DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: H7NV

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

	PART I -	TO BE COMPI	LETED BY T	THE STAT	E SURVEY	AGENC	CY	F	Facility ID: 00191
MEDICARE/MEDICAID PROVI (L1) 245587	IDER NO.	3. NAME AND AI (L3) EBENEZER						TYPE OF ACTION	N: <u>7</u> (L8)
2.STATE VENDOR OR MEDICAII (L2) 810542100	O NO.	(L4) 2545 PORT		E SOUTH	(16)	55404	;	1. Initial 3. Termination 5. Validation	 Recertification CHOW Complaint
	AE OWATED CLIED	, ,		NODW.				7. On-Site Visit	9. Other
5. EFFECTIVE DATE CHANGE O (L9) 05/01/2012	F OWNERSHIP	7. PROVIDER/SU 01 Hospital	05 HHA	ORY 09 ESRD	03 (L7) 13 PTIP	22 CLIA	. :	8. Full Survey After	Complaint
	13/14 _(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	0111	-		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISO	CAL YEAR ENDIN	IG DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Othe	r	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE			06/30	
11LTC PERIOD OF CERTIFICATI	ION	10.THE FACILITY	IS CERTIFIED	AS:					
From (a):		X A. In Complia	nce With		And/Or Appro	ved Waive	ers Of The Fo	llowing Requireme	ents:
To (b):			equirements e Based On:		2. Tech 3. 24 H			6. Scope of Ser	
12.Total Facility Beds	127 (L18)	•	cceptable POC		4. 7-Da	ioui KN iy RN (Ru Safety Co	ral SNF)	7. Medical Direction8. Patient Room9. Beds/Room	
13.Total Certified Beds	127 (L17)		npliance with Properties and/or Appli		* Code:		(L12	_	
14. LTC CERTIFIED BED BREAKI	DOWN				15. FACILITY M	IEETS			
18 SNF 18/19 SN	F 19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) ((1):	(L15)	
34	93								
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY RE	EMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):					
See Attached Remarks									
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGI	ENCY APPR	OVAL	Date:
Becky Wong, HFE	NE II	<u>O</u>	2/19/14	(L19)	Anne Kle	ppe, E	nforcen	nent Special	<u>ist</u> 03/18/2014 (L20
P	ART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OF	R SINGI	LE STATI	E AGENCY	
19. DETERMINATION OF ELIGIE	BILITY		IPLIANCE WITI	H CIVIL				olvency (HCFA-2572	*
X 1. Facility is Eligible t	o Participate	RIGI	HTS ACT:			Both of the		est Disclosure Stmt (псга-1313)
2. Facility is not Eligi	ble (L21)								
	(==-/								
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION AC	TION:	(1	L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	<u>VOLUNTARY</u>		00	INVOLUN	
06/01/1991					01-Merger, Clos 02-Dissatisfaction		mbursamant		Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involu				Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS n of Admissions:			04-Other Reason			OTHER 07-Provide	r Status Change
	A. Suspension	i of Admissions.	(L44)					00-Active	i Status Change
(L27)	B. Rescind Su	uspension Date:	, ,						
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS				
		00320			Posted	03/28/	/14 CO		
				(T 21)					
	(L28)			(L31)					
31 RO RECEIPT OF CMS 1520		DETERMINATION	I OE A PPP OVA I						
31. RO RECEIPT OF CMS-1539		2. DETERMINATION 02/11/2014	I OF APPROVAL						

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

Facility ID: 00191

C&T REMARKS - CMS 1539 FORM

CCN: 24-5587

STATE AGENCY REMARKS

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 the 12/05/13 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.



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, Enforcement Specialist Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health Telephone: (651) 201-4124

Done Klegge

Fax: (651) 215-9697

cc: Licensing and Certification File



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.

Ebenezer Care Center March 6, 2014 Page 2

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

Dre Klegge

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report (Y1) Provider / Supplier / CLIA / Identification Number 00191 Name of Facility EBENEZER CARE CENTER (Y2) Multiple Construction A. Building B. Wing (Y3) Date of Revisit 2/13/2014 Street Address, City, State, Zip Code 2545 PORTLAND AVENUE SOUTH

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).

MINNEAPOLIS, MN 55404

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix 205	Correction Completed 02/13/2014	ID Prefix	Correction Completed	ID Prefix		Correction Completed
	Rule 4658.0405 Subp.	Reg. #		Reg. #		
Reg. #	Correction Completed	Reg. #	Correction Completed	ID Prefix		Correction Completed
Reg. #	Correction Completed	Reg. #	Correction Completed	ID Prefix Reg. #		
ID Prefix Reg. #	Correction Completed	Reg. #	Correction Completed	ID Prefix		
Reg. #	Correction Completed	ID Prefix	Correction Completed	ID Prefix		
Reviewed By _ State Agency	Reviewed By GD/AK	Date: 02/19/2014	Signature of Surveyor:	30	951 Date 02/	13/2014
Reviewed By -	Reviewed By	Date:	Signature of Surveyor:		Date	:
Followup to Sur	rvey Completed on: 12/5/2013	c	heck for any Uncorrected Def Uncorrected Deficiencies (Cl			s no

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245587	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/13/2014
Name of Facility		Street Address, City, State, Zip Code	
EBENEZER CARE CENTER		2545 PORTLAND AVENUE SOL	JTH

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 02/11/2014	ID Prefix			Correction Completed 02/11/2014		ID Prefix			Correction Completed 02/11/2014
Reg. # LSC	483.15(b)			Reg. # LSC	483.20(k)(3)(ii)					483.25(a)(2)		<u> </u>
ID Prefix			Correction Completed 02/11/2014				Correction Completed					Correction Completed
LSC	483.25(a)(3)			Reg. #					Reg. # LSC			<u> </u>
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		ъ "			Correction Completed
Reg. #				Reg. #					D "			
Reviewed E State Agen		eviewed SD/AK	-	Date: 02/19/20	Signature	of Sur	veyor:		3	0951	Date: 02/1	3/2014
Reviewed E	Зу Re	eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Comp		:		Check for any Uncorrected					Summary of the Facility?	YES	NO

State Form: Revisit Report (Y1) Provider / Supplier / CLIA / Identification Number 00191 Name of Facility (Y2) Multiple Construction A. Building B. Wing Street Address, City, State, Zip Code

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).

2545 PORTLAND AVENUE SOUTH

MINNEAPOLIS, MN 55404

(Y4) Item	(Y5) [Date (Y	(4) Item	(Y5)	Date	(Y4) It	em	(Y5) [Date
ID Prefix	Cor	rection npleted 13/2014	ID Prefix		Correction Completed 02/13/2014	IC	O Prefix	31810		Correction Completed 02/13/2014
	IN Rule 4655.6400 Subp.		Reg. # LSC	MN Rule 4655.6400 Sub	p. :			MN Rule 144.6		
Reg. #		rection	ID Prefix Reg. #		Correction Completed		O Prefix			Correction Completed
ID Prefix _ Reg. #	Cor	rection npleted	ID Prefix Reg. #		Correction Completed		D Prefix Reg. #			Correction Completed
Reg. #		rection	Reg. #			IC	Dog #			
Reg. #		rection	Reg. #		Correction Completed		Reg. #			Correction Completed
Reviewed By State Agency	GD/AK	(Date: 02/19/20	Signature of Sur	veyor:	3	30951		Date: 02/13	3/2014
Reviewed By			Date:	Signature of Sur	veyor:				Date:	
	Survey Completed on: 12/5/2013			Check for any Uncor Uncorrected Defic					YES	NO

EBENEZER CARE CENTER

Event ID: H7NV13



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, Enforcement Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Telephone: (651) 201-4124

Done Klegge

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: H7NV

 ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY		Facility	ID: 00191
1. MEDICARE/MEDICAID PROVID (L1) 245587 2.STATE VENDOR OR MEDICAID (L2) 810542100		3. NAME AND AI (L3) EBENEZER (L4) 2545 PORT (L5) MINNEAPO	R CARE CEN' LAND AVENU	ΓER	I (L6) 55404	4. TYPE O 1. Initial 3. Termin 5. Validat	FACTION: 2. ation 4.	7 (L8) Recertification CHOW Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 05/01/2012 6. DATE OF SURVEY 01/05	2/4.4	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	09 ESRD	03 (L7) 13 PTIP 22 CLIA	7. On-Site		Other
6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 2 AOA 1 TJC 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEA	AR ENDING DA	TE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	127 (L18) 127 (L17)	Compliance1. A X B. Not in Cor	equirements be Based On: acceptable POC	gram	And/Or Approved Waivers C 2. Technical Personne3. 24 Hour RN4. 7-Day RN (Rural S5. Life Safety Code * Code: B*		Requirements: ope of Services I edical Director tient Room Size eds/Room	Limit
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF 93	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L	15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM See Attached Remarks	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENC	CY APPROVAL	D	Date:
Ann Hyrkas, HFE N	E II	02	/12/14	(L19)	Anne Kleppe, Enfo	orcement S	pecialist	03/18/2014 (L20
PA	RT II - TO BE	COMPLETED	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE	STATE AGEN	NCY	
19. DETERMINATION OF ELIGIBI _X	Participate e		IPLIANCE WIT HTS ACT:	H CIVIL	21. 1. Statement of Fir2. Ownership/Con3. Both of the Abo	trol Interest Disclos		-1513)
	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 06/01/1991	23. LTC AGREEI BEGINNINC		4. LTC AGREEI ENDING DA		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbu	<u>11</u>	(L30) NVOLUNTARY 5-Fail to Meet H	lealth/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions:	(L25) (L44) (L45)		03-Risk of Involuntary Terminal 04-Other Reason for Withdrawa	tion <u>C</u>	6-Fail to Meet A OTHER 7-Provider Statu 0-Active	
28. TERMINATION DATE:	29	. INTERMEDIARY			30. REMARKS			
	(L28)	00320		(L31)	Posted 03/28/201	14 CO> H7	7NV	
31. RO RECEIPT OF CMS-1539	(L32)	DETERMINATION 02/11/2014	I OF APPROVAI	L DATE (L33)	DETERMINATION AP	PROVAL		

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

Facility ID: 00191

C&T REMARKS - CMS 1539 FORM

CCN: 24-5587

STATE AGENCY REMARKS

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 <u>BOARDING CARE HOMES</u>

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

Ebenezer Care Center March 4, 2014 Page 2

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,

Dre Klegge

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



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:

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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

Ebenezer Care Center January 31, 2014 Page 6 Feel free to contact me if you have questions.

