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

(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
{3 000}	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME 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: On 1/6/14, through 1/9/14, a surveyor of this Department's staff completed a revisit for the survey exited on 12/5/13, for the above provider and the following correction orders are not corrected: (3 970, 3 975, 3 1810). These uncorrected orders will remain in effect from the	{3 000}	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 Boarding Care Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	R 01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
{3 000}	Continued From page 1 original survey on 12/5/13, and will be reviewed at the next site visit. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; 85 East Seventh Place, P.O. Box 64882, St. Paul, MN 55164-0882. Census 123	{3 000}	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.	
3 970	MN Rule 4655.6400 Subp. 2E Adequate Care; Assist with Oral hygiene Subp. 2. Criteria for determining adequate care. Criteria for determining adequate and proper care shall include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips.	3 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	R 01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
3 970	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with oral care as ordered, assessed and directed by the care plan for 2 of 4 residents (R21, R12) reviewed for activities of daily living (ADLs). Findings include: R21 was not provided assistance with oral cares on the morning of 1/8/14. On 1/8/14, at 10:00 a.m. nursing assistant (NA)-A stated oral care had already been completed R21's oral care using toothbrush and toothpaste. NA-A further stated R21 did not wear dentures and would some times resist cares. NA-A went on to state he would re-approach R21 if cares were refused. At 10:15 a.m. NA-A entered R21's room and opened the top drawer in R21's bedside table. The drawer was observed to contain many papers and other articles. NA-A located R21's toothbrush, but was unable to locate any toothpaste. NA-A demonstrated how he would brush R21's natural teeth. During the observation, R21 would not open their mouth for viewing. NA-A recanted his earlier statement and stated he did not use either the toothbrush or any toothpaste for R21's oral care earlier. R21 stated he instead used toothettes for oral care and denied knowing where R21's toothpaste was located. A computer-generated Diagnosis Report dated 1/9/14, indicated R21's diagnoses included hemiplegia, aphasia, and vascular dementia with delusions. R21's quarterly Minimum Data Set (MDS) dated	3 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	R 01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
3 970	Continued From page 3 12/24/13, indicated R21 had short and long-term memory deficits, moderate impaired daily decision making skills, inattention and psychomotor retardation behaviors. The MDS further indicated R21 displayed no rejection of care and required extensive assistance with all ADL's and personal hygiene activities. R21's annual MDS dated 9/24/13, indicated R21 had obvious or likely cavity or broken natural teeth. The ADL Care Area Assessment (CAA) dated 9/18/13, identified R21 required staff assistance with ADLs including grooming. Although the CAA identified pertinent mouth information such as R21 having a "lower lip that protrudes with thick tongue that hangs over, drools frequently" and R21's behavioral concerns, the CAA did not identify oral/dental care needs. R21's Care Plan revised 12/18/13, directed staff to assist with brushing R21's natural teeth for three minutes using a soft toothbrush and fluoride toothpaste. The care plan directed to twice daily (as R21 allows) brush all sides of teeth and to pay special attention to R21's gum line. On 1/8/14, at 3:15 p.m. registered nurse (RN)-D stated both a toothbrush and toothpaste should have been readily available in R21's room for use with oral care. RN-D confirmed the care plan was not followed for R21 for oral care. R12 was not provided assistance to complete oral care as ordered. A computer generated Diagnosis Report dated 1/9/14, indicated R12's diagnoses included bipolar disorder, dementia and osteoarthritis. R12's quarterly MDS dated 11/27/13, indicated	3 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	R 01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
3 970	Continued From page 4 R12 had short and long-term memory deficits, had moderately impaired daily decision making skills, behaviors of inattention, and required extensive assistance with personal hygiene. R12's Care Plan revised 8/23/12, directed assistance of one staff with all grooming tasks and to use Prevident 5000 plus with a toothbrush twice daily. An Order Summary Report dated and signed 12/3/13, indicated R12 was to receive Prevident 5000 Plus (Sodium Fluoride Dental) cream 1.1% twice daily with toothbrush for cavity prevention. A computer-generated Treatment Administration Record (TAR) dated 1/9/14, indicated R12 had received the Prevident tooth cream twice daily from 12/1/13, to 1/9/14; with one afternoon treatment and four evening treatments not signed as provided. On 1/9/14, at 10:15 a.m. NA-D stated R12's oral cares had already been provided that am. NA-D stated she had used a pink toothette to clean R12's teeth. Upon observation of R12's bedside table, NA-D was able to locate a toothbrush along with a small tube of Colgate toothpaste. NA-D stated R12 resisted use of a toothbrush in the mouth. NA-D further stated she was not aware R12 had a special toothpaste to use. On 1/9/14, at 10:30 a.m. RN-C stated R12's Prevident tooth cream and treatment would not be specified on the care guide for the NA's. RN-C stated since the Prevident was a prescription item, the NA's would have to obtain the tooth cream from the unit nurse from the treatment cart to use with R12's toothbrush.	3 970		

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3 970	Continued From page 5 On 1/9/14, at 10:47 a.m. with RN-A present, an observation of the 2 South treatment and medication carts revealed no evidence of the Prevident tooth cream. RN-A stated the NA's would get the tooth cream from the nurse and return it to the nurse when the oral care was completed. RN-A further stated she was not sure where the tooth cream was located or how long it had been missing from the medication cart. On 1/9/14, at approximately 2:00 p.m. RN-C stated R12's Prevident tooth cream was expensive and required a pre-authorization for R12's insurance to pay for a refill. RN-C further stated he was not aware R12's tooth cream supply had run out. An Oral Hygiene policy dated 1/2009, not revised since the original survey, directed staff to offer oral hygiene before breakfast, and at bedtime or per assignment sheet.	3 970		
{3 975}	MN Rule 4655.6400 Subp. 2F Adequate Care; Care of hands. feet, nails Subp. 2. Criteria for determining adequate care. Criteria for determining adequate and proper care shall includes: F. Proper care and attention to hands and feet. Fingernails and toenails shall be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care for 1 of 3 residents (R45) reviewed for activities of daily living (ADLs).	{3 975}		

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{3 975}	Continued From page 6 Findings include: A computer-generated Diagnosis Report dated 1/9/14, indicated R45's diagnoses included hemiplegia and diabetes type 2. R45's quarterly Minimum Data Set (MDS) dated 10/23/13, indicated R45 had moderate cognitive impairment, was independent in personal hygiene and required set up help for bathing. R45's Care Plan revised 7/30/13, directed assistance of one staff with all personal hygiene activities and directed the nurse to provide nail care. On 1/8/14, at 9:05 a.m. R45 was observed to be in the facility lobby area seated in a chair. Many of R45's finger nails on both hands were observed to be long, jagged, and to contain dark-colored matter under the finger nail tips. On 1/8/14, at 10:15 a.m. nursing assistant (NA)-A stated R45 was very resistive to cares. NA-A stated they were able to talk R45 into a shower the other day due to severe body odor. NA-A stated nail care was not done by the NA's for diabetic residents. On 1/8/14, at 10:30 a.m. licensed practical nurse (LPN)-A stated R45 went to podiatry for toe nail/foot care. LPN-A further stated she had never done finger nail care for R45. On 1/8/14, at 3:00 p.m. RN-D stated R45 had refused a shower on 1/6/14, but took a shower with minimal assistance on 1/7/14. RN-D stated the nurses should have provided R45 with finger nail care and documented the offer and/or refusal	{3 975}		

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{3 975}	Continued From page 7 in the progress notes. RN-D confirmed the lack of documentation on nail care. On 1/9/14, at 1:35 p.m. RN-D reported R45 allowed the nurse to provide finger nail care yesterday. At 2:22 p.m. R45's fingernails were observed to be trimmed neat and clean. R45 stated the nails felt okay.	{3 975}		
{31810}	MN Rule 144.651 Subd. 6 Patients & Residents of HCF 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 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 observation, interview, and document review, the facility failed to honor the choice of bathing type and/or frequency for 2 of 3 residents (R21, R80) reviewed for choices. Findings include: R80 was not provided with the requested number of baths per week. A computer-generated Diagnosis Report dated 1/9/14, indicated R80's diagnoses included hemiplegia and multiple sclerosis.	{31810}		

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{31810}	Continued From page 8 R80's quarterly Minimum Data Set (MDS) dated 1/1/14, indicated R80 had a Brief Interview for Mental Status (BIMS) score of 12 and moderate cognitive impairment, required set up assistance for personal hygiene activities, and required physical help in part of bathing activities. R80's Care Plan revised 4/15/10, directed staff to physically prepare bath, adjust water temperature, provide assist of one staff in/out of tub/shower, and provide assist of one staff to wash/dry R80's entire body. A Bath Schedule dated 12/30/13, was observed to be posted on a bulletin board at the first floor nurses station. The form indicated R80 was scheduled for a bath during the day shift on Tuesday with "please give shower early" typed on the Tuesday block, and on the Thursday and Saturday day shift blocks. On 1/8/14, at 2:10 p.m. R80 stated only one tub bath per week was being provided. R80 stated they used to have a frequent bathing schedule in the past and stated staff did not have time for any more than one tub bath per week. R80 stated they had lived at the facility a "long time"and it really did not matter any more and R80 had just become "used to" one bath per week. R80 further stated an early morning bath was preferred as R80 slept poorly at night and was an early riser. Although R80 stated staff had offered a bath later in the day, R80 stated later did not work, as R80 had to get undressed then re-dressed after the later bath was completed. On 1/8/14, at 2:30 p.m. registered nurse (RN)-C stated if R80 had been refusing baths, the refusal should be documented in the nurses notes. RN-C further stated R80 was just getting one bath per	{31810}		

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{31810}	Continued From page 9 week on Tuesday morning. RN-C stated R80 could not agree to a time or day for the requested three times per week. Review of the electronic nurses progress notes for R80 revealed a bath/skin check was performed on 12/24/13, and on 1/7/14. The progress notes lacked documentation R80 had refused the other two scheduled baths per week and lacked documentation a bath/skin check was performed on 12/31/13. On 1/8/14, at 4:00 p.m. RN-C confirmed R80's medical record lacked documentation of the declined bath times/days offered and staff did not inform him R80 was refusing the other two scheduled baths per week. RN-C stated R80 did receive a bath on 12/31/13, along with a weekly skin check, but the nurse forgot to chart the skin check was performed on that day. R21 was not receiving the preferred type of bath. A computer-generated Diagnosis Report dated 1/9/14, indicated R21's diagnoses included hemiplegia, aphasia and vascular dementia with delusions. R21's quarterly MDS dated 12/24/13, indicated R21 had short and long-term memory deficits, moderately impairment decision making skills, inattention and psychomotor retardation behaviors. The MDS indicated R21 displayed no rejection of care, required extensive assistance with all activities of daily living (ADL's) including personal hygiene activities, and was totally dependent with bathing. R21's annual MDS dated 9/24/13, indicated R21 preferred a tub bath. R21's Care Plan revised 12/18/13, directed staff	{31810}		

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{31810}	Continued From page 10 to physically prepare bath, adjust water temperature, two staff to transfer R21 in and out of tub/shower, and one staff to wash and dry R21's entire body with assistance of two staff as needed. An electronic Progress Note labeled late entry dated 12/31/13, indicated a care conference was held for R21. The Progress Note identified R21 preferred a shower. A Bath Schedule dated 1/7/14, was observed to be located in a 3-ring binder book on the 3 South unit. The form indicated R21 was to receive a bath on Tuesday day shift. On 1/8/14, at 10:00 a.m. NA-A stated R21 was not getting in the tub for the weekly bath, but was being provided with a full bed bath. NA-A stated R21 was too resistive to be bathed either in the shower or the bath tub; NA-A stated R21 was more cooperative with a bed bath. On 1/8/14, at 3:15 p.m. RN-D stated R21 pointed to "shower" as choice of bath type to be provided. RN-D further stated she was not aware R21 was being provided with a weekly bed bath. RN-D confirmed the written note she provided to R21 to select the bath type only contained a shower or tub bath as choices and did not contain bed bath as a choice. The faciliy's Your Right Under The Combined Federal And Minnesota Bill Of Rights booklet dated 7/2007, was not updated, and contained the statement, "5. You have the right to reside and receive services in the facility with reasonable accommodations of your needs and preferences..."	{31810}		

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{F 000}	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. Census 123	{F 000}		
{F 242} SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to honor the choice of bathing type and/or frequency for 2 of 3 residents (R21, R80) reviewed for choices. Findings include: R80 was not provided with the requested number of baths per week.	{F 242}		