Sincerely,

Dre Klegge

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245587	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 1/13/2014
Name	e of Facility		Street Address, City, State, Zip Code	
EE	SENEZER CARE CENTER		2545 PORTLAND AVENUE SOL	JTH

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).

MINNEAPOLIS, MN 55404

(Y4) Item		(Y5)) Date	(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date
	NFPA 101 K0012		Correction Completed 12/19/2013	Reg. #	NFPA 101 K0038		Correction Completed 12/19/2013	Reg. #	NFPA 101 K0040		Correction Completed 12/19/2013
	NFPA 101 K0045		Correction Completed 12/19/2013	Reg. #	NFPA 101 K0144		Correction Completed 12/19/2013	Reg. #	: :		Correction Completed
Reg. #			Correction Completed	Reg. #			Correction Completed		: :		Correction Completed
Reg. #							Correction Completed		s		
Reg. #									: :		
Reviewed E	Ву	Reviewed PS/AK	Ву	Date: 01/29/2014	Signature	e of Sur	veyor:	2	28120	Date: 01/13/	2014
	Ву	Reviewed	Ву	Date:	Signature	e of Sur	veyor:			Date:	
Followup t	to Survey Co 12/1	mpleted or 0/2013	1:					iencies. Was S-2567) Sent to	a Summary of the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245587	(Y2) Multiple Construc A. Building B. Wing	tion - BLDG TWO	(Y3) Date of Revisit 1/13/2014
Name of Facility		Street Address, City, State, Zip Co	ode
EBENEZER CARE CENTER		2545 PORTLAND AVENU 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	(Y	5) Date	(Y4)	Item	(Y	5)	Date
ID Prefix	NFPA 101	Correction Completed 12/19/2013		 NFPA 101	Correction Completed 12/19/2013		ID Prefix Reg. #			
_	K0045	<u></u>	_	K0144	<u></u>		LSC			_
ID Prefix Reg. #			ID Prefix Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Reg. #				ID Prefix Reg. # LSC			
Reviewed E	PS/	ewed By AK	Date: 01/29/2014	Signature of S	urveyor:		28120		Date: 01/13	/2014
	-	ewed By	Date:	Signature of S	urveyor:			С	Date:	
Followup t	o Survey Complete			Check for any Unc Uncorrected De			ies. Was a Sumr 67) Sent to the Fa	0.0114.70	YES	NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00191	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/9/2014
Name of Facility		Street Address, City, State, Zip Code	
EBENEZER CARE CENTER		2545 PORTLAND AVENUE SOL	JTH

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).

MINNEAPOLIS, MN 55404

Y4) Item	(Yt	5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date
	30601 MN St. Statute 144.56			Correction Complete 30615 12/30/2013 MN Rule 4655.3200 Subp.	d ID Prefix Reg. #	31145 MN Rule 4655.7830	
ID Prefix		Correction Completed 12/30/2013	ID Prefix Reg. #	Correction Completed	ID Prefix		Correction Completed
Reg. #			Reg. #	Correction Completed	ID Prefix		
Reg. #			Reg. #	Correction	ID Prefix		
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #	Correction Completed	ID Prefix		
Reviewed B State Agenc Reviewed B	gD/AK		Date: 01/28/2014 Date:	Signature of Surveyor: Signature of Surveyor:	31	768 Date 01/	09/2014
•	Survey Completed of 12/5/2013 M: REVISIT REPORT (Check for any Uncorrected De Uncorrected Deficiencies (C			

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245587	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/9/2014
Name of Facility		Street Address, City, State, Zip Code	
EBENEZER CARE CENTER		2545 PORTLAND AVENUE SOL	JTH

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	(Y	5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0279	Correction Completed 01/09/2014	ID Prefix	F0371		Correction Completed 01/09/2014		ID Prefix	F0411		Correction Completed 01/09/2014
Reg. # LSC	483.20(d), 483.20(k)(1	<u>) </u>	Reg. # LSC	483.35(i)					483.55(a)		<u> </u>
	F0431 483.60(b), (d), (e)	Correction Completed 01/09/2014		483.65		Correction Completed 01/09/2014					Correction Completed
LSC			LSC					LSC			_
ID Prefix Reg. # LSC		Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #			Correction Completed		ъ "			Correction Completed
Reg. #			Reg. #			Correction Completed		D "			
Reviewed E	GD/AK	-	Date: 01/28/2014	Signature	of Sur	veyor:		31	768	Date: 01/09	9/2014
Reviewed E	By Reviewe	ed By	Date:	Signature	of Sur	veyor:				Date:	
Followup t	to Survey Completed of 12/5/2013	on:		Check for any Uncorrected					Summary of the Facility?	YES	NO

State Form: Revisit Report (Y1) Provider / Supplier / CLIA / Identification Number 00191 Name of Facility (Y2) Multiple Construction A. Building B. Wing Street Address, City, State, Zip Code

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).

2545 PORTLAND AVENUE SOUTH

MINNEAPOLIS, MN 55404

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix	Correction Completed 21095 12/30/2013	ID Prefix	Correction Completed 12/30/2013		21415	Correction Completed 12/30/2013
	MN Rule 4658.0650 Subp.		MN Rule 4658.0800 Subp.		MN Rule 4658.0815 S	
ID Prefix Reg. # LSC	Correction Completed 12/30/2013 MN Rule 4658.1340 Subp.	Reg. #	Correction Completed	ID Prefix		
Reg. #	Correction Completed	Reg. #	Correction Completed	ID Prefix Reg. #		
Reg. #	Correction Completed	Reg. #	Correction Completed	ID Prefix		
ID Prefix Reg. #	Correction Completed	ID Prefix	Correction Completed	I ID Prefix		Correction Completed
Reviewed E	GD/AK	Date: 01/28/2014	Signature of Surveyor:	3	Date: 01/09	9/2014
Reviewed E		Date:	Signature of Surveyor:		Date:	
Followup to Survey Completed on: 12/5/2013 STATE FORM: REVISIT REPORT (5/99)		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO				NO

EBENEZER CARE CENTER

PRINTED: 01/31/2014 FORM APPROVED

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMPI	
			A. BOILDING.		R	1
		00191	B. WING			9/2014
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
{3 000}	INITIAL COMMENT	ΓS	{3 000}			
	****ATTENTIC	DN*****				
	BOARDING CAR LICENSING CORR					
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance iines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tagule number indicated below. In several items, failure to the items will be considered. Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff survey exited on 12 and the following co corrected: (3 970, 3	TS: 1/9/14, a surveyor of this completed a revisit for the 2/5/13, for the above provider prection orders are not 3 975, 3 1810). These will remain in effect from the		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Boarding Care Homes.	oftware.	

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

(X6) DATE TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00191	B. WING		R 01/0 9	9/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{3 000}	original survey on 1 the next site visit. When corrections a date, make a copy original to the Minne Division of Complia Certification Progra	ge 1 2/5/13, and will be reviewed at are completed, please sign and of these orders and return the esota Department of Health, nce Monitoring, Licensing and m; 85 East Seventh Place, . Paul, MN 55164-0882.	{3 000}	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings is the Time Period For Complete Disregard The Fourth Column Which States, "Provider's Plan of Correction." This applies the Federal Deficiencies only. Will appear on Each Page. There is no requirement to Submit a Plan of Correction of Minnesota's Statutes/Rules.	Fag." the tute/rule ties" ply" his s which after the s rection. DING OF THIS ON FOR	
3 970	Assist with Oral hyg Subp. 2. Criteria care. Criteria for de	for determining adequate etermining adequate and	3 970			
	keep the mouth, tee	clude: as needed with oral hygiene to eth, or dentures clean. used to prevent dry, cracked				

Minnesota Department of Health STATE FORM

H7NV12 If continuation sheet 2 of 11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		F	,
		00191	B. WING			9/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
3 970	Continued From pa	age 2	3 970			
	by: Based on observat review, the facility f with oral care as or by the care plan for reviewed for activiti Findings include:	ent is not met as evidenced ion, interview, and document ailed to provide assistance dered, assessed and directed 2 of 4 residents (R21, R12) ies of daily living (ADLs).				
	on the morning of 1					
	stated oral care had R21's oral care usin NA-A further stated and would some tirt to state he would rerefused. At 10:15 a and opened the top table. The drawer was papers and other a toothbrush, but was toothpaste. NA-A dbrush R21's natura R21 would not opened the top table. The drawer was toothpaste. NA-A dbrush R21's natura R21 would not opened the either the top to the control of R21's oral care used toothettes for where R21's toothpaste.					
	1/9/14, indicated R	ted Diagnosis Report dated 21's diagnoses included a, and vascular dementia with				
	R21's quarterly Min	nimum Data Set (MDS) dated				

Minnesota Department of Health

STATE FORM 6899 H7NV12 If continuation sheet 3 of 11

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:		F	
		00191	B. WING) 9/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ZER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
3 970	12/24/13, indicated memory deficits, m decision making sk psychomotor retard further indicated R2 care and required e ADL's and persona annual MDS dated obvious or likely ca The ADL Care Area 9/18/13, identified fwith ADLs including identified pertinent R21 having a "lowe tongue that hangs of R21's behavioral condentify oral/dental R21's Care Plan re to assist with brush three minutes using toothpaste. The care (as R21 allows) bruspecial attention to On 1/8/14, at 3:15 pstated both a toothly have been readily a with oral care. RN-not followed for R2 R12 was not provide care as ordered. A computer genera 1/9/14, indicated R bipolar disorder, definition of the computer general sports of the care as ordered.	R21 had short and long-term oderate impaired daily ills, inattention and dation behaviors. The MDS 21 displayed no rejection of extensive assistance with all I hygiene activities. R21's 9/24/13, indicated R21 had vity or broken natural teeth. A Assessment (CAA) dated R21 required staff assistance grooming. Although the CAA mouth information such as er lip that protrudes with thick over, drools frequently" and oncerns, the CAA did not care needs. Vised 12/18/13, directed staffing R21's natural teeth for g a soft toothbrush and fluoride re plan directed to twice daily ush all sides of teeth and to pay R21's gum line. D.m. registered nurse (RN)-D orush and toothpaste should available in R21's room for use D confirmed the care plan was				

Minnesota Department of Health STATE FORM

STATE FORM 6899 H7NV12 If continuation sheet 4 of 11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00404	B. WING		F	
		00191	b. WING		01/0	9/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		RTLAND AVE POLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
3 970	Continued From pa	ge 4	3 970			
	R12 had short and had moderately imposkills, behaviors of interest extensive assistance	long-term memory deficits, paired daily decision making inattention, and required the with personal hygiene.				
	assistance of one s	vised 8/23/12, directed taff with all grooming tasks at 5000 plus with a toothbrush				
	12/3/13, indicated F 5000 Plus (Sodium	Report dated and signed R12 was to receive Prevident Fluoride Dental) cream 1.1% hbrush for cavity prevention.				
	Record (TAR) dated received the Previolation 12/1/13, to 1/9	ted Treatment Administration d 1/9/14, indicated R12 had ent tooth cream twice daily l/14; with one afternoon evening treatments not signed				
	cares had already be stated she had used R12's teeth. Upon of table, NA-D was ab with a small tube of stated R12 resisted	a.m. NA-D stated R12's oral been provided that am. NA-D d a pink toothette to clean observation of R12's bedside le to locate a toothbrush along Colgate toothpaste. NA-D use of a toothbrush in the er stated she was not aware oothpaste to use.				
	Prevident tooth created specified on the stated since the President, the NA's would	a.m. RN-C stated R12's am and treatment would not care guide for the NA's. RN-C evident was a prescription d have to obtain the tooth a nurse from the treatment cart oothbrush.				

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00191	B. WING		01/0	{ 9/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 970	Continued From pa	ge 5	3 970			
	On 1/9/14, at 10:47 observation of the 2 medication carts re Prevident tooth crea would get the tooth return it to the nurse completed. RN-A further where the tooth crehad been missing from 1/9/14, at approstated R12's Previde expensive and requentable insurance to stated he was not a supply had run out. An Oral Hygiene posince the original supply and run oral hygiene before per assignment she	a.m. with RN-A present, an 2 South treatment and vealed no evidence of the am. RN-A stated the NA's cream from the nurse and e when the oral care was urther stated she was not sure am was located or how long it rom the medication cart. Eximately 2:00 p.m. RN-C lent tooth cream was uired a pre-authorization for pay for a refill. RN-C further tware R12's tooth cream Solicy dated 1/2009, not revised curvey, directed staff to offer breakfast, and at bedtime or set.				
{3 975}	Care of hands. feet	•	{3 975}			
		for determining adequate etermining adequate and cludes:				
		and attention to hands and nd toenails shall be kept clean				
	This MN Requirements	ent is not met as evidenced				
	Based on observati review, the facility fa	on, interview, and document ailed to provide nail care for 1) reviewed for activities of daily				

Minnesota Department of Health

STATE FORM 6899 H7NV12 If continuation sheet 6 of 11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00191	B. WING			R 09/2014
					1 01/0	J3/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		POLIS, MN 5	NUE SOUTH 5404		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)		COMPLETE DATE
{3 975}	Continued From pa	ge 6	{3 975}			
	Findings include:					
		ted Diagnosis Report dated 45's diagnoses included betes type 2.				
	10/23/13, indicated	imum Data Set (MDS) dated R45 had moderate cognitive dependent in personal hygiene help for bathing.				
	assistance of one s	vised 7/30/13, directed taff with all personal hygiene ed the nurse to provide nail				
	in the facility lobby a of R45's finger nails observed to be long	a.m. R45 was observed to be area seated in a chair. Many son both hands were g, jagged, and to contain r under the finger nail tips.				
	stated R45 was ver stated they were ab the other day due to	a.m. nursing assistant (NA)-A y resistive to cares. NA-A ble to talk R45 into a shower o severe body odor. NA-A s not done by the NA's for				
	(LPN)-A stated R45	a.m. licensed practical nurse went to podiatry for toe A further stated she had never e for R45.				
	refused a shower o with minimal assista the nurses should h	o.m. RN-D stated R45 had n 1/6/14, but took a shower ance on 1/7/14. RN-D stated have provided R45 with finger nented the offer and/or refusal				

Minnesota Department of Health

STATE FORM 6899 H7NV12 If continuation sheet 7 of 11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00191	B. WING		F 01/0	≀ 9/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/0	9/2014
			, ,	NUE SOUTH		
EBENEZ	ER CARE CENTER		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{3 975}	Continued From pa	ge 7	{3 975}			
	in the progress note documentation on r	es. RN-D confirmed the lack of nail care.				
	allowed the nurse to yesterday. At 2:22 p	o.m. RN-D reported R45 o provide finger nail care o.m. R45's fingernails were med neat and clean. R45 okay.				
{31810}	MN Rule 144.651 S of HCF Bill of Right	subd. 6 Patients & Residents	{31810}			
	and residents shall medical and person needs. Appropriate care designed to en highest level of phys This right is limited	priate health care. Patients have the right to appropriate all care based on individual care for residents means table residents to achieve their sical and mental functioning. Where the service is not blic or private resources.				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview, and document ailed to honor the choice of frequency for 2 of 3 residents d for choices.				
	Findings include:					
	R80 was not provid of baths per week.	ed with the requested number				
		ted Diagnosis Report dated 30's diagnoses included tiple sclerosis.				

Minnesota Department of Health

STATE FORM 6899 H7NV12 If continuation sheet 8 of 11

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00191	B. WING		01/0	R 09/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
EBENEZ	ER CARE CENTER		RTLAND AVE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{31810}	R80's quarterly Min 1/1/14, indicated R8 Mental Status (BIM cognitive impairmer for personal hygien physical help in par R80's Care Plan rephysically prepare between temperature, provid tub/shower, and prowash/dry R80's entited as to be posted on a benurses station. The scheduled for a bat Tuesday with "pleas the Tuesday with "pleas the Tuesday block, Saturday day shift be On 1/8/14, at 2:10 plath per week was they used to have a the past and stated more than one tub between the past and stated more than one tub become "used to" ostated an early more R80 slept poorly at Although R80 state in the day, R80 state later bath was compared to the past and to get undresselater bath was compared to the past and to get undresselater bath was compared to the past and to get undresselater bath was compared to the past and to get undresselater bath was compared to the past and to get undresselater bath was compared to the past and to get undresselater bath was compared to the past and to get undresselater bath was compared to the past and th	imum Data Set (MDS) dated 30 had a Brief Interview for S) score of 12 and moderate at, required set up assistance activities, and required to bathing activities. Vised 4/15/10, directed staff to bath, adjust water le assist of one staff in/out of ovide assist of one staff to ire body. Atted 12/30/13, was observed ulletin board at the first floor form indicated R80 was hid during the day shift on se give shower early" typed on and on the Thursday and olocks. D.m. R80 stated only one tub being provided. R80 stated a frequent bathing schedule in staff did not have time for any boath per week. R80 stated as facility a "long time" and it rany more and R80 had just one bath per week. R80 further ning bath was preferred as night and was an early riser. It is a staff had offered a bath later and the red later did not work, as R80 and then re-dressed after the oleted.				
	stated if R80 had be should be documen	o.m. registered nurse (RN)-C een refusing baths, the refusal ated in the nurses notes. RN-C was just getting one bath per				

Minnesota Department of Health

STATE FORM 6899 H7NV12 If continuation sheet 9 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00191	B. WING		01/0	R 99/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EBENEZER CARE CENTER 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{31810}	week on Tuesday in could not agree to a three times per wee nurses progress no bath/skin check was on 1/7/14. The progress not bath/skin check was on 1/7/14. The progress not be documentation R80 scheduled baths per documentation a basin class on 12/31/13. On 1/8/14, at 4:00 predicts inform him R80 was scheduled bath times inform him R80 was scheduled baths per receive a bath on 1 skin check, but the check was performed. R21 was not received. A computer-general 1/9/14, indicated R2 hemiplegia, aphasia delusions. R21's quarterly MD R21 had short and moderately impairminattention and psycobehaviors. The MD rejection of care, rewith all activities of personal hygiene and dependent with battle 9/24/13, indicated F8/24/13, indicated F8/24	norning. RN-C stated R80 a time or day for the requested ek. Review of the electronic tes for R80 revealed a s performed on 12/24/13, and press notes lacked had refused the other two er week and lacked ath/skin check was performed on RN-C confirmed R80's red documentation of the days offered and staff did not so refusing the other two er week. RN-C stated R80 did 2/31/13, along with a weekly nurse forgot to chart the skin	{31810}				

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					F	₹	
		00191	B. WING		01/0	9/2014	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
EBENEZER CARE CENTER 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{31810}	to physically prepar temperature, two st of tub/shower, and R21's entire body wineeded. An electronic Progradated 12/31/13, individed for R21. The Preferred a shower. A Bath Schedule daily be located in a 3-rinunit. The form indicibath on Tuesday daily on 1/8/14, at 10:00 not getting in the tubeing provided with R21 was too resistively shower or the bath more cooperative with confirmed the written select the bath type tub bath as choices as a choice.	e bath, adjust water aff to transfer R21 in and out one staff to wash and dry with assistance of two staff as ess Note labeled late entry icated a care conference was trogress Note identified R21 ated 1/7/14, was observed to a binder book on the 3 South ated R21 was to receive a sy shift. a.m. NA-A stated R21 was a full bed bath. NA-A stated we to be bathed either in the tub; NA-A stated R21 was with a bed bath. b.m. RN-D stated R21 pointed a she was not aware R21 was a weekly bed bath. RN-D en note she provided to R21 to only contained a shower or and did not contain bed bath	{31810}				
	Federal And Minnes dated 7/2007, was I the statement, "5. `` and receive service	ight Under The Combined sota Bill Of Rights booklet not updated, and contained You have the right to reside s in the facility with nodations of your needs and					

6899

Minnesota Department of Health STATE FORM

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

PRINTED: 01/31/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING			R	
NAME OF I	NAME OF PROVIDER OR SUPPLIER		B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	01/	09/2014
NAME OF I	THOVIDER OR SUPPLIER				45 PORTLAND AVENUE SOUTH		
EBENEZ	ER CARE CENTER				INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	PRRECTIVE ACTION SHOULD BE CONTERENCED TO THE APPROPRIATE	
{F 000}	INITIAL COMMEN	TS	{F 00	00}			
	as your allegation of Department's acceleration of the first place be used as verificated. Upon receipt of an revisit of your facilities.	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance. acceptable POC an on-site ty may be conducted to antial compliance with the					
		en attained in accordance with					
{F 242} SS=D	Census 123 483.15(b) SELF-DI MAKE CHOICES	ETERMINATION - RIGHT TO	{F 24	42}			
	schedules, and hea her interests, asses interact with memb inside and outside	ne right to choose activities, alth care consistent with his or ssments, and plans of care; pers of the community both the facility; and make choices is or her life in the facility that he resident.					
	by: Based on observa review, the facility f	NT is not met as evidenced tion, interview, and document failed to honor the choice of r frequency for 2 of 3 residents ed for choices.					
	Findings include:						
	R80 was not provio of baths per week.	ded with the requested number					
I ABORATOR	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