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

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{F 242}	Continued From page 1 A computer-generated Diagnosis Report dated 1/9/14, indicated R80's diagnoses included hemiplegia and multiple sclerosis. R80's quarterly Minimum Data Set (MDS) dated 1/1/14, indicated R80 had a Brief Interview for Mental Status (BIMS-tool used to measure cognitive status) score of 12 and moderate cognitive impairment, required set up assistance for personal hygiene activities, and required physical help in part of bathing activities. R80's Care Plan revised 4/15/10, directed staff to physically prepare bath, adjust water temperature, provide assist of one staff in/out of tub/shower, and provide assist of one staff to wash/dry R80's entire body. A Bath Schedule dated 12/30/13, was observed to be posted on a bulletin board at the first floor nurses station. The form indicated R80 was scheduled for a bath during the day shift on Tuesday with "please give shower early" typed on the Tuesday block, and on the Thursday and Saturday day shift blocks. On 1/8/14, at 2:10 p.m. R80 stated only one tub bath per week was being provided. R80 stated they used to have a frequent bathing schedule in the past and stated staff did not have time for any more than one tub bath per week. R80 stated they had lived at the facility a "long time"and it really did not matter any more and R80 had just become "used to" one bath per week. R80 further stated an early morning bath was preferred as R80 slept poorly at night and was an early riser. Although R80 stated staff had offered a bath later in the day, R80 stated later did not work, as R80 had to get undressed then re-dressed after the	{F 242}		

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{F 242}	Continued From page 2 later bath was completed. On 1/8/14, at 2:30 p.m. registered nurse (RN)-C stated if R80 had been refusing baths, the refusal should be documented in the nurses notes. RN-C further stated R80 was just getting one bath per week on Tuesday morning. RN-C stated R80 could not agree to a time or day for the requested three times per week. Review of the electronic nurses progress notes for R80 revealed a bath/skin check was performed on 12/24/13, and on 1/7/14. The progress notes lacked documentation R80 had refused the other two scheduled baths per week and lacked documentation a bath/skin check was performed on 12/31/13. On 1/8/14, at 4:00 p.m. RN-C confirmed R80's medical record lacked documentation of the declined bath times/days offered and staff did not inform him R80 was refusing the other two scheduled baths per week. RN-C stated R80 did receive a bath on 12/31/13, along with a weekly skin check, but the nurse forgot to chart the skin check was performed on that day. R21 was not receiving the preferred type of bath. A computer-generated Diagnosis Report dated 1/9/14, indicated R21's diagnoses included hemiplegia, aphasia and vascular dementia with delusions. R21's quarterly MDS dated 12/24/13, indicated R21 had short and long-term memory deficits, moderately impairment decision making skills, inattention and psychomotor retardation behaviors. The MDS indicated R21 displayed no	{F 242}		

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{F 242}	Continued From page 3	{F 242}		

rejection of care, required extensive assistance with all activities of daily living (ADL's) including personal hygiene activities, and was totally dependent with bathing. R21's annual MDS dated 9/24/13, indicated R21 preferred a tub bath.

R21's Care Plan revised 12/18/13, directed staff to physically prepare bath, adjust water temperature, two staff to transfer R21 in and out of tub/shower, and one staff to wash and dry R21's entire body with assistance of two staff as needed.

An electronic Progress Note labeled late entry dated 12/31/13, indicated a care conference was held for R21. The Progress Note identified R21 preferred a shower.

A Bath Schedule dated 1/7/14, was observed to be located in a 3-ring binder book on the 3 South unit. The form indicated R21 was to receive a bath on Tuesday day shift.

On 1/8/14, at 10:00 a.m. NA-A stated R21 was not getting in the tub for the weekly bath, but was being provided with a full bed bath. NA-A stated R21 was too resistive to be bathed either in the shower or the bath tub; NA-A stated R21 was more cooperative with a bed bath.

On 1/8/14, at 3:15 p.m. RN-D stated R21 pointed to "shower" as choice of bath type to be provided. RN-D further stated she was not aware R21 was being provided with a weekly bed bath. RN-D confirmed the written note she provided to R21 to select the bath type only contained a shower or tub bath as choices and did not contain bed bath as a choice.

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{F 242}	Continued From page 4 The faciliy's Your Right Under The Combined Federal And Minnesota Bill Of Rights booklet dated 7/2007, was not updated, and contained the statement, "5. You have the right to reside and receive services in the facility with reasonable accommodations of your needs and preferences..."	{F 242}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: On 1/8/14, at 3:00 p.m. RN-D stated the nurses should provide R45 with finger nail care and documented the offer and/or refusal in the progress notes. RN-D confirmed the lack of documentation on nail care. R12 was not provided with oral care as directed by the care plan. A computer generated Diagnosis Report dated 1/9/14, indicated R12's diagnoses included bipolar disorder, dementia and osteoarthritis. On 1/9/14, at 10:15 a.m. NA-D stated R12's oral cares had already been provided that am. NA-D stated she had used a pink toothette to clean R12's teeth. Upon observation of R12's bedside table, NA-D was able to locate a toothbrush along with a small tube of Colgate toothpaste. NA-D stated R12 resisted use of a toothbrush in the	{F 282}		

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{F 282}	Continued From page 5 mouth. An Order Summary Report dated and signed 12/3/13, indicated R12 was to receive PreviDent 5000 Plus (Sodium Fluoride Dental) cream 1.1% twice daily with toothbrush for cavity prevention. R12's Care Plan revised 8/23/12, directed assistance of one staff with all grooming tasks and to use PreviDent 5000 plus with a toothbrush twice daily. On 1/9/14, at 10:30 a.m. RN-C stated R12's PreviDent tooth cream and treatment would not be specified on the care guide for the NA's. RN-C stated since the PreviDent was a prescription item, the NA's would have to obtain the tooth cream from the unit nurse from the treatment cart to use with R12's toothbrush. On 1/9/14, at 10:47 a.m. with RN-A present, an observation of the 2 South treatment and medication carts revealed no evidence of the PreviDent tooth cream. RN-A stated the NA's would get the tooth cream from the nurse and return it to the nurse when the oral care was completed. RN-A further stated she was not sure where the tooth cream was located or how long it had been missing from the medication cart. On 1/9/14, at approximately 2:00 p.m. RN-C stated he was not aware R12's tooth cream supply had run out.	{F 282}		
{F 311} SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	{F 311}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 311}	Continued From page 6	{F 311}		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to follow the plan of care for 3 of 4 residents (R21, R12, R45) reviewed for activities of daily living (ADLs).

Findings include:

R21's care plan for dental health was not followed.

A computer-generated Diagnosis Report dated 1/9/14, indicated R21's diagnoses included hemiplegia, aphasia, and vascular dementia with delusions.

On 1/8/14, at 10:00 a.m. nursing assistant (NA)-A stated oral care had already been completed R21's oral care using toothbrush and toothpaste. NA-A further stated R21 did not wear dentures and would sometimes resist cares. NA-A went on to state he would re-approach R21 if cares were refused. At 10:15 a.m. NA-A entered R21's room and opened the top drawer in R21's bedside table. The drawer was observed to contain many papers and other articles. NA-A located R21's toothbrush, but was unable to locate any toothpaste. NA-A demonstrated how NA-A would brush R21's natural teeth. During the observation, R21 would not open their mouth for viewing. NA-A recanted his earlier statement and stated he did not use either the toothbrush or any toothpaste for R21's oral care earlier. R21 stated he instead used toothettes for oral care and denied knowing where R21's toothpaste was located.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	R 01/09/2014

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{F 311}	Continued From page 7 R21's Care Plan revised 12/18/13, directed staff to assist with brushing R21's natural teeth for three minutes using a soft toothbrush and fluoride toothpaste. The care plan directed to twice daily (as R21 allows) brush all sides of teeth and to pay special attention to R21's gum line. On 1/8/14, at 3:15 p.m. registered nurse (RN)-D stated both a toothbrush and toothpaste should have been readily available in R21's room for use with oral care. RN-D confirmed the care plan was not followed for R21 for oral care. R45 was not provided with nail care as directed by the care plan. A computer-generated Diagnosis Report dated 1/9/14, indicated R45's diagnoses included hemiplegia and diabetes type 2. On 1/8/14, at 9:05 a.m. R45 was observed in the facility lobby area seated in a chair. Many of R45's finger nails on both hands were observed to be long, jagged, and to contain dark-colored matter under their finger nail tips. At 10:15 a.m. NA-A stated R45 was very resistive to cares, however NA-A stated they were able to talk R45 into a shower "the other day" due to severe body odor. NA-A stated nail care was not done by the NA's for diabetic residents. R45's Care Plan revised 7/30/13, directed assistance of one staff with all personal hygiene activities and directed the nurse to provide nail care. On 1/8/14, at 10:30 a.m. licensed practical nurse (LPN)-A stated R45 went to podiatry for toe	{F 311}		

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{F 311}	Continued From page 8 nail/foot care. LPN-A further stated she had never done finger nail care for R45. Based on observation, interview, and document review, the facility failed to provide nail care for 1 of 3 residents (R45) reviewed for activities of daily living (ADLs). Findings include: A computer-generated Diagnosis Report dated 1/9/14, indicated R45's diagnoses included hemiplegia and diabetes type 2. R45's quarterly Minimum Data Set (MDS) dated 10/23/13, indicated R45 had moderate cognitive impairment, was independent in personal hygiene and required set up help for bathing. R45's Care Plan revised 7/30/13, directed assistance of one staff with all personal hygiene activities and directed the nurse to provide nail care. On 1/8/14, at 9:05 a.m. R45 was observed to be in the facility lobby area seated in a chair. Many of R45's finger nails on both hands were observed to be long, jagged, and to contain dark-colored matter under the finger nail tips. On 1/8/14, at 10:15 a.m. nursing assistant (NA)-A stated R45 was very resistive to cares. NA-A stated they were able to talk R45 into a shower the other day due to severe body odor. NA-A stated nail care was not done by the NA's for diabetic residents. On 1/8/14, at 10:30 a.m. licensed practical nurse (LPN)-A stated R45 went to podiatry for toe	{F 311}		

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{F 311}	Continued From page 9 nail/foot care. LPN-A further stated she had never done finger nail care for R45. On 1/8/14, at 3:00 p.m. RN-D stated R45 had refused a shower on 1/6/14, but took a shower with minimal assistance on 1/7/14. RN-D stated the nurses should have provided R45 with finger nail care and documented the offer and/or refusal in the progress notes. RN-D confirmed the lack of documentation on nail care. On 1/9/14, at 1:35 p.m. RN-D reported R45 allowed the nurse to provide finger nail care yesterday. At 2:22 p.m. R45's fingernails were observed to be trimmed neat and clean. R45 stated the nails felt okay. A Care of Nails Policy dated 1/2009, not revised since original survey; directed fingernails of diabetic residents were to be cut by the nurse.	{F 311}		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with oral care as ordered, assessed and directed by the care plan for 2 of 4 residents (R21, R12) reviewed for activities of daily living (ADLs).	F 312		

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 312	Continued From page 10 Findings include: R21 was not provided assistance with oral cares on the morning of 1/8/14. On 1/8/14, at 10:00 a.m. nursing assistant (NA)-A stated oral care had already been completed R21's oral care using toothbrush and toothpaste. NA-A further stated R21 did not wear dentures and would sometimes resist cares. NA-A went on to state he would re-approach R21 if cares were refused. At 10:15 a.m. NA-A entered R21's room and opened the top drawer in R21's bedside table. The drawer was observed to contain many papers and other articles. NA-A located R21's toothbrush, but was unable to locate any toothpaste. NA-A demonstrated how NA-A would brush R21's natural teeth. During the observation, R21 would not open their mouth for viewing. NA-A recanted his earlier statement and stated he did not use either the toothbrush or any toothpaste for R21's oral care earlier. R21 stated he instead used toothettes for oral care and denied knowing where R21's toothpaste was located. A computer-generated Diagnosis Report dated 1/9/14, indicated R21's diagnoses included hemiplegia, aphasia, and vascular dementia with delusions. R21's quarterly Minimum Data Set (MDS) dated 12/24/13, indicated R21 had short and long-term memory deficits, moderate impaired daily decision making skills, inattention and psychomotor retardation behaviors. The MDS further indicated R21 displayed no rejection of care and required extensive assistance with all ADL's and personal hygiene activities. R21's annual MDS dated 9/24/13, indicated R21 had	F 312		

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F 312	Continued From page 11 obvious or likely cavity or broken natural teeth. The ADL Care Area Assessment (CAA) dated 9/18/13, identified R21 required staff assistance with ADLs including grooming. Although the CAA identified pertinent mouth information such as R21 having a "lower lip that protrudes with thick tongue that hangs over, drools frequently" and R21's behavioral concerns, the CAA did not identify oral/dental care needs. R21's Care Plan revised 12/18/13, directed staff to assist with brushing R21's natural teeth for three minutes using a soft toothbrush and fluoride toothpaste. The care plan directed to twice daily (as R21 allows) brush all sides of teeth and to pay special attention to R21's gum line. On 1/8/14, at 3:15 p.m. registered nurse (RN)-D stated both a toothbrush and toothpaste should have been readily available in R21's room for use with oral care. RN-D confirmed the care plan was not followed for R21 for oral care. R12 was not provided assistance to complete oral care as ordered. A computer generated Diagnosis Report dated 1/9/14, indicated R12's diagnoses included bipolar disorder, dementia and osteoarthritis. R12's quarterly MDS dated 11/27/13, indicated R12 had short and long-term memory deficits, had moderately impaired daily decision making skills, behaviors of inattention, and required extensive assistance with personal hygiene. R12's Care Plan revised 8/23/12, directed assistance of one staff with all grooming tasks	F 312		

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F 312	Continued From page 12	F 312		

and to use PreviDent 5000 plus with a toothbrush twice daily.