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

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING				R 09/2014
	PROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 242}	1/9/14, indicated R8 hemiplegia and mu R80's quarterly Min 1/1/14, indicated R8 Mental Status (BIM cognitive status) sc cognitive impairment for personal hygien physical help in par R80's Care Plan rephysically prepare between temperature, provious tub/shower, and prowash/dry R80's entited at the posted on a benurses station. The scheduled for a bat Tuesday with "pleast the Tuesday with "pleast the Tuesday block, Saturday day shift between than one tub between than one tub they had lived at the really did not matter become "used to" ostated an early mor R80 slept poorly at Although R80 state in the day, R80 state in the day, R80 state	ted Diagnosis Report dated 30's diagnoses included litiple sclerosis. imum Data Set (MDS) dated 30 had a Brief Interview for S-tool used to measure ore of 12 and moderate at, required set up assistance e activities, and required to fobathing activities. vised 4/15/10, directed staff to both, adjust water le assist of one staff in/out of ovide assist of one staff to brief body. ated 12/30/13, was observed ulletin board at the first floor form indicated R80 was high during the day shift on se give shower early" typed on and on the Thursday and	{F 2-	42}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245587	B. WING				R 09/2014
	PROVIDER OR SUPPLIER ER CARE CENTER			ST 25	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404	<u> U170</u>	09/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 242}	stated if R80 had be should be document further stated R80 week on Tuesday in could not agree to a three times per week nurses progress no bath/skin check was on 1/7/14. The progress documentation R80 scheduled baths per documentation a base on 12/31/13. On 1/8/14, at 4:00 pmedical record lack declined bath times inform him R80 was scheduled baths per receive a bath on 1.	poleted. D.m. registered nurse (RN)-C een refusing baths, the refusal ated in the nurses notes. RN-C was just getting one bath pernorning. RN-C stated R80 a time or day for the requested ek. Review of the electronic tes for R80 revealed a sperformed on 12/24/13, and gress notes lacked had refused the other two er week and lacked ath/skin check was performed on.m. RN-C confirmed R80's seed documentation of the cydays offered and staff did not as refusing the other two er week. RN-C stated R80 did 2/31/13, along with a weekly nurse forgot to chart the skin	{F 24	42}			
	A computer-genera 1/9/14, indicated R2	ing the preferred type of bath. ted Diagnosis Report dated 21's diagnoses included a and vascular dementia with					
	R21 had short and moderately impairm inattention and psyc	S dated 12/24/13, indicated long-term memory deficits, nent decision making skills, chomotor retardation S indicated R21 displayed no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245587	B. WING			R 01/09/2014	
	PROVIDER OR SUPPLIER ER CARE CENTER	240001		STREET ADDRESS, CITY, STATE, ZIP COE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		/09/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
{F 242}	with all activities of personal hygiene addependent with bath 9/24/13, indicated FR21's Care Plan reto physically prepartemperature, two stoof tub/shower, and R21's entire body wineeded. An electronic Progridated 12/31/13, individed for R21. The Preferred a shower. A Bath Schedule daily be located in a 3-rir unit. The form indicibath on Tuesday daily on 1/8/14, at 10:00 not getting in the tubeing provided with R21 was too resisting shower or the bath more cooperative with the confirmed the writted being provided with confirmed the writted select the bath type	quired extensive assistance daily living (ADL's) including ctivities, and was totally hing. R21's annual MDS dated R21 preferred a tub bath. vised 12/18/13, directed staff e bath, adjust water aff to transfer R21 in and out one staff to wash and dry with assistance of two staff as respectively. ess Note labeled late entry icated a care conference was regress Note identified R21 at a care and the staff as regress of the staff as regr		12}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		245587	B. WING				R	
NAME OF I	PROVIDER OR SUPPLIER	245587	b. Willia		TREET ADDRESS SITV STATE ZID SODE	01/0	09/2014	
	ER CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ON SHOULD BE HE APPROPRIATE		
{F 242}	Federal And Minnes dated 7/2007, was in the statement, "5." and receive service reasonable accommander preferences"	ight Under The Combined sota Bill Of Rights booklet not updated, and contained You have the right to reside s in the facility with modations of your needs and	{F 2					
{F 282} SS=D	PERSONS/PER CA The services provide must be provided b	RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of	{F 2	82}				
	by: On 1/8/14, at 3:00 should provide R45 documented the off progress notes. RN documentation on r	p.m. RN-D stated the nurses with finger nail care and er and/or refusal in the -D confirmed the lack of nail care.						
	by the care plan. A computer general 1/9/14, indicated Rabipolar disorder, de On 1/9/14, at 10:15 cares had already be stated she had used R12's teeth. Upon cotable, NA-D was ab with a small tube of	ted Diagnosis Report dated 12's diagnoses included mentia and osteoarthritis. a.m. NA-D stated R12's oral been provided that am. NA-D d a pink toothette to clean observation of R12's bedside le to locate a toothbrush along Colgate toothpaste. NA-D use of a toothbrush in the						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245587	B. WING _		R 01/09/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	1 01/00/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
{F 282}	12/3/13, indicated F 5000 Plus (Sodium twice daily with tooth R12's Care Plan revassistance of one sand to use PreviDer twice daily. On 1/9/14, at 10:30 PreviDent tooth crebe specified on the stated since the PreviDent to use with R12's to On 1/9/14, at 10:47 observation of the 2 medication carts reversible previDent tooth crewould get the tooth return it to the nurse completed. RN-A further where the tooth crehad been missing from the contraction of the completed. RN-A further the tooth crehad been missing from the contraction of the completed. RN-A further the tooth crehad been missing from the contraction of the completed. RN-A further the tooth crehad been missing from the contraction of the contraction of the contraction of the contraction of the completed. RN-A further the tooth crehad been missing from the contraction of the cont	Report dated and signed R12 was to receive PreviDent Fluoride Dental) cream 1.1% hbrush for cavity prevention. vised 8/23/12, directed taff with all grooming tasks at 5000 plus with a toothbrush a.m. RN-C stated R12's am and treatment would not care guide for the NA's. RN-C eviDent was a prescription d have to obtain the tooth a nurse from the treatment cart othbrush. a.m. with RN-A present, an a south treatment and vealed no evidence of the am. RN-A stated the NA's cream from the nurse and a when the oral care was orther stated she was not sure am was located or how long it from the medication cart.	{F 28	2}		
{F 311} SS=D	stated he was not a supply had run out. 483.25(a)(2) TREAT IMPROVE/MAINTA		{F 31	1}		
	services to maintain	the appropriate treatment and n or improve his or her abilities uph (a)(1) of this section.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245587	B. WING			R	
	PROVIDER OR SUPPLIER ER CARE CENTER	240001		STREET ADDRESS, CITY, STATE, ZIP COD 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		(09/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{F 311}	Continued From pa	ge 6	{F 3	11}			
	by: Based on observate review, the facility for 3 of 4 residents activities of daily living Findings include: R21's care plan for followed. A computer-generate 1/9/14, indicated R2 hemiplegia, aphasia delusions. On 1/8/14, at 10:00 stated oral care had R21's oral care using NA-A further stated and would sometime to state he would refused. At 10:15 at and opened the top table. The drawer we papers and other are toothbrush, but was toothpaste. NA-A debrush R21's natural R21 would not open recanted his earlier not use either the tofor R21's oral care of the control of the	dental health was not ted Diagnosis Report dated 21's diagnoses included a, and vascular dementia with a.m. nursing assistant (NA)-A d already been completed ng toothbrush and toothpaste. R21 did not wear dentures es resist cares. NA-A went on e-approach R21 if cares were m. NA-A entered R21's room drawer in R21's bedside vas observed to contain many rticles. NA-A located R21's unable to locate any emonstrated how NA-A would teeth. During the observation, n their mouth for viewing. NA-A statement and stated he did bothbrush or any toothpaste earlier. R21 stated he instead oral care and denied knowing					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING		R 01/09/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 311}	to assist with brush three minutes using toothpaste. The car (as R21 allows) bruspecial attention to On 1/8/14, at 3:15 pstated both a toothl have been readily a with oral care. RN-not followed for R2 R45 was not provide by the care plan. A computer-general 1/9/14, indicated Rahemiplegia and dia On 1/8/14, at 9:05 a facility lobby area s R45's finger nails of to be long, jagged, matter under their followed R45 whowever NA-A stated R45 whowever NA-A stated R45 whowever NA-A stated rodor.	vised 12/18/13, directed staff ing R21's natural teeth for g a soft toothbrush and fluoride re plan directed to twice daily ish all sides of teeth and to pay R21's gum line. o.m. registered nurse (RN)-D orush and toothpaste should available in R21's room for use D confirmed the care plan was 1 for oral care. Ided with nail care as directed at ted Diagnosis Report dated 45's diagnoses included betes type 2. a.m. R45 was observed in the eated in a chair. Many of n both hands were observed and to contain dark-colored inger nail tips. At 10:15 a.m. as very resistive to cares, ed they were able to talk R45 other day" due to severe body nail care was not done by the	{F 31			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245587	B. WING			R 01/09/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 311}	done finger nail car Based on observati review, the facility f of 3 residents (R45 living (ADLs). Findings include: A computer-genera 1/9/14, indicated R4 hemiplegia and dia R45's quarterly Min 10/23/13, indicated impairment, was interpretable and required set up R45's Care Plan re assistance of one s activities and direct care. On 1/8/14, at 9:05 a in the facility lobby of R45's finger nails observed to be long dark-colored matte On 1/8/14, at 10:15 stated R45 was ver stated they were ab the other day due to stated nail care was diabetic residents.	A further stated she had never to for R45. Ion, interview, and document ailed to provide nail care for 1) reviewed for activities of daily Ited Diagnosis Report dated 45's diagnoses included betes type 2. Immum Data Set (MDS) dated R45 had moderate cognitive dependent in personal hygiene of help for bathing. Ivised 7/30/13, directed staff with all personal hygiene ed the nurse to provide nail In a.m. R45 was observed to be area seated in a chair. Many is on both hands were go, jagged, and to contain runder the finger nail tips. In a.m. nursing assistant (NA)-A by resistive to cares. NA-A of the totalk R45 into a shower of severe body odor. NA-A is not done by the NA's for	{F 31				
		a.m. licensed practical nurse went to podiatry for toe					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING			R / 09/2014
	PROVIDER OR SUPPLIER ER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 312 SS=D	done finger nail car. On 1/8/14, at 3:00 prefused a shower o with minimal assistathe nurses should half care and documentation on roon 1/9/14, at 1:35 pallowed the nurse to yesterday. At 2:22 pobserved to be trim stated the nails felt. A Care of Nails Polisince original surve diabetic residents who is undaily living receives maintain good nutri and oral hygiene. This REQUIREMENT by: Based on observative review, the facility for with oral care as or by the care plan for	A further stated she had never e for R45. D.m. RN-D stated R45 had n 1/6/14, but took a shower ance on 1/7/14. RN-D stated have provided R45 with finger mented the offer and/or refusal es. RN-D confirmed the lack of nail care. D.m. RN-D reported R45 o provide finger nail care o.m. R45's fingernails were med neat and clean. R45 okay. Scy dated 1/2009, not revised y; directed fingernails of were to be cut by the nurse.	{F3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING		R 01/09/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		703/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	on the morning of on 1/8/14, at 10:00 stated oral care had R21's oral care usin NA-A further stated and would someting to state he would refused. At 10:15 and opened the tograph to the tograph of the t	ded assistance with oral cares 1/8/14. Dia.m. nursing assistant (NA)-A dialready been completed ing toothbrush and toothpaste. If R21 did not wear dentures inces resist cares. NA-A went on e-approach R21 if cares were it.m. NA-A entered R21's room of drawer in R21's bedside was observed to contain many urticles. NA-A located R21's is unable to locate any lemonstrated how NA-A would all teeth. During the observation, in their mouth for viewing. NA-A in statement and stated he did oothbrush or any toothpaste earlier. R21 stated he instead oral care and denied knowing	F 312	,		
	further indicated Ricare and required ADL's and persona	21 displayed no rejection of extensive assistance with all lygiene activities. R21's 9/24/13, indicated R21 had				

NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER (A) ID (SA) ID (SA	-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COMPLETED	
REBENEZER CARE CENTER X312 X410 X410			245587	B. WING				
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 P21 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					2	545 PORTLAND AVENUE SOUTH	1 01/	03/2014
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 perfinent 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	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
skills, behaviors of inattention, and required extensive assistance with personal hygiene. R12's Care Plan revised 8/23/12, directed	F 312	obvious or likely car The ADL Care Area 9/18/13, identified F with ADLs including identified pertinent R21 having a "lowe tongue that hangs of R21's behavioral co identify oral/dental of R21's Care Plan re to assist with brush three minutes using toothpaste. The car (as R21 allows) bruspecial attention to On 1/8/14, at 3:15 p stated both a tooth have been readily a with oral care. RN-I not followed for R2 R12 was not provid care as ordered. A computer genera 1/9/14, indicated R bipolar disorder, de R12's quarterly MD R12 had short and had moderately imp skills, behaviors of extensive assistance	vity or broken natural teeth. Assessment (CAA) dated R21 required staff assistance grooming. Although the CAA mouth information such as or lip that protrudes with thick over, drools frequently" and oncerns, the CAA did not care needs. vised 12/18/13, directed staff ing R21's natural teeth for g a soft toothbrush and fluoride re plan directed to twice daily ish all sides of teeth and to pay R21's gum line. o.m. registered nurse (RN)-D orush and toothpaste should available in R21's room for use D confirmed the care plan was 1 for oral care. ded assistance to complete oral ted Diagnosis Report dated 12's diagnoses included mentia and osteoarthritis. S dated 11/27/13, indicated long-term memory deficits, paired daily decision making inattention, and required the with personal hygiene.		312			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245587	B. WING		0-	R 01/09/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		1/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	twice daily. An Order Summari 12/3/13, indicated 5000 Plus (Sodium twice daily with too A computer-general Record (TAR) date received the Previt from 12/1/13, to 1/5 treatment and four as provided. On 1/9/14, at 10:15 cares had already stated she had use R12's teeth. Upon table, NA-D was alwith a small tube ostated R12 resisted mouth. NA-D furth R12 had special to On 1/9/14, at 10:30 PreviDent tooth crebe specified on the stated since the Pritem, the NA's wou cream from the unito use with R12's to On 1/9/14, at 10:47 observation of the medication carts repreviDent tooth crewould get the tooth	y Report dated and signed R12 was to receive PreviDent a Fluoride Dental) cream 1.1% thbrush for cavity prevention. Ated Treatment Administration d 1/9/14, indicated R12 had Dent tooth cream twice daily 9/14; with one afternoon evening treatments not signed been provided that am. NA-D and a pink toothette to clean observation of R12's bedside ble to locate a toothbrush along of Colgate toothpaste. NA-D duse of a toothbrush in the per stated she was not aware othpaste to use. Dia.m. RN-C stated R12's eam and treatment would not be care guide for the NA's. RN-C eviDent was a prescription lid have to obtain the tooth it nurse from the treatment cart	F 3	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245587	B. WING			R / 09/2014	
	PROVIDER OR SUPPLIER ER CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 312	completed. RN-A further where the tooth creshad been missing from 1/9/14, at approstated R12's PreviDicated R12's insurance to stated he was not a supply had run out. An Oral Hygiene posince the original surance to state or supply had run out.	arrither stated she was not sure am was located or how long it from the medication cart. Eximately 2:00 p.m. RN-C Dent tooth cream was uired a pre-authorization for pay for a refill. RN-C further tware R12's tooth cream Dlicy dated 1/2009, not revised urvey, directed staff to offer breakfast, and at bedtime or	F3	12			

PRINTED: 01/31/2014 FORM APPROVED

Minnesota Department of Health

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	
			7t. Bolebiita.		F	1
		00191	B. WING		01/0	9/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	****ATTE	NTION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deputermination of which corrected requires requirements of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff survey exited on 12 and the following no issued: (2 565). The remain in effect from	TS: 1/9/14, a surveyor of this completed a revisit for the 2/5/13, for the above provider ew correction order was as new corrected order will me the original survey on a reviewed at the next site visit.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

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

(X6) DATE TITLE

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
					R	
		00191	B. WING		01/0	9/2014
	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Continued From pa	ge 1	{2 000}			
	date, make a copy original to the Minne Division of Complia Certification Progra	are completed, please sign and of these orders and return the esota Department of Health, nce Monitoring, Licensing and m; 85 East Seventh Place, . Paul, MN 55164-0882.		The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. To column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Metho Correction and the Time Period For Correction. PLEASE DISREGARD THE HEAD	Tag." the tute/rule ies" ply" his s which after the s veyors d of or	
				THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES T FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.	TO THIS	
				THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTAS STATUTES/RULES.	ON FOR	
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the .				
	This MN Requireme	ent is not met as evidenced				

Minnesota Department of Health

STATE FORM 6899 H7NV12 If continuation sheet 2 of 6

	ita Department of He		(VO) MULTIPLE	E CONCERNICATION	(VO) DATE	OLIDVE)/
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:	 -	_	
		00191	B. WING		01/0	२ 9/ 2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDENEZ		2545 POR	TLAND AVE	NUE SOUTH		
EBENEZ	ER CARE CENTER	MINNEAP	OLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	by: Based on observatireview, the facility fa for 3 of 4 residents activities of daily living for 3 of 4 residents activities of daily living for 3 of 4 residents activities of daily living for 3 of 4 residents activities of daily living for 3 of 4 residents activities of daily living for 3 of 4 residents activities of daily living for followed. R21's care plan for followed. A computer-generative for 1/9/14, indicated R2 hemiplegia, aphasia delusions. On 1/8/14, at 10:00 stated oral care using NA-A further stated and would some time to state he would refused. At 10:15 at and opened the top table. The drawer we papers and other and toothbrush, but was toothpaste. NA-A debrush R21's natural R21 would not oper recanted his earlier not use either the tof or R21's oral care of the for R21's oral care of the factor of the factor of R21's oral care of the factor of the factor of R21's oral care of the factor of the f	on, interview, and document ailed to follow the plan of care (R21, R12, R45) reviewed for ing (ADLs). dental health was not ted Diagnosis Report dated 21's diagnoses included a, and vascular dementia with a.m. nursing assistant (NA)-A dialready been completed ing toothbrush and toothpaste. R21 did not wear dentures nes resist cares. NA-A went on e-approach R21 if cares were in NA-A entered R21's room of drawer in R21's bedside was observed to contain many rticles. NA-A located R21's unable to locate any emonstrated how he would be teeth. During the observation, in their mouth for viewing. NA-A estatement and stated he did bothbrush or any toothpaste earlier. R21 stated he instead oral care and denied knowing	2 565			
	R21's Care Plan reto assist with brush three minutes using	vised 12/18/13, directed staff ing R21's natural teeth for g a soft toothbrush and fluoride re plan directed to twice daily				

Minnesota Department of Health

STATE FORM 6899 H7NV12 If continuation sheet 3 of 6

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
		00191	B. WING			R 09/2014
	PROVIDER OR SUPPLIER	2545 POR		STATE, ZIP CODE NUE SOUTH 5404	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	(as R21 allows) bruspecial attention to On 1/8/14, at 3:15 g stated both a tooth have been readily a with oral care. RN-I not followed for R2: R45 was not provid by the care plan. A computer-genera 1/9/14, indicated R4 hemiplegia and dial On 1/8/14, at 9:05 a facility lobby area se R45's finger nails of to be long, jagged, matter under their find NA-A stated R45 with however NA-A stated into a shower "the codor. NA-A stated in NA's for diabetic research as activities and direct care. On 1/8/14, at 10:30 (LPN)-A stated R45 nail/foot care. LPN-done finger nail car. On 1/8/14, at 3:00 g	sh all sides of teeth and to pay R21's gum line. o.m. registered nurse (RN)-D brush and toothpaste should available in R21's room for use D confirmed the care plan was I for oral care. ed with nail care as directed ted Diagnosis Report dated to be test type 2. a.m. R45 was observed in the eated in a chair. Many of In both hands were observed and to contain dark-colored inger nail tips. At 10:15 a.m. as very resistive to cares, and they were able to talk R45 other day" due to severe body at all care was not done by the sidents. vised 7/30/13, directed taff with all personal hygiene ed the nurse to provide nail a.m. licensed practical nurse is went to podiatry for toe A further stated she had never	2 565			

Minnesota Department of Health

STATE FORM 6899 H7NV12 If continuation sheet 4 of 6

AND DLAN OF CORRECTION INFINITEICATION NUMBER		` ′	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			
		00191	B. WING			R 09/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	· ·	
EBENEZ	ER CARE CENTER		RTLAND AVE	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 565	document the offer notes. RN-D confir documentation on research and all ready by the care plan. A computer general 1/9/14, indicated Resipolar disorder, de On 1/9/14, at 10:15 cares had already by stated she had user R12's teeth. Upon to table, NA-D was abwith a small tube of stated R12 resisted mouth. An Order Summary 12/3/13, indicated R12 resisted mouth. An Order Summary 12/3/13, indicated R12's Care Plan revial care plan revial sistence of one sand to use Previder twice daily. On 1/9/14, at 10:30 Prevident tooth create specified on the stated since the President control of the stated since the President resident control of the stated since the President resident control of the stated since the President resident control of the stated since the President control of the stated since the stated since the President control of the stated since th	and/or refusal in the progress med the lack of nail care. ed with oral care as directed ted Diagnosis Report dated 12's diagnoses included mentia and osteoarthritis. a.m. NA-D stated R12's oral been provided that am. NA-D d a pink toothette to clean observation of R12's bedside let to locate a toothbrush along Colgate toothpaste. NA-D I use of a toothbrush in the Report dated and signed R12 was to receive Prevident Fluoride Dental) cream 1.1% hbrush for cavity prevention. Vised 8/23/12, directed taff with all grooming tasks and 5000 plus with a toothbrush a.m. RN-C stated R12's am and treatment would not care guide for the NA's. RN-C evident was a prescription				
	Prevident tooth created specified on the stated since the President, the NA's would cream from the unit to use with R12's to On 1/9/14, at 10:47	am and treatment would not care guide for the NA's. RN-C evident was a prescription d have to obtain the tooth thurse from the treatment cart				

Minnesota Department of Health STATE FORM

H7NV12 If continuation sheet 5 of 6

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMP	LETED
		00191	B. WING		R 01/09/2014	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	medication carts re Prevident tooth crea would get the tooth return it to the nurse completed. RN-A fu where the tooth cre had been missing for	vealed no evidence of the am. RN-A stated the NA's cream from the nurse and e when the oral care was urther stated she was not sure am was located or how long it rom the medication cart. eximately 2:00 p.m. RN-C aware R12's tooth cream	2 565			