An Order Summary Report dated and signed 12/3/13, indicated R12 was to receive PreviDent 5000 Plus (Sodium Fluoride Dental) cream 1.1% twice daily with toothbrush for cavity prevention.

A computer-generated Treatment Administration Record (TAR) dated 1/9/14, indicated R12 had received the PreviDent tooth cream twice daily from 12/1/13, to 1/9/14; with one afternoon treatment and four evening treatments not signed as provided.

On 1/9/14, at 10:15 a.m. NA-D stated R12's oral cares had already been provided that am. NA-D stated she had used a pink toothette to clean R12's teeth. Upon observation of R12's bedside table, NA-D was able to locate a toothbrush along with a small tube of Colgate toothpaste. NA-D stated R12 resisted use of a toothbrush in the mouth. NA-D further stated she was not aware R12 had special toothpaste to use.

On 1/9/14, at 10:30 a.m. RN-C stated R12's PreviDent tooth cream and treatment would not be specified on the care guide for the NA's. RN-C stated since the PreviDent was a prescription item, the NA's would have to obtain the tooth cream from the unit nurse from the treatment cart to use with R12's toothbrush.

On 1/9/14, at 10:47 a.m. with RN-A present, an observation of the 2 South treatment and medication carts revealed no evidence of the PreviDent tooth cream. RN-A stated the NA's would get the tooth cream from the nurse and return it to the nurse when the oral care was

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F 312	Continued From page 13 completed. RN-A further stated she was not sure where the tooth cream was located or how long it had been missing from the medication cart. On 1/9/14, at approximately 2:00 p.m. RN-C stated R12's PreviDent tooth cream was expensive and required a pre-authorization for R12's insurance to pay for a refill. RN-C further stated he was not aware R12's tooth cream supply had run out. An Oral Hygiene policy dated 1/2009, not revised since the original survey, directed staff to offer oral hygiene before breakfast, and at bedtime or per assignment sheet.	F 312		

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{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: On 1/6/14, through 1/9/14, a surveyor of this Department's staff completed a revisit for the survey exited on 12/5/13, for the above provider and the following new correction order was issued: (2 565). This new corrected order will remain in effect from the original survey on 12/5/13, and will be reviewed at the next site visit.	{2 000}	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.	

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{2 000}	Continued From page 1 When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; 85 East Seventh Place, P.O. Box 64882, St. Paul, MN 55164-0882. Census 123	{2 000}	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 which 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		

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2 565	Continued From page 2 by: Based on observation, interview, and document review, the facility failed to follow the plan of care for 3 of 4 residents (R21, R12, R45) reviewed for activities of daily living (ADLs). Findings include: R21's care plan for dental health was not followed. A computer-generated Diagnosis Report dated 1/9/14, indicated R21's diagnoses included hemiplegia, aphasia, and vascular dementia with delusions. On 1/8/14, at 10:00 a.m. nursing assistant (NA)-A stated oral care had already been completed R21's oral care using toothbrush and toothpaste. NA-A further stated R21 did not wear dentures and would some times resist cares. NA-A went on to state he would re-approach R21 if cares were refused. At 10:15 a.m. NA-A entered R21's room and opened the top drawer in R21's bedside table. The drawer was observed to contain many papers and other articles. NA-A located R21's toothbrush, but was unable to locate any toothpaste. NA-A demonstrated how he would brush R21's natural teeth. During the observation, R21 would not open their mouth for viewing. NA-A recanted his earlier statement and stated he did not use either the toothbrush or any toothpaste for R21's oral care earlier. R21 stated he instead used toothettes for oral care and denied knowing where R21's toothpaste was located. R21's Care Plan revised 12/18/13, directed staff to assist with brushing R21's natural teeth for three minutes using a soft toothbrush and fluoride toothpaste. The care plan directed to twice daily	2 565		

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2 565	Continued From page 3 (as R21 allows) brush all sides of teeth and to pay special attention to R21's gum line. On 1/8/14, at 3:15 p.m. registered nurse (RN)-D stated both a toothbrush and toothpaste should have been readily available in R21's room for use with oral care. RN-D confirmed the care plan was not followed for R21 for oral care. R45 was not provided with nail care as directed by the care plan. A computer-generated Diagnosis Report dated 1/9/14, indicated R45's diagnoses included hemiplegia and diabetes type 2. On 1/8/14, at 9:05 a.m. R45 was observed in the facility lobby area seated in a chair. Many of R45's finger nails on both hands were observed to be long, jagged, and to contain dark-colored matter under their finger nail tips. At 10:15 a.m. NA-A stated R45 was very resistive to cares, however NA-A stated they were able to talk R45 into a shower "the other day" due to severe body odor. NA-A stated nail care was not done by the NA's for diabetic residents. R45's Care Plan revised 7/30/13, directed assistance of one staff with all personal hygiene activities and directed the nurse to provide nail care. On 1/8/14, at 10:30 a.m. licensed practical nurse (LPN)-A stated R45 went to podiatry for toe nail/foot care. LPN-A further stated she had never done finger nail care for R45. On 1/8/14, at 3:00 p.m. RN-D stated the nurses should provide R45 with finger nail care and	2 565		

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2 565	Continued From page 4 document the offer and/or refusal in the progress notes. RN-D confirmed the lack of documentation on nail care. R12 was not provided with oral care as directed by the care plan. A computer generated Diagnosis Report dated 1/9/14, indicated R12's diagnoses included bipolar disorder, dementia and osteoarthritis. On 1/9/14, at 10:15 a.m. NA-D stated R12's oral cares had already been provided that am. NA-D stated she had used a pink toothette to clean R12's teeth. Upon observation of R12's bedside table, NA-D was able to locate a toothbrush along with a small tube of Colgate toothpaste. NA-D stated R12 resisted use of a toothbrush in the mouth. An Order Summary Report dated and signed 12/3/13, indicated R12 was to receive Prevident 5000 Plus (Sodium Fluoride Dental) cream 1.1% twice daily with toothbrush for cavity prevention. R12's Care Plan revised 8/23/12, directed assistance of one staff with all grooming tasks and to use Prevident 5000 plus with a toothbrush twice daily. On 1/9/14, at 10:30 a.m. RN-C stated R12's Prevident tooth cream and treatment would not be specified on the care guide for the NA's. RN-C stated since the Prevident was a prescription item, the NA's would have to obtain the tooth cream from the unit nurse from the treatment cart to use with R12's toothbrush. On 1/9/14, at 10:47 a.m. with RN-A present, an observation of the 2 South treatment and	2 565		

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2 565	Continued From page 5 medication carts revealed no evidence of the Prevident tooth cream. RN-A stated the NA's would get the tooth cream from the nurse and return it to the nurse when the oral care was completed. RN-A further stated she was not sure where the tooth cream was located or how long it had been missing from the medication cart. On 1/9/14, at approximately 2:00 p.m. RN-C stated he was not aware R12's tooth cream supply had run out.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	R 01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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{F 000}	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 242} SS=D	Census 123 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to honor the choice of bathing type and/or frequency for 2 of 3 residents (R21, R80) reviewed for choices. Findings include: R80 was not provided with the requested number of baths per week.	{F 242}	The facility will ensure residents have choice with activities, schedules, and health care. R80's bath schedule was reviewed and changed according to R80's preference effective 1/9/14. R80's care plan was updated and is current reflecting R80's bathing schedule preferences. R21's bath schedule was reviewed and changed according to R21's preference effective 1/9/14.	2/11/14

Accepted 2/7/14 Glenn Dutton

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Campus Administrator — (X6) DATE: 2/5/14

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 242}	Continued From page 1 A computer-generated Diagnosis Report dated 1/9/14, indicated R80's diagnoses included hemiplegia and multiple sclerosis. R80's quarterly Minimum Data Set (MDS) dated 1/1/14, indicated R80 had a Brief Interview for Mental Status (BIMS-tool used to measure cognitive status) score of 12 and moderate cognitive impairment, required set up assistance for personal hygiene activities, and required physical help in part of bathing activities. R80's Care Plan revised 4/15/10, directed staff to physically prepare bath, adjust water temperature, provide assist of one staff in/out of tub/shower, and provide assist of one staff to wash/dry R80's entire body. A Bath Schedule dated 12/30/13, was observed to be posted on a bulletin board at the first floor nurses station. The form indicated R80 was scheduled for a bath during the day shift on Tuesday with "please give shower early" typed on the Tuesday block, and on the Thursday and Saturday day shift blocks. On 1/8/14, at 2:10 p.m. R80 stated only one tub bath per week was being provided. R80 stated they used to have a frequent bathing schedule in the past and stated staff did not have time for any more than one tub bath per week. R80 stated they had lived at the facility a "long time"and it really did not matter any more and R80 had just become "used to" one bath per week. R80 further stated an early morning bath was preferred as R80 slept poorly at night and was an early riser. Although R80 stated staff had offered a bath later in the day, R80 stated later did not work, as R80 had to get undressed then re-dressed after the	{F 242}	R21's care plan was updated and is current. All nursing employees were educated on 1/29/14 about honoring and documenting resident choices. Audits will be conducted by nurse managers with oversight by the director of nursing for 2 months or until ongoing compliance is achieved.	

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{F 242}	Continued From page 2 later bath was completed. On 1/8/14, at 2:30 p.m. registered nurse (RN)-C stated if R80 had been refusing baths, the refusal should be documented in the nurses notes. RN-C further stated R80 was just getting one bath per week on Tuesday morning. RN-C stated R80 could not agree to a time or day for the requested three times per week. Review of the electronic nurses progress notes for R80 revealed a bath/skin check was performed on 12/24/13, and on 1/7/14. The progress notes lacked documentation R80 had refused the other two scheduled baths per week and lacked documentation a bath/skin check was performed on 12/31/13. On 1/8/14, at 4:00 p.m. RN-C confirmed R80's medical record lacked documentation of the declined bath times/days offered and staff did not inform him R80 was refusing the other two scheduled baths per week. RN-C stated R80 did receive a bath on 12/31/13, along with a weekly skin check, but the nurse forgot to chart the skin check was performed on that day. R21 was not receiving the preferred type of bath. A computer-generated Diagnosis Report dated 1/9/14, indicated R21's diagnoses included hemiplegia, aphasia and vascular dementia with delusions. R21's quarterly MDS dated 12/24/13, indicated R21 had short and long-term memory deficits, moderately impairment decision making skills, inattention and psychomotor retardation behaviors. The MDS indicated R21 displayed no	{F 242}		

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{F 242}	Continued From page 3 rejection of care, required extensive assistance with all activities of daily living (ADL's) including personal hygiene activities, and was totally dependent with bathing. R21's annual MDS dated 9/24/13, indicated R21 preferred a tub bath. R21's Care Plan revised 12/18/13, directed staff to physically prepare bath, adjust water temperature, two staff to transfer R21 in and out of tub/shower, and one staff to wash and dry R21's entire body with assistance of two staff as needed. An electronic Progress Note labeled late entry dated 12/31/13, indicated a care conference was held for R21. The Progress Note identified R21 preferred a shower. A Bath Schedule dated 1/7/14, was observed to be located in a 3-ring binder book on the 3 South unit. The form indicated R21 was to receive a bath on Tuesday day shift. On 1/8/14, at 10:00 a.m. NA-A stated R21 was not getting in the tub for the weekly bath, but was being provided with a full bed bath. NA-A stated R21 was too resistive to be bathed either in the shower or the bath tub; NA-A stated R21 was more cooperative with a bed bath. On 1/8/14, at 3:15 p.m. RN-D stated R21 pointed to "shower" as choice of bath type to be provided. RN-D further stated she was not aware R21 was being provided with a weekly bed bath. RN-D confirmed the written note she provided to R21 to select the bath type only contained a shower or tub bath as choices and did not contain bed bath as a choice.	{F 242}		

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{F 242}	Continued From page 4 The faciliy's Your Right Under The Combined Federal And Minnesota Bill Of Rights booklet dated 7/2007, was not updated, and contained the statement, "5. You have the right to reside and receive services in the facility with reasonable accommodations of your needs and preferences..."	{F 242}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: On 1/8/14, at 3:00 p.m. RN-D stated the nurses should provide R45 with finger nail care and documented the offer and/or refusal in the progress notes. RN-D confirmed the lack of documentation on nail care. R12 was not provided with oral care as directed by the care plan. A computer generated Diagnosis Report dated 1/9/14, indicated R12's diagnoses included bipolar disorder, dementia and osteoarthritis. On 1/9/14, at 10:15 a.m. NA-D stated R12's oral cares had already been provided that am. NA-D stated she had used a pink toothette to clean R12's teeth. Upon observation of R12's bedside table, NA-D was able to locate a toothbrush along with a small tube of Colgate toothpaste. NA-D stated R12 resisted use of a toothbrush in the	{F 282}	The facility will ensure that services will be provided by a qualified person in accordance with each resident's plan of care. R45's nail care is provided in accordance with current care plan. R12's oral care is provided in accordance with current care plan. All nursing employees were educated on providing proper nail and oral care consistent with resident plan of care as well as proper documentation on 1/29/14.	2/11/14

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{F 282}	Continued From page 5 mouth. An Order Summary Report dated and signed 12/3/13, indicated R12 was to receive PreviDent 5000 Plus (Sodium Fluoride Dental) cream 1.1% twice daily with toothbrush for cavity prevention. R12's Care Plan revised 8/23/12, directed assistance of one staff with all grooming tasks and to use PreviDent 5000 plus with a toothbrush twice daily. On 1/9/14, at 10:30 a.m. RN-C stated R12's PreviDent tooth cream and treatment would not be specified on the care guide for the NA's. RN-C stated since the PreviDent was a prescription item, the NA's would have to obtain the tooth cream from the unit nurse from the treatment cart to use with R12's toothbrush. On 1/9/14, at 10:47 a.m. with RN-A present, an observation of the 2 South treatment and medication carts revealed no evidence of the PreviDent tooth cream. RN-A stated the NA's would get the tooth cream from the nurse and return it to the nurse when the oral care was completed. RN-A further stated she was not sure where the tooth cream was located or how long it had been missing from the medication cart. On 1/9/14, at approximately 2:00 p.m. RN-C stated he was not aware R12's tooth cream supply had run out.	{F 282}	Care plan audits will be conducted by nurse management with oversight by the director of nursing for 3 months or until ongoing compliance is achieved.	
{F 311} SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	{F 311}		

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{F 311}	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the plan of care for 3 of 4 residents (R21, R12, R45) reviewed for activities of daily living (ADLs). Findings include: R21's care plan for dental health was not followed. A computer-generated Diagnosis Report dated 1/9/14, indicated R21's diagnoses included hemiplegia, aphasia, and vascular dementia with delusions. On 1/8/14, at 10:00 a.m. nursing assistant (NA)-A stated oral care had already been completed R21's oral care using toothbrush and toothpaste. NA-A further stated R21 did not wear dentures and would sometimes resist cares. NA-A went on to state he would re-approach R21 if cares were refused. At 10:15 a.m. NA-A entered R21's room and opened the top drawer in R21's bedside table. The drawer was observed to contain many papers and other articles. NA-A located R21's toothbrush, but was unable to locate any toothpaste. NA-A demonstrated how NA-A would brush R21's natural teeth. During the observation, R21 would not open their mouth for viewing. NA-A recanted his earlier statement and stated he did not use either the toothbrush or any toothpaste for R21's oral care earlier. R21 stated he instead used toothettes for oral care and denied knowing where R21's toothpaste was located.	{F 311}	The facility will ensure that residents are provided appropriate treatment and services to maintain or improve his or her abilities. R21's care plan was updated and is current. R21's oral care is being provided in accordance with R21's plan of care. R45's care plan was updated and is current. R45's nail care is being provided in accordance with R45's plan of care. R12's care plan was updated and is current. R12's care is being provided in accordance with R12's plan of care. All nursing employees were educated on providing care that maintains or improves residents abilities on 1/29/14	2/11/14

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{F 311}	Continued From page 7 R21's Care Plan revised 12/18/13, directed staff to assist with brushing R21's natural teeth for three minutes using a soft toothbrush and fluoride toothpaste. The care plan directed to twice daily (as R21 allows) brush all sides of teeth and to pay special attention to R21's gum line. On 1/8/14, at 3:15 p.m. registered nurse (RN)-D stated both a toothbrush and toothpaste should have been readily available in R21's room for use with oral care. RN-D confirmed the care plan was not followed for R21 for oral care. R45 was not provided with nail care as directed by the care plan. A computer-generated Diagnosis Report dated 1/9/14, indicated R45's diagnoses included hemiplegia and diabetes type 2. On 1/8/14, at 9:05 a.m. R45 was observed in the facility lobby area seated in a chair. Many of R45's finger nails on both hands were observed to be long, jagged, and to contain dark-colored matter under their finger nail tips. At 10:15 a.m. NA-A stated R45 was very resistive to cares, however NA-A stated they were able to talk R45 into a shower "the other day" due to severe body odor. NA-A stated nail care was not done by the NA's for diabetic residents. R45's Care Plan revised 7/30/13, directed assistance of one staff with all personal hygiene activities and directed the nurse to provide nail care. On 1/8/14, at 10:30 a.m. licensed practical nurse (LPN)-A stated R45 went to podiatry for toe	{F 311}	Audits will be conducted by nurse management with oversight by the director of nursing for 3 months or until ongoing compliance is achieved.	

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{F 311}	Continued From page 8 nail/foot care. LPN-A further stated she had never done finger nail care for R45. Based on observation, interview, and document review, the facility failed to provide nail care for 1 of 3 residents (R45) reviewed for activities of daily living (ADLs). Findings include: A computer-generated Diagnosis Report dated 1/9/14, indicated R45's diagnoses included hemiplegia and diabetes type 2. R45's quarterly Minimum Data Set (MDS) dated 10/23/13, indicated R45 had moderate cognitive impairment, was independent in personal hygiene and required set up help for bathing. R45's Care Plan revised 7/30/13, directed assistance of one staff with all personal hygiene activities and directed the nurse to provide nail care. On 1/8/14, at 9:05 a.m. R45 was observed to be in the facility lobby area seated in a chair. Many of R45's finger nails on both hands were observed to be long, jagged, and to contain dark-colored matter under the finger nail tips. On 1/8/14, at 10:15 a.m. nursing assistant (NA)-A stated R45 was very resistive to cares. NA-A stated they were able to talk R45 into a shower the other day due to severe body odor. NA-A stated nail care was not done by the NA's for diabetic residents. On 1/8/14, at 10:30 a.m. licensed practical nurse (LPN)-A stated R45 went to podiatry for toe	{F 311}		

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{F 311}	Continued From page 9 nail/foot care. LPN-A further stated she had never done finger nail care for R45. On 1/8/14, at 3:00 p.m. RN-D stated R45 had refused a shower on 1/6/14, but took a shower with minimal assistance on 1/7/14. RN-D stated the nurses should have provided R45 with finger nail care and documented the offer and/or refusal in the progress notes. RN-D confirmed the lack of documentation on nail care. On 1/9/14, at 1:35 p.m. RN-D reported R45 allowed the nurse to provide finger nail care yesterday. At 2:22 p.m. R45's fingernails were observed to be trimmed neat and clean. R45 stated the nails felt okay. A Care of Nails Policy dated 1/2009, not revised since original survey; directed fingernails of diabetic residents were to be cut by the nurse.	{F 311}		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with oral care as ordered, assessed and directed by the care plan for 2 of 4 residents (R21, R12) reviewed for activities of daily living (ADLs).	F 312	The facility will ensure that residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R21's oral care is being provided in accordance with R21's updated care plan.	2/11/14

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F 312	Continued From page 10 Findings include: R21 was not provided assistance with oral cares on the morning of 1/8/14. On 1/8/14, at 10:00 a.m. nursing assistant (NA)-A stated oral care had already been completed R21's oral care using toothbrush and toothpaste. NA-A further stated R21 did not wear dentures and would sometimes resist cares. NA-A went on to state he would re-approach R21 if cares were refused. At 10:15 a.m. NA-A entered R21's room and opened the top drawer in R21's bedside table. The drawer was observed to contain many papers and other articles. NA-A located R21's toothbrush, but was unable to locate any toothpaste. NA-A demonstrated how NA-A would brush R21's natural teeth. During the observation, R21 would not open their mouth for viewing. NA-A recanted his earlier statement and stated he did not use either the toothbrush or any toothpaste for R21's oral care earlier. R21 stated he instead used toothettes for oral care and denied knowing where R21's toothpaste was located. A computer-generated Diagnosis Report dated 1/9/14, indicated R21's diagnoses included hemiplegia, aphasia, and vascular dementia with delusions. R21's quarterly Minimum Data Set (MDS) dated 12/24/13, indicated R21 had short and long-term memory deficits, moderate impaired daily decision making skills, inattention and psychomotor retardation behaviors. The MDS further indicated R21 displayed no rejection of care and required extensive assistance with all ADL's and personal hygiene activities. R21's annual MDS dated 9/24/13, indicated R21 had	F 312	R12's oral care is being provided in accordance with R12's updated care plan. R12's order summary was updated to reflect discontinued use of PreviDent 5000 reflecting R12's choice through R12's responsible party effective 1/10/14. All nursing employees were educated ab providing proper oral care and the importance of accurate documentation on 1/29/14. Audits will be conducted by nurse management with oversight by the director of nursing for 3 months or until ongoing compliance is achieved.	

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F 312	Continued From page 11 obvious or likely cavity or broken natural teeth. The ADL Care Area Assessment (CAA) dated 9/18/13, identified R21 required staff assistance with ADLs including grooming. Although the CAA identified pertinent mouth information such as R21 having a "lower lip that protrudes with thick tongue that hangs over, drools frequently" and R21's behavioral concerns, the CAA did not identify oral/dental care needs. R21's Care Plan revised 12/18/13, directed staff to assist with brushing R21's natural teeth for three minutes using a soft toothbrush and fluoride toothpaste. The care plan directed to twice daily (as R21 allows) brush all sides of teeth and to pay special attention to R21's gum line. On 1/8/14, at 3:15 p.m. registered nurse (RN)-D stated both a toothbrush and toothpaste should have been readily available in R21's room for use with oral care. RN-D confirmed the care plan was not followed for R21 for oral care. R12 was not provided assistance to complete oral care as ordered. A computer generated Diagnosis Report dated 1/9/14, indicated R12's diagnoses included bipolar disorder, dementia and osteoarthritis. R12's quarterly MDS dated 11/27/13, indicated R12 had short and long-term memory deficits, had moderately impaired daily decision making skills, behaviors of inattention, and required extensive assistance with personal hygiene. R12's Care Plan revised 8/23/12, directed assistance of one staff with all grooming tasks	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	R 01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

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F 312	Continued From page 12 and to use PreviDent 5000 plus with a toothbrush twice daily. An Order Summary Report dated and signed 12/3/13, indicated R12 was to receive PreviDent 5000 Plus (Sodium Fluoride Dental) cream 1.1% twice daily with toothbrush for cavity prevention. A computer-generated Treatment Administration Record (TAR) dated 1/9/14, indicated R12 had received the PreviDent tooth cream twice daily from 12/1/13, to 1/9/14; with one afternoon treatment and four evening treatments not signed as provided. On 1/9/14, at 10:15 a.m. NA-D stated R12's oral cares had already been provided that am. NA-D stated she had used a pink toothette to clean R12's teeth. Upon observation of R12's bedside table, NA-D was able to locate a toothbrush along with a small tube of Colgate toothpaste. NA-D stated R12 resisted use of a toothbrush in the mouth. NA-D further stated she was not aware R12 had special toothpaste to use. On 1/9/14, at 10:30 a.m. RN-C stated R12's PreviDent tooth cream and treatment would not be specified on the care guide for the NA's. RN-C stated since the PreviDent was a prescription item, the NA's would have to obtain the tooth cream from the unit nurse from the treatment cart to use with R12's toothbrush. On 1/9/14, at 10:47 a.m. with RN-A present, an observation of the 2 South treatment and medication carts revealed no evidence of the PreviDent tooth cream. RN-A stated the NA's would get the tooth cream from the nurse and return it to the nurse when the oral care was	F 312		

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 312	Continued From page 13 completed. RN-A further stated she was not sure where the tooth cream was located or how long it had been missing from the medication cart. On 1/9/14, at approximately 2:00 p.m. RN-C stated R12's PreviDent tooth cream was expensive and required a pre-authorization for R12's insurance to pay for a refill. RN-C further stated he was not aware R12's tooth cream supply had run out. An Oral Hygiene policy dated 1/2009, not revised since the original survey, directed staff to offer oral hygiene before breakfast, and at bedtime or per assignment sheet.	F 312		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	R 01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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{3 000}	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME 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: On 1/6/14, through 1/9/14, a surveyor of this Department's staff completed a revisit for the survey exited on 12/5/13, for the above provider and the following correction orders are not corrected: (3 975, 3 1810). These uncorrected orders will remain in effect from the original	{3 000}	DRAFT	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8019

January 31, 2014

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

Re: Project Number - S5587023

Dear Mr. Prevost:

On January 9, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 5, 2013 with orders received by you on December 21, 2013.