Minnesota Department of Health STATE FORM

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	PLETED
		245587	B. WING		1	1 19/2014
	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	TS	(F 000)			
{F 242} SS=D	as your allegation of Department's accelebottom of the first period be used as verificated. Upon receipt of an revisit of your facility validate that substated regulations has be your verification. Census 123 483.15(b) SELF-DI MAKE CHOICES The resident has the schedules, and he her interests, assee interact with member inside and outside about aspects of her are significant to the sased on observative, the facility bathing type and/or acceptance.	acceptable POC an on-site ty may be conducted to antial compliance with the en attained in accordance with ETERMINATION - RIGHT TO The right to choose activities, alth care consistent with his or assments, and plans of care; bers of the community both the facility; and make choices is or her life in the facility that the resident. ENT is not met as evidenced ation, interview, and document failed to honor the choice of or frequency for 2 of 3 residents	(F 242)	The facility will ensuresidents have choice activities, schedules, health care. R80's bath schedule was reviewed and changed according to R80's preference effective 1/9/14. R80's care plaupdated and is current reflecting R80's bathischedule preferences.	with and s n was ng	2/11/14
	(R21, R80) review Findings include:	ed for choices.		R21's bath schedule wareviewed and changed	S	
	R80 was not provi of baths per week	ded with the requested number	Ç., 1000000000000000000000000000000000000	preference effective 1/9/14.		And the second s
LABORATION	M DÎREC POR'S O R PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
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		245587	B. WING			01/0	09/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EDENE7	ER CARE CENTER			2545 PORTLAND AVENUE SOUTH			
EDENEZ	EN CARE CENTER			N	/IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 242}	1/9/14, indicated Rehemiplegia and mu R80's quarterly Min 1/1/14, indicated Remember and Status (BIM cognitive status) so cognitive impairment for personal hygien physical help in par R80's Care Plan rephysically prepared temperature, proviously shower, and prowash/dry R80's ent A Bath Schedule date be posted on a benurses station. The scheduled for a bat Tuesday with "please the Tuesday with "please the Tuesday block, Saturday day shift is con 1/8/14, at 2:10 plath per week was they used to have at the past and stated more than one tub they had lived at the really did not matter become "used to" of stated an early mor R80 slept poorly at Although R80 state in the day, R80 state in the day, R80 state in the state of R80 state in the state of R80 state in the day, R80 state in the day, R80 state in the state of R80 state in the day, R80 state in the state of R80 state of R80 state in the state of R80 state of R80 state of R80 state of R80 st	ted Diagnosis Report dated 80's diagnoses included tiple sclerosis. imum Data Set (MDS) dated 80 had a Brief Interview for S-tool used to measure ore of 12 and moderate of 12 and moderate of 12 and required to foothing activities. vised 4/15/10, directed staff to both, adjust water le assist of one staff in/out of ovide assist of one staff to ore body. Atted 12/30/13, was observed ulletin board at the first floor form indicated R80 was high during the day shift on se give shower early" typed on and on the Thursday and	{F 24		R21's care plan was updated and is current All nursing employees educated on 1/29/14 about honoring and document: resident choices. Audits will be conducted by nurse managers with oversight by the direct of nursing for 2 month until ongoing compliant is achieved.	were out ng ed tor s or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245587	B. WING				3
	PROVIDER OR SUPPLIER	243307	B. Wild	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> U1/0</u>	09/2014
EDENEZ	ER CARE CENTER			M	IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 242}	stated if R80 had be should be documer further stated R80 week on Tuesday in could not agree to a three times per week nurses progress no bath/skin check wa on 1/7/14. The progress of documentation R80 scheduled baths per documentation a bath on 12/31/13. On 1/8/14, at 4:00 per medical record lack declined bath times inform him R80 was scheduled baths per receive a bath on 1 skin check, but the check was perform R21 was not received. A computer-general 1/9/14, indicated R2 hemiplegia, aphasis delusions. R21's quarterly MD R21 had short and moderately impairminattention and psychological progression.	pleted. D.m. registered nurse (RN)-C een refusing baths, the refusal ted in the nurses notes. RN-C was just getting one bath per norning. RN-C stated R80 a time or day for the requested ek. Review of the electronic tes for R80 revealed a sperformed on 12/24/13, and gress notes lacked had refused the other two er week and lacked ath/skin check was performed D.m. RN-C confirmed R80's ted documentation of the cydays offered and staff did not as refusing the other two er week. RN-C stated R80 did 2/31/13, along with a weekly nurse forgot to chart the skin	{F 2	42}			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		LE CONSTRUCTION		E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER	240001	B. WIING	,	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>U1/(</u>	09/2014
					2545 PORTLAND AVENUE SOUTH		
EBENEZ	ER CARE CENTER			ı	MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 242}	rejection of care, re with all activities of opersonal hygiene and dependent with bath 9/24/13, indicated F R21's Care Plan revito physically prepartemperature, two stoof tub/shower, and R21's entire body with meeded. An electronic Progradated 12/31/13, indicated 12/31/13, indicated for R21. The Preferred a shower. A Bath Schedule dable located in a 3-rinunit. The form indicated in a 3-rinunit. The form indicated for R21 was too resistively shower or the bath from the more cooperative with confirmed the writtes elect the bath type	equired extensive assistance daily living (ADL's) including ctivities, and was totally hing. R21's annual MDS dated R21 preferred a tub bath. Vised 12/18/13, directed staff re bath, adjust water taff to transfer R21 in and out one staff to wash and dry with assistance of two staff as ress Note labeled late entry licated a care conference was rogress Note identified R21 Atted 1/7/14, was observed to high binder book on the 3 South rated R21 was to receive a lay shift. In a.m. NA-A stated R21 was be for the weekly bath, but was a full bed bath. NA-A stated ve to be bathed either in the tub; NA-A stated R21 was	{F 2	42}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		SURVEY PLETED
				<u></u>	R	
		245587	B. WING _		01/0	9/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FRFNF7	ER CARE CENTER			2545 PORTLAND AVENUE SOUTH		
LDLINLL	EN OANE GENTEN			MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 242} {F 282} SS=D	Federal And Minnedated 7/2007, was the statement, "5. and receive service reasonable accompreferences" 483.20(k)(3)(ii) SEPPERSONS/PER CATHE SERVICES PROVICE MUST BE PROVICED BY THE SERVICES PROVICES PROVICED BY THE SERVICES PROVICES PROVICED BY THE SERVICES PROVICES PROVICED BY THE SERVICES PROVICES PROVI	ight Under The Combined sota Bill Of Rights booklet not updated, and contained You have the right to reside as in the facility with modations of your needs and RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in uch resident's written plan of NT is not met as evidenced p.m. RN-D stated the nurses with finger nail care and fer and/or refusal in the l-D confirmed the lack of nail care. ed with oral care as directed ted Diagnosis Report dated 12's diagnoses included mentia and osteoarthritis. a.m. NA-D stated R12's oral peen provided that am. NA-D d a pink toothette to clean observation of R12's bedside le to locate a toothbrush along	{F 242	2}	ed with of ee n. ean with as	2/11/14
	On 1/9/14, at 10:15 cares had already be stated she had use R12's teeth. Upon cotable, NA-D was ab with a small tube of	mentia and osteoarthritis. a.m. NA-D stated R12's oral been provided that am. NA-D d a pink toothette to clean observation of R12's bedside		oral care consistent resident plan of care well as proper	with as	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245587		B. WING		R 01/09/2014		
NAME OF F	PROVIDER OR SUPPLIER	243301		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/0	19/2014
	ER CARE CENTER			545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	Continued From page 5 mouth.		{F 282}	conducted by nurse		
		Report dated and signed R12 was to receive PreviDent		management with oversi	_	
	5000 Plus (Sodium	Fluoride Dental) cream 1.1%		by the director of nur	sing	
		hbrush for cavity prevention. vised 8/23/12, directed		for 3 months or until		
	assistance of one s	taff with all grooming tasks		ongoing compliance is		
	and to use PreviDe twice daily.	nt 5000 plus with a toothbrush		achieved.		
	PreviDent tooth cre be specified on the stated since the Pre item, the NA's woul	a.m. RN-C stated R12's cam and treatment would not care guide for the NA's. RN-C eviDent was a prescription d have to obtain the tooth t nurse from the treatment cart pothbrush.				
	observation of the 2 medication carts re PreviDent tooth cre would get the tooth return it to the nurse completed. RN-A further the tooth cre	a.m. with RN-A present, an 2 South treatment and vealed no evidence of the eam. RN-A stated the NA's cream from the nurse and e when the oral care was aurther stated she was not sure eam was located or how long it rom the medication cart.				
{F 311} SS=D	stated he was not a supply had run out. 483.25(a)(2) TREA	TMENT/SERVICES TO	{F 311}			
	services to maintain	the appropriate treatment and n or improve his or her abilities $aph(a)(1)$ of this section.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		A. BOILDING			R		
		245587	B. WING			01/09/2014	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EBENEZ	ER CARE CENTER				545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 311}	This REQUIREMEI by: Based on observa	JIREMENT is not met as evidenced observation, interview, and document		11}	The facility will ensure that residents are provided appropriate treatment and services to		2/11/14
		ailed to follow the plan of care (R21, R12, R45) reviewed for ing (ADLs).			maintain or improve hi her abilities.	s or	
	Findings include:				R21's care plan was		
R21's care plan for dental health was followed. A computer-generated Diagnosis Rep 1/9/14, indicated R21's diagnoses incl hemiplegia, aphasia, and vascular del delusions. On 1/8/14, at 10:00 a.m. nursing assis stated oral care had already been con R21's oral care using toothbrush and NA-A further stated R21 did not wear and would sometimes resist cares. Not to state he would re-approach R21 if or refused. At 10:15 a.m. NA-A entered I and opened the top drawer in R21's be table. The drawer was observed to copapers and other articles. NA-A located toothbrush, but was unable to locate a toothpaste. NA-A demonstrated how I brush R21's natural teeth. During the R21 would not open their mouth for virecanted his earlier statement and stanot use either the toothbrush or any to for R21's oral care earlier. R21 stated used toothettes for oral care and deniwhere R21's toothpaste was located.		ted Diagnosis Report dated 21's diagnoses included			updated and is current R21's oral care is bei provided in accordance with R21's plan of car R45's care plan was	.ng	
		d already been completed ng toothbrush and toothpaste. I R21 did not wear dentures nes resist cares. NA-A went on e-approach R21 if cares werem. NA-A entered R21's room o drawer in R21's bedside was observed to contain many rticles. NA-A located R21's sunable to locate any emonstrated how NA-A would It teeth. During the observation, n their mouth for viewing. NA-A r statement and stated he did oothbrush or any toothpaste earlier. R21 stated he instead oral care and denied knowing			updated and is current R45's nail care is bei provided in accordance with R45's plan of car R12's care plan was updated and is current R12's care is being provided in accordance with R12's plan of car All nursing employees educated on providing that maintains or impr residents abilities or 1/29/14	ing e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245587		B. WING			R 01/09/2014		
NAME OF I	PROVIDER OR SUPPLIER		Т	STREET ADDRESS, CITY, STATE, ZIP C		00/2011	
				2545 PORTLAND AVENUE SOUTH			
EBENEZ	ER CARE CENTER			MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
{F 311}	R21's Care Plan re to assist with brush three minutes using toothpaste. The car (as R21 allows) bruspecial attention to On 1/8/14, at 3:15 pstated both a tooth have been readily a with oral care. RN-I not followed for R2 R45 was not provide by the care plan. A computer-genera 1/9/14, indicated R4 hemiplegia and dial. On 1/8/14, at 9:05 a facility lobby area s R45's finger nails of to be long, jagged, matter under their f NA-A stated R45 whowever NA-A stated rinto a shower "the codor. NA-A stated rinto a shower "the	vised 12/18/13, directed staff ing R21's natural teeth for g a soft toothbrush and fluoride re plan directed to twice daily ish all sides of teeth and to pay R21's gum line. D.m. registered nurse (RN)-Dorush and toothpaste should available in R21's room for use Doconfirmed the care plan was 1 for oral care. Ided with nail care as directed ted Diagnosis Report dated 45's diagnoses included betes type 2. a.m. R45 was observed in the eated in a chair. Many of n both hands were observed and to contain dark-colored inger nail tips. At 10:15 a.m. as very resistive to cares, ed they were able to talk R45 other day" due to severe body nail care was not done by the	{F 31	Audits will be compared by nurse management oversight by the configuration of nursing for 3 muntil ongoing compared achieved.	nt with director months or		
		went to podiatry for toe					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	245587		B. WING			R 01/09/2014	
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	1 01/1	55/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 311}	nail/foot care. LPN-done finger nail care Based on observatireview, the facility fof 3 residents (R45 living (ADLs). Findings include: A computer-genera 1/9/14, indicated R-hemiplegia and dia R45's quarterly Min 10/23/13, indicated impairment, was in and required set up R45's Care Plan reassistance of one sactivities and direct care. On 1/8/14, at 9:05 in the facility lobby of R45's finger nails observed to be long dark-colored matter. On 1/8/14, at 10:15 stated R45 was verstated they were at the other day due to stated nail care was diabetic residents. On 1/8/14, at 10:30	A further stated she had never re for R45. ion, interview, and document failed to provide nail care for 1 is reviewed for activities of daily ated Diagnosis Report dated 45's diagnoses included abetes type 2. nimum Data Set (MDS) dated I R45 had moderate cognitive dependent in personal hygiene	{F 3	11)	}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	245587		B. WING		R 01/09/2014	
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION	
{F 311}	nail/foot care. LPN-done finger nail care On 1/8/14, at 3:00 prefused a shower of with minimal assist the nurses should be nail care and docur in the progress noted documentation on a compart of the progress noted documentation on a	A further stated she had never e for R45. D.m. RN-D stated R45 had in 1/6/14, but took a shower ance on 1/7/14. RN-D stated have provided R45 with finger mented the offer and/or refusal es. RN-D confirmed the lack of hail care. D.m. RN-D reported R45 or provide finger nail care on. R45's fingernails were med neat and clean. R45 okay. Dick dated 1/2009, not revised by; directed fingernails of were to be cut by the nurse. CARE PROVIDED FOR	{F 3		ving cood nd ene.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY PLETED
		245587	B. WING			1	R 09/2014
	PROVIDER OR SUPPLIER ER CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	on the morning of 1 On 1/8/14, at 10:00 stated oral care had R21's oral care usin NA-A further stated and would sometim to state he would re refused. At 10:15 a and opened the top table. The drawer v papers and other a toothbrush, but was toothpaste. NA-A d brush R21's natura R21 would not ope recanted his earlier not use either the to for R21's oral care used toothettes for where R21's toothp A computer-genera 1/9/14, indicated R hemiplegia, aphasi delusions. R21's quarterly Min 12/24/13, indicated memory deficits, m decision making sk psychomotor retard further indicated R care and required of ADL's and persona	led assistance with oral cares 1/8/14. It a.m. nursing assistant (NA)-A dalready been completed ng toothbrush and toothpaste. It R21 did not wear dentures nes resist cares. NA-A went on e-approach R21 if cares were .m. NA-A entered R21's room of drawer in R21's bedside was observed to contain many rticles. NA-A located R21's sunable to locate any emonstrated how NA-A would I teeth. During the observation, in their mouth for viewing. NA-A statement and stated he did bothbrush or any toothpaste earlier. R21 stated he instead oral care and denied knowing paste was located. Itted Diagnosis Report dated 21's diagnoses included a, and vascular dementia with aimum Data Set (MDS) dated R21 had short and long-term oderate impaired daily	F3		R12's oral care is being provided in accordance with R12's updated care plan. R12's order summade was updated to reflect discontinued use of PreviDent 5000 reflect R12's choice through Rivesponsible party effective 1/10/14. All nursing employees reducated ab providing proper oral care and this importance of accurate documentation on 1/29/Audits will be conducted by nurse management with oversight by the direct of nursing for 3 month until ongoing compliancies achieved.	ing 12's were he 14. ed th tor s or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245587	B. WING			R 01/09/2014
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312	obvious or likely can The ADL Care Area 9/18/13, identified I with ADLs including identified pertinent R21 having a "lowe tongue that hangs R21's behavioral or identify oral/dental R21's Care Plan re to assist with brush three minutes using toothpaste. The ca (as R21 allows) bruspecial attention to On 1/8/14, at 3:15 stated both a tooth have been readily a with oral care. RN-not followed for R2 R12 was not proviocare as ordered. A computer genera 1/9/14, indicated R bipolar disorder, de R12's quarterly MDR12 had short and had moderately im skills, behaviors of extensive assistance R12's Care Plan response readily a control of the readily in skills, behaviors of extensive assistance R12's Care Plan response readily a control of the readily and readily	vity or broken natural teeth. A Assessment (CAA) dated R21 required staff assistance g grooming. Although the CAA mouth information such as er lip that protrudes with thick over, drools frequently" and oncerns, the CAA did not care needs. vised 12/18/13, directed staff sing R21's natural teeth for g a soft toothbrush and fluoride re plan directed to twice daily ush all sides of teeth and to pay R21's gum line. p.m. registered nurse (RN)-D brush and toothpaste should available in R21's room for use D confirmed the care plan was	F3	12		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245587	B. WING			i	⊰ 09/ 2014
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	twice daily. An Order Summary 12/3/13, indicated F 5000 Plus (Sodium twice daily with toot A computer-general Record (TAR) dated received the Previous from 12/1/13, to 1/9 treatment and four as provided. On 1/9/14, at 10:15 cares had already a stated she had use R12's teeth. Upon a table, NA-D was abwith a small tube of stated R12 resisted mouth. NA-D furth R12 had special too On 1/9/14, at 10:30 PreviDent tooth crebe specified on the stated since the PreviDent tooth crebe with R12's too On 1/9/14, at 10:47 observation of the 2 medication carts re PreviDent tooth crewould get the tooth	Report dated and signed R12 was to receive PreviDent Fluoride Dental) cream 1.1% thbrush for cavity prevention. Ited Treatment Administration d 1/9/14, indicated R12 had Dent tooth cream twice daily 0/14; with one afternoon evening treatments not signed been provided that am. NA-D d a pink toothette to clean observation of R12's bedside ble to locate a toothbrush along if Colgate toothpaste. NA-D If use of a toothbrush in the er stated she was not aware othpaste to use. It a.m. RN-C stated R12's sam and treatment would not care guide for the NA's. RN-C eviDent was a prescription d have to obtain the tooth t nurse from the treatment cart	F3	312			

A. BUILDING R 245587 B. WING 01/09/2	/2014
245587 B. WING 01/09/2	/2014
	2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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.	