State licensing orders issued pursuant to the last survey completed on December 5, 2013 and found corrected at the time of the January 9, 2014 revisit, are listed on the attached Revisit Report Form.

Also, at the time of the reinspection completed on January 9, 2014 additional violations were cited as follows:

- **20565 -- S/S: -- MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use**

They are delineated on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, when all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Po Box 64900 St Paul Mn 55164-0900. 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.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Gloria Derfus, Metro Team C Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

CCN-245587

At the time of the standard survey completed December 5, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required.

See attached Fire Safety Evaluation System (FSES) dated December 19, 2013 for Life Safety Code results.

In addition, at the time of the December 10, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5587036 that was found to be unsubstantiated. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7079

December 17, 2013

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5587023 and H5587036

Dear Mr. Prevost:

On December 10, 2013, 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. In addition, at the time of the December 10, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5587036.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 10, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5587036 that was found to be unsubstantiated.

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>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;

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
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 January 14, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 14, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 March 5, 2014 (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 June 5, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 standard recertification survey and complaint investigation were conducted. Complaint H5587036 was not substantiated.	F 000	Submission of this credible allegation of compliance is not a legal admission that a deficiency exist or that the statement of deficiency was correctly cited, and is also not to be construed as an admission against the interest of the facility, its administrator or any employees, agents or other individuals who draft or may be discussed in this credible allegation of compliance. In addition, preparation and submission of this credible allegation of compliance does not constitute and admission or agreement of any kind by this facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident preferences was accommodated for bathing for 1 of 3 residents (R80) reviewed for choices in daily routine. Findings include:	F 242	The facility will ensure residents have the right to choose activities, schedules and health care consistent with his or her interests, assessments and plans of care and make choices about aspects of his or her life in the facility that are significant to the resident. R80's preference was reviewed and fulfilled on 12/5/13. All nurse management was educated on 12/5/13 the importance of providing choices for ADL's including their preference for frequency of bathing.	12/30/13 12/30/13

Accepted 12-31-13 Laura Dunn

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Campus Administrator — (X6) DATE: 12/30/13

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.

Received 12-30-13 Via Email

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F 242	Continued From page 1 R80's preference for having more than one shower in a week was not accommodated. During interview with R80 on 12/3/13, at 12:45 p.m. R80 stated " I want a bath at least daily but would compromise with three times weekly." R80 further commented the staff would not probably do it or do anything as she had made statements in the past to staff about wanting to be bathed more often and nothing had been done. R80 further stated her preference was to take a bath daily as she used to do so previously through her life prior coming to the facility when she lived in Florida. On 12/5/13, at 12:00 p.m. during an interview, R80 stated "I feel dirty with the one shower. I figured if they were to give me more they would just do it. I have been here so long that you would think they will get it right or ask." R80's diagnoses included cerebrovascular disease, hemiplegia affecting dominate side due to cerebrovascular disease (CVD), multiple sclerosis (MS), unspecified peripheral vascular disease, and generalized pain obtained from the quarterly Minimum Data Set (MDS) dated 9/25/13. R80's annual MDS dated 3/25/13, and two following quarterly MDS's indicated R80's Brief Interview for Mental Status (BIMS-tool used to measure cognition) was intact with a score of 15 out of the possible 15. The quarterly MDS dated 9/25/13, indicated R80 needed physical help in part with bathing needs. The Preference for Customary Routine section of the MDS was blank in the activities of daily living (ADL's) section of the previous two annual MDS's dated 3/35/12,	F 242	All resident's preferences are being updated at their next scheduled care conferences and all licensed nurses were educated on the importance to honor residents wishes with respect to scheduling plans of care including bathing effective 12/19. All nursing assistants were educated for the same on 12/30/13 Nurse managers will administer audits for 3 months or until ongoing compliance is achieved with oversight by the Director of Nursing.	

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 242	Continued From page 2 and 3/25/13. The ADL care plan dated 4/15/10, identified R80 with a self-care deficit related to right side hemiplegia, right shoulder fracture 4/23/08. Goal "will be clean, odor free and appropriately dressed and groomed daily." The care plan directed staff to physically prepare bath, adjust water temperature, assist of one in/out of tub/shower and assist of one to wash/dry entire body. The ADL Care Area Assessment (CAA) dated 3/27/13, indicated R80 required assistance of one staff with bathing. On 12/5/13, at 12:47 p.m. during an interview the MDS RN-D stated the nurse manager's is responsible to oversee what days a resident would be scheduled to get a shower/bath. If a resident needed more showers the manager would re-arrange to help with the floor work flow to accommodate the resident needs. RN-D further stated the facility does not have a tool or assessment that would actually ask how many baths/shower a resident would prefer and only had the MDS portion and verified that the ADL portion in the last two annuals had not be completed by the nurse manager. RN-D verified R80 was receiving a bath once a week and on Tuesday. On 12/5/13, at 2:14 p.m. the director of nursing (DON) stated resident preferences should have been asked with the annual MDS and that R80 was currently being interviewed on the number of showers by the manager and would be accommodated. The facility Your Right Under The Combined Federal And Minnesota Residents Bill Of Rights	F 242		

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 242	Continued From page 3 booklet dated July 2007, "5. You have the right to reside and receive services in the facility with reasonable accommodations of your needs and preferences ... "	F 242		
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 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 observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 3 residents (R45) reviewed for oral health care. Findings include:	F 279	The facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. R45's care plan is updated and is current. R45 was provided a toothbrush and toothpaste on 12/4/13. All licensed nurses were educated on the importance of oral care and following the facility policy for proper oral care effective 12/19. All nursing assistants were educated for the same effective 12/30. Audits by nurse management of resident care plans will continue for 3 months or until ongoing compliance is achieved with oversight by the director of nursing.	12/30/13

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 279	Continued From page 4 The care plan lacked direction for R45's oral care. Observation on 12/3/13, at 8:53 a.m. revealed R45's teeth were yellow and contained food particles. When interviewed at that time R45 stated that he had not brushed his teeth since he had been there (six months). He said he was never offered a toothbrush or toothpaste and never asked for one. He also stated cleans his teeth with his fingers once in a while. R45 stated he had especially good teeth with only one cavity in his whole life. Observation of R45's room on 12/4/13, at 1:15 p.m. revealed there was no toothbrush or toothpaste in the room. Registered nurse (RN)-A looked in the pink basin which was empty, there was a hairbrush in the room. RN-A looked in R45's drawers and confirmed that there was no toothpaste or toothbrush in R45's room. RN-A confirmed oral care was important to an individual's overall health. She would be sure to get him a toothbrush and toothpaste right away. RN-A also said R45 had been non-compliant with showers in the past. The plan of care dated 10/8/13, indicated R45 had problems with activity of daily living (ADLs) related to self-care deficit from weakness, stroke with right sided hemiparesis (partial paralysis), and cognitive deficits. Interventions include assist of one with personal hygiene, showers, dressing, and to remind to do am/pm cares. The care plan lacked direction with regards to oral hygiene. The care plan also listed R45 as impulsive and easily frustrated. The care plan also included cognitive problems related to short and long term memory loss with intervention of to give	F 279		

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F 279	Continued From page 5 reminders to maintain appropriate function. The nurse's assistant assignment chart undated, directed staff that R45 required assist of one with dressing, oral care as needed, prompt and cue. When interviewed on 12/4/13, at 7:30 a.m. nursing assistant (NA)-B said R45 was independent with grooming and oral hygiene but did require reminders. When interviewed on 12/4/13, at 1:00 p.m. RN-A said the residents are given a bag of personal items including toothbrushes and toothpaste on admission. When interviewed on 12/5/13, at 1:00 p.m. the director of nursing (DON) said it was expected that residents receive assistance with oral hygiene needs. When asked how the facility ensured that residents have toothbrushes and toothpaste, she said room checks would need to be done on that resident to ensure he had the supplies he needed. The DON confirmed the care plan lacked oral hygiene care. The facility policy titled, Oral Hygiene, dated January 2009, instructed staff to offer oral hygiene before breakfast and at bedtime or per assignment sheet.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 2 of 3 residents (R19, R21) reviewed for activities of daily living. Findings include: R19 did not receive dental care as directed in the care plan. Observation on 12/2/13, at 4:40 p.m. revealed R19 had several teeth on the lower jaw that were loose and decayed. When interviewed on 12/2/13, at 4:55 p.m. R19 was asked if he had any problems with his mouth. R19 replied that he had several teeth on the lower jaw that need extraction. He also said he sometimes had trouble eating. R19 said, "I need to get those rotten teeth out." Observation on 12/4/13, at 7:59 a.m. R19 was at breakfast and with a facial expression of sadness, was frowning, ate the soft oatmeal cereal and half the toast and hardboiled egg. After breakfast staff assisted R19 back to room. Oral care was not offered. - At 1:30 p.m. registered nurse (RN)-A asked R19 if he was OK and he replied yes and he denied pain at that time. - At 2:00 p.m. revealed the resident was in dining room, no complaints of pain. Observation on 12/5/13, at 10:00 a.m. the resident was in the room in bed resting. When asked if he had any mouth pain at that time he said no but wants to get to the Veteran's	F 282	The facility will provide services by qualified persons in accordance with each residents written plan of care. R19's care plan is updated and is current. With coordination of the attending NP and dentist, a plan is in place for additional visit(s) to the dentist per NP recommendations. The facility continues to maintain R19's daily oral care and monitor/ treat pain as necessary. R21's nails were cleaned and effective 12/4/13. R21's care plan is updated and current. All licensed staff were educated about checking for referral returns from dentists and proper resident hygiene effective 12/19/13. Audits for dental referrals and resident hygiene began 12/16/13 and will continue for 3 months or until ongoing compliance is achieved with oversight by the director of nursing.	12/30/13

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F 282	Continued From page 7 Administration (VA) as they know him there. A doctor's order dated 4/17/13, included 2% Lidocaine solution (a topical anesthetic) 15cc to effected teeth/gums every four hours as needed. The doctor's orders dated 8/27/13, included: Brush teeth after meals, put toothpaste on lower tooth bid (twice daily) and PRN (as needed) for mouth pain. The admission Minimum Data Set (MDS) assessment dated 4/18/13, indicated R19 was admitted with obvious or likely cavity or broken natural teeth. The Care Area Assessment (CAA) date 4/18/13, noted R19 triggered for dental care due to having poor dentition. Staff was to arrange dental visits as needed. The residents plan of care dated, 10/10/13, listed self-care deficit related to cognitive impairment, has own teeth but has poor dentition and some missing teeth. Interventions included staff to assist of one with oral cares twice daily and dental services as needed. A care conference note dated 10/31/13, indicated R19 received Tylenol daily for pain and had not received PRN Tylenol recently. A progress note dated 11/3/13, by the residents medical doctor (MD) noted resident was quiet, fairly glum, complaining of teeth bothering him. Has had multiple dental visits and the problem had persisted. The MD impression was "pain in a tooth or teeth (primary encounter diagnosis) seems intractable without cause found despite extensive work up." The plan was to continue scheduled Tylenol (a mild analgesic) and oral Lidocaine solution.	F 282		

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F 282	Continued From page 8 A weekly pain assessment dated 11/16/13, noted R19 was assessed to have no pain. The PRN medication usage was reviewed in the medication administration record for December 2013. R19 had not received the PRN Tylenol or the PRN Lidocaine in December of 2013. RN-B also said R19 has not asked for the topical Lidocaine and said they used that more in the first months of admit over last summer. When requested, no documentation of a dental visit was found in the medical record. When interviewed on 12/4/13, at 9:00 a.m. nursing assistant (NA)-A said that R19 did complain of mouth pain occasionally. She also said the aides set up his toothbrush for him and he brushes himself. When interviewed on 12/4/13, at 10:55 a.m. family member (F)-A stated that he had taken his dad to the dentist with in the last six months. The dentist extracted two teeth at that time. FM-A said the direction for follow up was that he was supposed to return if he had any further problems. FM-A did say that he was aware that R19 still complained of occasional mild mouth pain and thought it was more related to dementia. When interviewed on 12/4/13, at 11:14 a.m. RN-B stated that R19 received Tylenol three times daily. There was also an order for additional Tylenol if needed. When interviewed on 12/4/13, at 11:31 a.m. the RN-A said that R19's son had taken him to the dentist sometime around date of admission. RN-A	F 282		

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F 282	Continued From page 9 was unable to find any documentation related to the dental visit. RN-A said, "I am betting the health unit coordinator did not set up those appointments, the son did. We likely sent a referral and it's always a fifty-fifty chance of getting information back. I know he has been out to the dentist, why we don't have any paperwork on it I don't know." When interviewed on 12/4/13, at 2:50 p.m. R19's nurse practitioner (NP) said," I would I like to see him get those rotten teeth pulled, yes." The NP went on to explain that the family had taken R19 to the dentist sometime around admission to the facility and that there was some dysfunction within the family dynamics. The NP and RN-A agreed it would be a good idea to contact the dentist and have them fax over recommendations for R19 in regards to his dental/oral health. The NP confirmed R19 had intermittent mild mouth pain. The NP confirmed R19 was on scheduled Tylenol and R19 had not been used the PRN topical Lidocaine but had used the PRN Tylenol once in the recent past. The NP saw resident on 12/4/13, in the afternoon. A progress note dated same indicated the goal for R19 was comfort care and that the family had inner turmoil. The family power of attorney was highly focused on saving money. The resident was assessed by the NP as having chronic intermittent mild mouth pain, repetitive in nature, and much better than when admitted. R19's dental pain was unchanged by dental visits per son. Not medically opposed to dental follow up for resident, addressed in past with them, family seemed to need break, suspect some caregiver fatigue. He needed family to escort, preferable to senior dentistry.	F 282		

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F 282	Continued From page 10 When interviewed on 12/5/13, at 2:00 p.m. RN-A said she had contacted the dentist and was informed that the resident had two extractions at the last visit. RN-A also said the dentist had indicated to her that R19 would not be treated by them in the future due to resident agitation at the last appointment. RN-A said she would call senior dentistry to obtain an appointment for R19. The facility policy titled, Dental Policy, dated October 2011, indicated that it was the facility policy to assist the residents in maintaining and achieving dental health. The purpose of the policy was to ensure residents maintain and achieve the best possible dental health. R21 was not provided assistance with nail care. R21 was observed to have long, soiled fingernails during the evening on 12/2/13, and during subsequent days of the survey 12/3/13, and 12/4/13. On 12/2/13, at 3:15 p.m. R21 was observed lying on the bed and was observed to have approximately a half (1/2) inch long, jagged and soiled nails to both hands with dark brown/black matter underneath them. On 12/3/13, 10:08 a.m. R21's nails were observed still long and untrimmed to both hands and soiled R21 was in his room lying on his bed. On 12/3/13, at 3:55 p.m. observed R21 lying in bed with head of bed elevated at 60 degrees RN-G observed administering resident medications in pudding. After she completed administering medications wipe R21's mouth but	F 282		

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F 282	Continued From page 11 never offered to trim R21's nails. On 12/4/13, at 7:22 a.m. observed R21 lying in bed all dressed and NA-C stated he had just completed providing morning cares. NA-C explained to surveyor all the cares he had assisted R21 with and that R21 was mostly resistive but would allow staff at times to do the cares to a certain extent. NA-C further stated he would attempt to shave R21 after breakfast. R21 still observed to have long uneven jagged soiled nails to both hands. On 12/4/13, at 8:34 a.m. observed R21 at the dining room RN-F sitting next to him feeding him never offered to remove R21's long nails after breakfast On 12/4/13, at 9:32 a.m. during random observations R21 lying in his bed with nails still uneven, jagged edged and soiled. -At 2:30 p.m. observed R21 lying in bed awake watching TV R21 able to nod to yes and no cues. Nails remain soiled jagged and uneven. The ADL care plan dated 12/19/12, identified R21had self-care deficit in ADL's related to stroke, hemiplegia, and muscle spasm. The care plan also identified R21 can be resistive with cares also. Care plan goal "Will be appropriately dressed with physical assist of staff." Care plan directed staff to provide R21 with physical assist of staff to do nail care after bath and PRN. The NA assignment sheets for all three shifts undated, directed R21 required total assistance with ADL's. The annual MDS dated 9/17/13, identified R21 required extensive to total physical assist of one to two staff with all ADLs including personal	F 282		

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F 282	Continued From page 12 hygiene. The ADL Functional/Rehabilitation CAA dated 9/18/13, indicated R21 had a self-care deficit and required staff assistance for dressing, undressing, grooming, bathing and toileting. During document review of the Skin/Bath Flow Sheet and Weekly Bath Skin and Pain Sheet from 5/14/13, through 11/26/13, nail care had been documented as completed once on 7/30/13, and on 6/18/13, had been documented "Refused" once. During further document review it was revealed in the Progress notes R21 had refused cares, medications and food five times between 5/6/13, through 11/26/13, with documentation specifically for refusing nail care on 10/12/13. On 12/4/13, at 2:36 p.m. interviewed the NA-C who stated he had not offered or attempt to do nail care during the shift but acknowledged the nails were soiled, uneven and jagged. NA-C further stated R21 was resistive with cares anyways. On 12/4/13, at 2:42 p.m. RN-F verified R21's nails were long, uneven and jagged then left the room and shortly came back with a clipper and a file. On 12/4/13, at 2:43 p.m. both RN-F and NA-C applied gloves and NA-C took the clipper from RN-F and started to trim R21's nails. During observation R21 allowed NA-C trim all his nails and NA-C even files the nails and was never resistive On 12/4/13, at 2:44 p.m. RN-C was interviewed he stated his expectation was R21 and all other	F 282		

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F 282	Continued From page 13 residents had to be well groomed and for residents who were resistive to cares the NA was supposed to let the nurse know for the nurse to attempt to see if resident would allow cares to be done and if not then to document the refusal. During interview on 12/4/13, at 3:11 p.m. RN-E stated her expectation was the NA's were to inform the nurse on refusal of cares and then the nurse would attempt to see if resident would allow the nurse to provide cares being a new face and if still not successful the nurse then to document on refusal and let her know. RN-E further stated refusal of cares would be communicated to the next shift to attempt cares as some residents are more familiar with other staff and would let the staff complete the cares. RN-E verified R21 received a bath on Tuesday day shift. The facility Nail-Care policy dated 1/2009, directed both fingernails and toenails for diabetic residents are to be cut by the licensed nurse and podiatrist respectively. The policy lacked information on who was responsible to complete nail care for other residents and who would oversee/check to make sure nail care was complete with resident bath per the plan of care weekly and as needed.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 311		

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F 311	Continued From page 14 Based on observation, interview and document review, the facility failed to provide assistance for 2 of 3 residents (R45, R21) reviewed for activities of daily living (ADL). Findings include: R45 had not brushed his teeth since admit, 7/13/13 (six months). Observation on 12/3/13, at 8:53 a.m. revealed R45's teeth were yellow and contained food particles. When interviewed at that time R45 stated he had not brushed his teeth since he was admitted. He said he was never offered a toothbrush or toothpaste and never asked for one. He cleaned his teeth with his fingers once in a while and said he had especially good teeth with only one cavity in his whole life. When interviewed on 12/4/13, at 7:30 a.m. nursing assistant (NA)-B said R45 was independent with grooming and oral hygiene but did require reminders. When interviewed on 12/4/13, at 1:00 p.m. nurse manager (RN)-A said residents are given a bag of personal items including toothbrushes and toothpaste upon admission. Observation of R45's room on 12/4/13, at 1:15 p.m. revealed there was no toothbrush or toothpaste in the room. RN-A looked in R45's drawers and confirmed there was no toothpaste or toothbrush in R45's room. RN-A confirmed oral care was important to an individual's overall health. She would be sure to get him a toothbrush and toothpaste right away.	F 311	The facility will ensure that all residents are given the appropriate treatment and services to maintain or improve his or her abilities specifically with respect to oral care. R45 was provided a toothbrush and toothpaste on 12/4/13. All staff were educated about oral care and the need to provide necessary assistance with each resident as described in their plan of care effective. 12/19/13 R21's nails were cleaned and effective 12/4/13. R21's care plan is updated and current. All licensed staff were educated about checking for referral returns from dentists and proper resident hygiene effective 12/19/13. Audits for dental referrals and resident hygiene began 12/16/13 and will continue for 3 months or until ongoing compliance is achieved with oversight by the director of nursing.	12/30/13

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F 311	Continued From page 15 Document review revealed that R45 was admitted to the nursing facility on 7/13/13, following a cerebral infarct (stroke) with partial paralysis. The admission Minimum Data Set (MDS) assessment dated 7/23/13, indicated R45 required supervision and one person physical assist with personal hygiene. The MDS also indicated direct care staff believed R45 was capable of increased independence in at least some ADL's. The care area assessment (CAA) worksheet dated 7/23/13, indicated that R45 triggered for ADL function due to needing supervision and assist with ADL's. The plan of care dated 10/8/13, indicated that R45 had problems with ADL's related to self-care deficit from weakness, stroke with right sided hemiparesis (partial paralysis), and cognitive deficits. Interventions include assist of one with personal hygiene, showers, dressing, and to remind to do am/pm cares. The care plan also listed R45 as impulsive and easily frustrated. The care plan also included cognitive problems related to short and long term memory loss with intervention of to give reminders to maintain appropriate function. The care plan lacked direction with regards to oral hygiene. The NA assignment chart undated directed staff that R45 required assist of one with dressing, oral care as needed, prompt and cue. When interviewed on 12/5/13, at 1:00 p.m. the director of nursing (DON) said it was expected that residents receive assistance with oral hygiene needs. When asked how the facility ensured residents have toothbrushes and toothpaste she said room checks would need to be done on that resident to ensure he had the	F 311		

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F 311	Continued From page 16 supplies he needed. The DON confirmed that the care plan lacked oral hygiene interventions. The facility policy titled, Oral Hygiene, dated January 2009, instructed staff to offer oral hygiene before breakfast and at bedtime or per assignment sheet. R21 was observed to have long, soiled fingernails during the evening on 12/2/13, and during subsequent days of the survey 12/3/13, and 12/4/13. R21's fingernails remained long, jagged and soiled. On 12/2/13, at 3:15 p.m. R21 was observed lying in his bed and was observed to have approximately a half (1/2) inch long, jagged and soiled nails to both hands with dark brown/black matter underneath them. - At 10:08 a.m. R21's nails were observed still long and untrimmed to both hands and soiled R21 was in his room lying in his bed. - At 3:55 p.m. observed R21 lying in bed with head of bed elevated at 60 degrees RN-G observed administering resident medications in pudding. After she completed administering medications wipe R21's mouth but never offered to trim R21's nails. On 12/4/13, at 7:22 a.m. observed door to room shut, knocked the door went in saw R21 lying in bed all dressed and NA-C stated he had just completed providing morning cares. NA-C explained to surveyor all the cares he had assisted R21 with and that R21 is mostly resistive but would allow staff at times to do the cares to a certain extent. NA-C further stated he would attempt to shave R21 after breakfast. R21 still observed to have long uneven jagged soiled	F 311		

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F 311	Continued From page 17 nails to both hands. - At 8:34 a.m. observed R21 at the dining room RN-F sitting next to him feeding him never offered to remove R21's nails after breakfast - At 9:32 a.m. during random observations R21 lying in his bed with nails still uneven, jagged edged and soiled. - At 2:30 p.m. observed R21 lying in bed awake watching TV R21 able to nod to yes and no cues. Nails remain soiled jagged and uneven. R21's diagnoses included cerebrovascular accident (CVA), dementia, hearing loss, contracture to elbow, seizure disorder, aphasia, and hemiplegia obtained from the annual MDS dated 9/17/13. The annual MDS dated 9/17/13, identified R21 required extensive to total physical assist of one to two staff with all ADLs including personal hygiene. The ADL Functional/Rehabilitation CAA dated 9/18/13, indicated R21 had a self-care deficit and required staff assistance for dressing, undressing, grooming, bathing and toileting. The ADL care plan dated 12/19/12, identified R21 had self-care deficit in ADL's related to CVA, Hemiplegia, and muscle spasm. The care plan also identified R21 can be resistive with cares also. Care plan goal "Will be appropriately dressed with physical assist of staff." Care plan directed to provide R21 with physical assist of staff to do nail care after bath and as needed (PRN). The NA assignment sheets undated for all three shifts directed R21 required total assistance with ADL's. During document review of the Skin/Bath Flow Sheet and Weekly Bath Skin and Pain Sheet	F 311		

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F 311	Continued From page 18 from 5/14/13, through 11/26/13, nail care had been documented as completed once on 7/30/13, and on 6/18/13, had been documented "Refused" once. During further document review it was revealed in the Progress notes R21 had refused cares, medications and food five times between 5/6/13, through 11/26/13, with documentation specifically for refusing nail care on 10/12/13. On 12/4/13, at 2:36 p.m. interviewed the NA-C who stated he had not offered or attempt to do nail care during the shift but acknowledged the nails were soiled, uneven and jagged. NA-C further stated R21 was resistive with cares. On 12/4/13, at 2:42 p.m. RN-F verified R21's nails were long, uneven and jagged then left the room and shortly came back with a clipper and a file. On 12/4/13, at 2:43 p.m. both RN-F and NA-C applied gloves and NA-C took the clipper from RN-F and started to trim R21's nails. During observation R21 allowed NA-C trim all his nails and NA-C even files the nails and was never resistive. On 12/4/13, at 2:44 p.m. RN-C was interviewed he stated his expectation was R21 and all other residents had to be well groomed and for residents who were resistive to cares the NA was supposed to let the nurse know for the nurse to attempt to see if resident would allow cares to be done and if not then to document the refusal. During interview on 12/4/13, at 3:11 p.m. RN-E stated her expectation was the NA's were to	F 311		

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F 311	Continued From page 19 inform the nurse on refusal of cares and then the nurse would attempt to see if resident would allow the nurse to provide cares being a new face and if still not successful the nurse then to document on refusal and let her know. RN-E further stated refusal of cares would be communicated to the next shift to attempt cares as some residents are more familiar with other staff and would let the staff complete the cares. RN-E verified R21 received a bath on Tuesday day shift. The facility Nail - Care policy dated 1/2009, directed both fingernails and toenails for diabetic residents are to be cut by the licensed nurse and podiatrist respectively. The policy lacked information on who was responsible to complete nail care for other residents and who would oversee/check to make sure nail care was complete with resident bath per the plan of care weekly and as needed.	F 311		
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 the juice	F 371		

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F 371	Continued From page 20 dispenser in the kitchen was stored in a sanitary manner and had the potential to affect 113 of 124 residents, families and staff that would drink juices from the machine. In addition, the facility failed to ensure outdated milk was removed from 2 of 2 nourishment refrigerators on the second floor. Findings include: On 12/3/13, at 3:55 p.m. observed three long juice dispenser hose with gun at the end of each where the juice pours from hanging over the silver divider and the guns resting inside the sink located outside the kitchen door at the back wall. The dietary aide (D)-A was observed standing at the sink washed hands on the same sink for approximately 17 seconds and the water he was rinsing his hands with was splashing and dripping over to the juice dispenser guns and entire portion of the hoses inside the sink then dried his hands -At 3:56 p.m. D-A entered the kitchen went over to the dishwashing area pulled a cart and came out of the kitchen to the dining room. On 12/3/13, at 4:00 p.m. interviewed the dietary manager (DM) stated "He knows better than that" talked to the staff not to wash hands with the juice dispensers in the sink. Then DM rinsed all three juice dispenser guns and hose contaminated with water then got a bottle of sanitizer sanitized then and placed the dispensers in three different sliver holding trays next to the juice dispenser. On 12/3/13, at 4:05 p.m. interviewed D-A stated he did not see the juice dispensers guns inside the sink when washing his hands yet the DM had. D-A further stated if he had seen them he would	F 371	The facility will (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. All dietary staff were educated how to clean juice dispenser guns and nozzles properly with the use of sanitizer and they are not to be left in the sink for any length of time effective 12/19/13. All outdated milk was discarded immediately on 12/5/13. All dietary and nursing staff were educated to discard all outdated food immediately upon discovery effective 12/19/13. Audits for proper sanitation and properly dated food will be conducted for 3 months or until ongoing compliance is achieved with oversight by the director of nursing and dietary manager.	12/30/13

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F 371	Continued From page 21 not have washed his hands there. On 12/5/13, at 3:26 p.m. DM provided surveyor with facility Supervisor's Report Of Accident report dated 12/4/13, that D-A had filed a report indicating he had burned himself from the coffee maker and had gone over to the sink to run cold water over his hand. During this time surveyor clarified with DM that this had not been what D-A had told surveyor during interview right at the time observation was made. The undated General Infection Control In The Food Service Department policy directed "Sanitary conditions will be maintained throughout the food service department in order to prevent transmission of disease. Sanitary conditions mean storing, preparing, distributing, and serving food properly to prevent foodborne illness in accordance with Federal, State, and local health department regulations." Outdated milk was observed in the 2 South and 2 North nourishment refrigerators. On 12/4/13, at 11:38 a.m. the 2 South nourishment refrigerator in the nurse's station was observed to have stored in it an open container of thickened milk. The container had one quarter of the contents remaining and the stamped use by date was 9/2/13, (should have been discarded three months prior). Registered nurse (RN)-B was present, confirmed the date and agreed it needed to be discarded immediately. RN-B added that dietary staff was supposed to go through the refrigerator daily to	F 371		

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F 371	Continued From page 22 check for outdates. The refrigerator also contained opened single use half pints of milk that were undated. RN-B stated that they re-use the unfinished opened half pints of milk at the next meal. RN-B confirmed they should have been dated when opened. On 12/5/13, at 9:16 a.m. the 2 North nourishment refrigerator in the nurse's station was observed to have stored in it an unopened half pint of one percent milk with a use by date of 10/21/13, (should have been discarded six weeks prior). The clinical nurse manager (RN)-A confirmed that the milk was old and discarded it immediately When interviewed on 12/5/13, at 9:20 a.m. RN-A indicated that the dietary staff may have been assuming that the nursing staff was checking for outdated milk. The facility policy titled, Refrigerator and Microwave Daily Cleaning Flow Sheet directed staff to thoroughly clean refrigerators every Tuesday. In bold letters it directed staff: Anything older than one week will be thrown out.	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making	F 411		

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F 411	Continued From page 23 appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were met for 1 of 3 residents (R19) reviewed for dental needs. Findings include: R19 did not receive dental care. Observation on 12/2/13, at 4:40 p.m. revealed R19 had several teeth on the lower jaw that were loose and decayed. When interviewed on 12/2/13, at 4:55 p.m. R19 was asked if he had any problems with his mouth. R19 replied that he had several teeth on the lower jaw that need extraction. He also said he sometimes had trouble eating. R19 said, "I need to get those rotten teeth out." Observation on 12/4/13, at 7:59 a.m. R19 was at breakfast and with a facial expression of sadness, was frowning, ate the soft oatmeal cereal and half the toast and hardboiled egg. After breakfast staff assisted R19 back to room. Oral care was not offered. - At 1:30 p.m. registered nurse (RN)-A asked R19 if he was OK and he replied yes and he denied pain at that time. - At 2:00 p.m. revealed the resident was in dining room, no complaints of pain.	F 411	The facility will assist residents in obtaining routine and 24-hour emergency dental care. R19's care plan is updated and is current. With coordination of the attending NP and dentist, a plan is in place for additional visit(s) to the dentist per NP recommendations. The facility continues to maintain R19's daily oral care and monitor/ treat pain as necessary. Audits will be completed for 3 months or until ongoing compliance is achieved with oversight by the director of nursing.	12/30/13

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F 411	Continued From page 24 Observation on 12/5/13, at 10:00 a.m. the resident was in the room in bed resting. When asked if he had any mouth pain at that time he said no but wants to get to the Veteran's Administration (VA) as they know him there. A doctor's order dated 4/17/13, included 2% Lidocaine solution (a topical anesthetic) 15cc to effected teeth/gums every four hours as needed. The doctor's orders dated 8/27/13, included: Brush teeth after meals, put toothpaste on lower tooth bid (twice daily) and PRN (as needed) for mouth pain. The admission Minimum Data Set (MDS) assessment dated 4/18/13, indicated that R19 was admitted with obvious or likely cavity or broken natural teeth. The Care Area Assessment (CAA) dated 4/18/13, noted R19 triggered for dental care due to having poor dentition. Staff was to arrange dental visits as needed. The residents plan of care dated, 10/10/13, listed self-care deficit related to cognitive impairment, has own teeth but has poor dentition and some missing teeth. Interventions included staff to assist of one with oral cares twice daily and dental services as needed. A care conference note dated 10/31/13, indicated R19 received Tylenol daily for pain and had not received prn Tylenol recently. A progress note dated 11/3/13, by the residents medical doctor (MD) noted resident was quiet, fairly glum, complaining of teeth bothering him. Has had multiple dental visits and the problem had persisted. The MD impression was "pain in a tooth or teeth (primary encounter diagnosis)	F 411		

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F 411	Continued From page 25 seems intractable without cause found despite extensive work up." The plan was to continue scheduled Tylenol (a mild analgesic) and oral Lidocaine solution. A weekly pain assessment dated 11/16/13, noted R19 was assessed to have no pain. The PRN medication usage was reviewed in the medication administration record for December 2013. R19 had not received the PRN Tylenol or the PRN Lidocaine in December of 2013. RN-B also said that R19 has not asked for the topical Lidocaine and said they used that more in the first months of admit over last summer. When requested, no documentation of a dental visit was found in the medical record. When interviewed on 12/4/13, at 9:00 a.m. nursing assistant (NA)-A said that R19 did complain of mouth pain occasionally. She also said the aides set up his toothbrush for him and he brushes himself. When interviewed on 12/4/13, at 10:55 a.m. family member (F)-A stated that he had taken his dad to the dentist with in the last six months. The dentist extracted two teeth at that time. FM-A said the direction for follow up was that he was supposed to return if he had any further problems. FM-A did say that he was aware that R19 still complained of occasional mild mouth pain and thought it was more related to dementia. When interviewed on 12/4/13, at 11:14 a.m. registered nurse (RN-B) stated that R19 received Tylenol three times daily. There was also an order for additional Tylenol if needed.	F 411		

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F 411	Continued From page 26 When interviewed on 12/4/13, at 11:31 a.m. the nurse manager (RN)-A said that R19's son had taken him to the dentist sometime around date of admission. RN-A was unable to find any documentation related to the dental visit. RN-A said, "I am betting the health unit coordinator did not set up those appointments, the son did. We likely sent a referral and it's always a fifty-fifty chance of getting information back. I know he has been out to the dentist, why we don't have any paperwork on it I don't know." When interviewed on 12/4/13, at 2:50 p.m. R19's nurse practitioner (NP) said," I would I like to see him get those rotten teeth pulled, yes." The NP went on to explain that the family had taken R19 to the dentist sometime around admission to the facility and that there was some dysfunction within the family dynamics. The NP and RN-A agreed it would be a good idea to contact the dentist and have them fax over recommendations for R19 in regards to his dental/oral health. The NP confirmed R19 had intermittent mild mouth pain. The NP confirmed that R19 was on scheduled Tylenol and that R19 had not been using the prn topical Lidocaine but had used the prn Tylenol once in the recent past. The NP saw resident on 12/4/13, in the afternoon. A progress note dated same indicated the goal for R19 was comfort care and that the family had inner turmoil. The family power of attorney was highly focused on saving money. The resident was assessed by the NP as having chronic intermittent mild mouth pain, repetitive in nature, and much better than when admitted. R19's dental pain was unchanged by dental visits per son. Not medically opposed to dental follow up for	F 411		

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F 411	Continued From page 27 resident, addressed in past with them, family seemed to need break, suspect some caregiver fatigue. He needed family to escort, preferable to senior dentistry. When interviewed on 12/5/13, at 2:00 p.m. RN-A said she had contacted the dentist and was informed that the resident had two extractions at the last visit. RN-A also said the dentist had indicated to her that R19 would not be treated by them in the future due to resident agitation at the last appointment. RN-A said she would call senior dentistry to obtain an appointment for R19. The facility policy titled, Dental Policy, dated October 2011, indicated that it was the facility policy to assist the residents in maintaining and achieving dental health. The purpose of the policy was to ensure residents maintain and achieve the best possible dental health.	F 411		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

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EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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 431	Continued From page 28 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications with shortened use dates were properly dated after opening and discarded when expired on 2 of 5 units. This had the potential to affect 2 of 22 residents (R32, R15) who used insulin pens for diabetes. In addition, the facility failed to properly store medications in 1 of 5 nursing unit refrigerators and the facility failed to ensure eye drops were stored properly for 1 of 5 residents (R7). Findings include: Insulin pens on two units were found to be undated when opened and not discarded when expired. On 12/2/13, at 4:45 p.m. during the medication pass observation on three south, the licensed practical nurse (LPN)-A prepared Humalog insulin	F 431	The facility will provide store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. R32 and R15's insulin was properly discarded or labeled as appropriate on 12/2/13. All improperly stored medication was discarded properly effective 12/5/13. All licensed nurses were educated regarding the proper storage and labeling of medications and biological effective 12/19/13. Audits will be completed for 3 months or until ongoing compliance is achieved with oversight by the director of nursing.	12/30/13

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F 431	Continued From page 29 (used to treat diabetes) for R32. The insulin pen included a date opened of 10/7/13. LPN-A stated Humalog insulin expired 28 days after it was opened and disposed of the expired insulin. On 12/2/13, at 5:15 p.m. during observation of the first floor north medication cart, an insulin pen of Humalog for R15 was found not to have a date when it was opened. The delivery date on the pen from the pharmacy was 10/22/13. LPN-B verified the insulin pen was not dated and stated if an insulin pen was undated; the delivery date from the pharmacy would be used as the open date. When interviewed on 12/5/13, at 10:32 a.m. the director of nursing (DON) stated insulin pens needed to be dated when opened and if not dated the nurse should use the delivery date from the pharmacy as the opened date. The DON stated the insulin pen for R15 was discarded. The facility Insulin Storage Recommendations (undated) revealed Humalog was good for 28 days after being opened. Medications were stored in unlocked, with food in a nursing station refrigerator. On 12/5/13, at 9:50 a.m. the first floor nursing station refrigerator was observed and was noted to be unlocked. The door of the refrigerator contained a bottle of pantoprazole (used to treat reflux disease) and a bottle of gabapentin (used for neuropathy) for R128. The door of the refrigerator also contained a carton of juice, pudding, yogurt, and a Plus 2 supplement. Registered nurse (RN)-C verified the medications were stored on the door of the unlocked refrigerator and stated she did not have the key for the medication storage drawers in the refrigerator. When interviewed on 12/5/13, at 10:05 a.m. RN-B verified medications should not be stored in	F 431		

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F 431	Continued From page 30 an unlocked refrigerator with food. The DON was interviewed on 12/5/13, at 10:32 a.m. and stated medications should not be stored with food on the refrigerator door. The facility Storage of Medication policy dated January 2011, directed medications would be stored safely, securely and properly. The medication supply was to be accessible only to licensed nursing personnel, pharmacy personnel, or staff lawfully allowed to administer medications. R7's eye drops not stored in a safe locked compartment. On 12/2/13, at 3:30 p.m. during interview with R7, a bottle of artificial eye drops was observed on top of bedside dresser. On 12/2/13, at 7:57 p.m. LPN-B went to R7's room observed the bottle of eye drops still on top of the bedside dresser. LPN-B grabbed it stated "It was not supposed to be left here." She further stated R7 received the eye drops in the morning as she had an as needed order and maybe the nurse forgot to take drops out of room. LPN-A stated it was the facility policy to not leave medications at bedside when resident has no orders to self-administer medication (SAM). R7's diagnoses included encephalopathy, nuclear cataract, contracture of hand joint, left side hemiplegia, traumatic brain injury and depression obtained from quarterly Minimum Data Set (MDS) dated 10/16/13. The MDS also indicated R7 required extensive physical assist of one to two staff with activities of daily living (ADL's).	F 431		

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F 431	Continued From page 31 In addition, R7's cognitive and communication care plan dated 10/23/09, identified R7 had memory loss and moderately impaired decision making skills secondary to encephalopathy. During further document review, revealed R7 had an order dated 2/3/11, for Artificial Tears 1.4% two drops to both eyes every hour as needed for dry eyes. A SAM assessment dated 10/10/13, indicated R7 did not wish to self-administer medications, had several diagnoses that may affect SAM which included traumatic brain injury. On 12/3/13, at 8:32 a.m. interviewed the RN-B stated all residents have to be assessed to determine that they are appropriate to self-administer medications and in addition has to be discussed with the interdisciplinary team (IDT). RN-B further stated the nurse may have forgotten the drops and will make sure it does not happen. On 12/5/13, at 2:18 p.m. the DON stated R7 does not have a SAM and the eye drops should not have been left at bedside.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	Continued From page 32 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store reusable ice packs in a sanitary manner. Four of five nourishment/medication freezers contained medical use, reusable ice packs and ice cream containers. This had the potential to affect 97 of 124 residents who use ice packs or consume food from the refrigerators.	F 441	The facility maintains an infection control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection. All ice packs were removed from unit refrigerators effective 12/6/13. Facility practice is to no longer store ice packs on the units. All staff were educated regarding the proper storage of ice packs effective 12/30/13. Audits will be completed for 3 months or until ongoing compliance is achieved with oversight by the director of nursing.	12/30/13

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F 441	Continued From page 33 Findings include: First floor: On 12/5/13, at 9:50 a.m. the first floor nursing station nourishment freezer contained six reusable ice packs and nine containers of ice cream. Registered nurse (RN)-C verified the ice packs were stored with the ice cream and stated she was unsure what the ice packs were used for. When interviewed on 12/5/13, at 10:05 a.m. RN-B verified the ice packs were used for resident needs and were cleaned and reused. Third floor: On 12/5/13, at 10:12 a.m. the third floor south nursing station nourishment freezer contained nine reusable ice packs and ten containers of ice cream. Licensed practical nurse (LPN)-C verified the ice packs were used for resident injuries and were reused. Upon interview on 12/5/13, at 10:32 a.m. the director of nursing (DON) stated ice packs and food should be stored separately. Second floor: South: The two south refrigerator at the nurses station was observed on 12/4/13, at 11:18 a.m. The freezer held six re-useable ice packs next to fourteen individual ice cream cups. Four of the six ice packs were in clear plastic bags. When interviewed on 12/4/13, at 11:19 a.m. RN-A said they do keep resident food in there and that the ice packs are from the medication container	F 441		

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F 441	Continued From page 34 when medications are delivered. They just throw those in the freezer and staff should be discarding them after use on residents. North: The two north refrigerator was observed on 12/5/13, at 9:16 a.m. The freezer held ten re-useable ice packs and 12 cups of ice cream. The facility Refrigerator Safety policy revised 9/7/12, was reviewed and did not include guidance on storage of reusable ice packs with resident food items.	F 441		

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

F5587022

PRINTED: 12/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Ebenezer Care Center (Buildng 1) 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 TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	Submission of this credible allegation of compliance is not a legal admission that a deficiency exist or that the statement of deficiency was correctly cited, and is also not to be construed as an admission against the interest of the facility, its administrator or any employees, agents or other individuals who draft or may be discussed in this credible allegation of compliance. In addition, preparation and submission of this credible allegation of compliance does not constitute and admission or agreement of any kind by this facility of the truth of	

DC: 1-14-14
Exit: 12-5-13
POC ok w/an FSES
FSI- 6-14

RECEIVED
DEC 30 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Campus Administrator | (X6) DATE: 12/30/13

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 Marian.Whitney@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 Care Center is a 3-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1919 and was determined to be of Type III(200) construction. In 1924, an addition was constructed to the North side of the building that was determined to be of Type III(200) construction. In 1928, another addition was constructed to the South side of the building that was determined to be of Type III(200) construction. Because the original building and the 2 additions to this buildng are all of the same construction type, even though the Type III(200) construction type does not meet the code for existing buildings, this building was surveyed as one building, but the entire facility was surveyed as two buildings under two booklets. The building has a complete fire sprinkler system throughout. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for	K 000	any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

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K 000	Continued From page 2 automatic fire department notification. The facility has a licensed capacity of 127 beds and had a census of 124 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirement for construction type and height. This deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 12:00 PM on 12/10/2013, observation revealed that this 3-story, wood frame facility of Type III(200) construction does not meet the minimum construction requirements for a building of this height. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012	The facility has achieved a passing FSES score effective 12/19/13	12/19/13
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038 SS=F	Continued From page 3 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 12:00 PM on 12/10/2013, observation revealed that the south stairway doors on the second and third floors swing against the path of egress travel. These deficient practices were verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 038	The facility has achieved a passing FSES score effective 12/19/13	12/19/13
K 040 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5	K 040	The facility has achieved a passing FSES score effective 12/19/13	12/19/13

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K 040	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the resident room doors do not meet the 32-inch clear width requirement. This deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 12:00 PM on 12/10/2013, observation revealed that the doors in the 1919 construction year building were found to be only 29-30 inches in clear width. This does not meet the 32-inch requirement for existing exit access doors. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 040		
K 045 SS=F	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 interview, the facility failed to provide adequate emergency lighting in accordance with LSC (00) 19.2.8. This deficient	K 045	The facility will ensure there is illumination for means of egress, including exit discharge. Corridor lighting was reconfigured to meet this standard.An electrician removed switches for critical lighting ensuring that they remain on in all situations.	12/19/13

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K 045	Continued From page 5 practice can effect all residents. Findings include: During facility tour between 10:00 AM and 12:00 PM on 12/10/2013, observation revealed that all of the corridor lights have the ability to be turned off by a light switch. The emergency lighting system runs through the same light switches. This deficient practice was verified by the administrator at the time of the inspection.	K 045	Effective 12/19/13 Audits will be maintained for 3 months or until ongoing compliance is observed with oversight by the plant supervisor.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observations and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby Power Systems (1998 edition). This deficient practice could affect all patients. Findings include: On facility tour between 10:00 AM and 12:00 PM on 12/10/2013, a record review revealed that	K 144	The facility will inspect generators weekly and monthly as required. All maintenance employees were educated regarding the requirement to maintain proper generator inspections and documentation. Effective 12/19/13 Weekly audits are in place and will continue for 3 months or until ongoing compliance is achieved with oversight by the environmental services supervisor.	12/19/13

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K 144	Continued From page 6 there was no documentation of weekly generator during the first week of July 2013. This deficient practice was verified by the administrator at the time of the inspection.	K 144		

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

F5587022

PRINTED: 12/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING 02 - BLDG TWO B. WING _____	12/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Ebenezer Care Center Building 2 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 TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	Submission of this credible allegation of compliance is not a legal admission that a deficiency exist or that the statement of deficiency was correctly cited, and is also not to be construed as an admission against the interest of the facility, its administrator or any employees, agents or other individuals who draft or may be discussed in this credible allegation of compliance. In addition, preparation and submission of this credible allegation of compliance does not constitute and admission or agreement of any kind by this facility of the truth of	

RECEIVED
DEC 30 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
1-6-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Campus Administrator | (X6) DATE: 12/30/13

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
	245587	A. BUILDING 02 - BLDG TWO B. WING _____	12/10/2013

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K 000	Continued From page 1 Marian.Whitney@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 Care Center Building 2 is a 3-story building with a full basement. The building was constructed in 1952 and was determined to be of Type I (332) construction. The building is fully fire sprinklered throughout. The facility has a complete 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 licensed capacity of 127 beds and had a census of 124 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
K 045 SS=F	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	K 045	The facility will ensure there is illumination for means of egress, including exit discharge. Corridor lighting was reconfigured to meet this standard.	12/19/13

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K 045	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide adequate emergency lighting in accordance with LSC (00) 19.2.8. This deficient practice can effect all residents. Findings include: During facility tour between 10:00 AM and 12:00 PM on 12/10/2013, observation revealed that all of the corridor lights have the ability to be turned off by a light switch. The emergency lighting system runs through the same light switches. This deficient practice was verified by the administrator at the time of the inspection.	K 045	An electrician removed switches for critical lighting ensuring that they remain on in all situations. Effective 12/19/13 Audits will be maintained for 3 months or until ongoing compliance is observed with oversight by the environmental services supervisor.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observations and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby Power Systems (1998 edition). This deficient	K 144	The facility will inspect generators weekly and monthly as required. All maintenance employees were educated regarding the requirement to maintain proper generator inspections and documentation. Effective 12/19/13	12/19/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 3 practice could affect all patients. Findings include: On facility tour between 10:00 AM and 12:00 PM on 12/10/2013, a record review revealed that there was no documentation of weekly generator during the first week of July 2013. This deficient practice was verified by the administrator at the time of the inspection.	K 144	Weekly audits are in place and will continue for 3 months or until ongoing compliance is achieved with oversight by the environmental services supervisor.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7079

December 17, 2013

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number S5587023 and H5587036

Dear Mr. Prevost:

The above facility survey was completed on December 10, 2013 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules and to investigate complaint number H5587036 that was found to be unsubstantiated. 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Boarding Care 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 is 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.

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7079

December 17, 2013

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Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5587023 and H5587036

Dear Mr. Prevost:

The above facility was surveyed on December 2, 2013 through December 5, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5587036 that was found to be unsubstantiated. 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.

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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.

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