Minnesota Department of Health									
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
AND FLAIN	O CONTROLLONG	ን የመረ የመርት መር ትር ነው	A, BUILDING:						
		00191	B, WING		01/0	≀ 9/2014			
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE					
EBENEZ	ER CARE CENTER		OLIS, MN 5	NUE SOUTH 5404					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE			
{3 000}	INITIAL COMMEN	TS	{3 000}						
	*****ATTENTIC	DN*****							
	BOARDING CAF LICENSING CORP								
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall with a schedule of the Minnesota Dep	hether a violation has been		DRAFT					
	number and MN Ru When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	e rule provided at the tag ule number indicated below, ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was							
	that may result fror orders provided tha the Department wit	hearing on any assessments in non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.							
Minnesota E	Department's staff survey exited on 12 and the following c corrected: (3 975, 3 orders will remain i	1/9/14, a surveyor of this completed a revisit for the 2/5/13, for the above provider orrection orders are not 3 1810). These uncorrected in effect from the original							
LABORATOR	Y DIRECTOR'S OF PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	77 TITLE		(X6) DATE			

STATE FORM

6899

H7NV12

If continuation sheet 1 of 11



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.

Ebenezer Care Center January 30, 2014 Page 2

Sincerely,

Dre Klegge

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00191

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

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.



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

Ebenezer Care Center December 17, 2013 Page 2

at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

Ebenezer Care Center December 17, 2013 Page 4

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

Ebenezer Care Center December 17, 2013 Page 5

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

Dre Klegge

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245587	B. WING		12/05/2013	
	PROVIDER OR SUPPLIED ER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
F 000	as your allegation Department's acc bottom of the first be used as verific Upon receipt of an revisit of your faci validate that subs regulations has be your verification. A standard recerti investigation were H5587036 was no 483.15(b) SELF-I MAKE CHOICES The resident has schedules, and he her interests, assi interact with mem inside and outside about aspects of are significant to t This REQUIREMI by: Based on observ review, the facility preferences was a of 3 residents (R8 routine. Findings include:	of correction (POC) will serve of compliance upon the eptance. Your signature at the page of the CMS-2567 form will ation of compliance. In acceptable POC an on-site lity may be conducted to tantial compliance with the een attained in accordance with fication survey and complaint a conducted. Complaint of substantiated. DETERMINATION - RIGHT TO the right to choose activities, ealth care consistent with his or essments, and plans of care; there of the community both a the facility; and make choices his or her life in the facility that	acceptus 17-3/13	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 construe as an admission against the interest the facility, its administrator or an employees, agents or other individual who draft or may be discussed in this credible allegation of compliance. In addition, preparation and submission 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 correctness of any conclusions set for in this allegation by the survey agen	d of of y s of e c c c c c c c c c c c c c c c c c c	

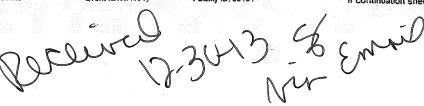
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H7NV1)

Facility ID: 00191

If continuation sheet Page 1 of 35



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245587	B. WING		12/	05/2013	
	PROVIDER OR SUPPLIER ER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	CODE	00/2013	
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F 242	R80's preference for shower in a week with two parts of the past to staff a more often and not further stated her past to staff a more often and not further stated her past to staff a more often and not further stated her past to staff a more often and not further stated her past to staff a more often and not further stated her past to stated her past to p	th R80 on 12/3/13, at 12:45 want a bath at least daily but with three times weekly." R80 the staff would not probably as she had made statements about wanting to be bathed hing had been done. R80 reference was to take a bath o do so previously through her the facility when she lived in to p.m. during an interview, irty with the one shower. I to give me more they would en here so long that you would	F 2	All resident's preference updated at their next so care conferences and a nurses were educated importance to honor rewishes with respect to plans of care including effective 12/19. All nurses assistants were educated same on 12/30/13. Nurse managers will accompliance is achieved oversight by the Director.	cheduled all licensed on the sidents scheduling bathing sing ted for the dminister until ongoing		
	disease, hemiplegic to cerebrovascular sclerosis (MS), unsidisease, and gener quarterly Minimum 9/25/13. R80's annual MDS following quarterly Interview for Mental measure cognition) out of the possible 9/25/13, indicated I part with bathing necustomary Routine in the activities of discourse in the section of the common out of the possible 9/25/13, indicated I part with bathing necustomary Routine in the activities of discourse in the section of the common of	cluded cerebrovascular a affecting dominate side due disease (CVD), multiple pecified peripheral vascular alized pain obtained from the Data Set (MDS) dated dated 3/25/13, and two MDS's indicated R80's Brief I Status (BIMS-tool used to was intact with a score of 15 15. The quarterly MDS dated R80 needed physical help in eeds. The Preference for esection of the MDS was blank aily living (ADL's) section of inual MDS's dated 3/35/12,					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 242	and 3/25/13. The ADL care plan with a self-care def hemiplegia, right sh "will be clean, odor dressed and groom directed staff to phy water temperature, tub/shower and ass body. The ADL Care	dated 4/15/10, identified R80 icit related to right side noulder fracture 4/23/08. Goal free and appropriately ned daily." The care plan /sically prepare bath, adjust assist of one in/out of sist of one to wash/dry entire e Area Assessment (CAA) cated R80 required assistance	F	242			
	MDS RN-D stated to responsible to over would be scheduled resident needed more would re-arrange to to accommodate the further stated the fassessment that we baths/shower a reshad the MDS portion portion in the last to completed by the n R80 was receiving Tuesday.	7 p.m. during an interview the the nurse manager's is see what days a resident d to get a shower/bath. If a pre showers the manager of help with the floor work flow the resident needs. RN-D acility does not have a tool or could actually ask how many ident would prefer and only on and verified that the ADL wo annuals had not be urse manager. RN-D verified a bath once a week and on					
	(DON) stated reside been asked with the was currently being showers by the mal accommodated. The facility Your Right	p.m. the director of nursing ent preferences should have e annual MDS and that R80 interviewed on the number of nager and would be ght Under The Combined sota Residents Bill Of Rights					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING		12/	05/2013	
	PROVIDER OR SUPPLIER ER CARE CENTER		. 2	STREET ADDRESS, CITY, STATE, ZIP CODE 1545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404			
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F 242	reside and receive reasonable accomm	ge 3 2007, "5. You have the right to services in the facility with nodations of your needs and	F 242				
F 279 SS=D	to develop, review a comprehensive plan The facility must de plan for each reside	he results of the assessment and revise the resident's n of care. velop a comprehensive care ent that includes measurable	F 279	The facility will use the results assessment to develop, review revise the resident's comprehalplan of care. R45's care plan is updated an current. R45 was provided a	w and ensive	12/30/13	
- -	medical, nursing, ar	tables to meet a resident's nd mental and psychosocial tified in the comprehensive		toothbrush and toothpaste on 12/4/13. All licensed nurses w educated on the importance of	ere		
	to be furnished to a highest practicable psychosocial well-b §483.25; and any se be required under § due to the resident's	describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under the right to refuse treatment.		care and following the facility for proper oral care effective 1 All nursing assistants were educated for the same effective 12/30. Audits by nurse management resident care plans will continuation.	12/19. /e of		
	by: Based observation review, the facility fa	e plan for 1 of 3 residents		3 months or until ongoing compliance is achieved with oversight by the director of nu	rsing.		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245587	B. WING			121	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404	1	00/2013
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F 279		ge 4 ed direction for R45's oral care.	F 2	279			
	R45's teeth were ye particles. When into stated that he had r had been there (six never offered a tool never asked for one teeth with his finger	3/13, at 8:53 a.m. revealed ellow and contained food erviewed at that time R45 not brushed his teeth since he months). He said he was thbrush or toothpaste and e. He also stated cleans his is once in a while. R45 stated ood teeth with only one cavity	-				
	p.m. revealed there toothpaste in the ro looked in the pink be was a hairbrush in R45's drawers and toothpaste or toothl confirmed oral care individual's overall left toothbrus	's room on 12/4/13, at 1:15 was no toothbrush or om. Registered nurse (RN)-A asin which was empty, there the room. RN-A looked in confirmed that there was no brush in R45's room. RN-A was important to an nealth. She would be sure to h and toothpaste right away. It is had been non-compliant with					
	had problems with a related to self-care with right sided hen and cognitive defici of one with persona and to remind to do	ated 10/8/13, indicated R45 activity of daily living (ADLs) deficit from weakness, stroke hiparesis (partial paralysis), ts. Interventions include assist al hygiene, showers, dressing, am/pm cares. The care plan h regards to oral hygiene.					
	easily frustrated. The cognitive problems	listed R45 as impulsive and ne care plan also included related to short and long term ntervention of to give					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245587	B. WING _			12/(05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			25	REET ADDRESS, CITY, STATE, ZIP CODE 45 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	3	PROVIDER'S PŁAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279		ain appropriate function.	F 2	79			
	directed staff that R	nt assignment chart undated, 45 required assist of one with as needed, prompt and cue.					
	nursing assistant (N	ooming and oral hygiene but					
	said the residents a	on 12/4/13, at 1:00 p.m. RN-A re given a bag of personal hbrushes and toothpaste on					
	director of nursing (that residents received hygiene needs. When sured that reside toothpaste, she said be done on that reside toothpaste.)	on 12/5/13, at 1:00 p.m. the DON) said it was expected we assistance with oral en asked how the facility nts have toothbrushes and d room checks would need to ident to ensure he had the . The DON confirmed the care giene care.					
F 282 SS=D	January 2009, instr hygiene before brea assignment sheet. 483.20(k)(3)(ii) SEF	led, Oral Hygiene, dated ucted staff to offer oral akfast and at bedtime or per RVICES BY QUALIFIED ARE PLAN	F 2	82			
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of			*		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245587	B. WING		1910)5/2013
	PROVIDER OR SUPPLIER ER CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	12/0	012013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From page 6 This REQUIREMENT is not met as evidenced		F 282	The facility will provide service	•	12/30/13
	by: Based on observar review, the facility f for 2 of 3 residents activities of daily liv Findings include: R19 did not receive care plan. Observation on 12/ R19 had several te loose and decayed 12/2/13, at 4:55 p.n any problems with I had several teeth o extraction. He also trouble eating. R19 rotten teeth out." Observation on 12/ breakfast and with a sadness, was frown cereal and half the After breakfast staff Oral care was not c At 1:30 p.m. regis if he was OK and h pain at that time. At 2:00 p.m. revear room, no complaint	cion, interview and document ailed to follow the plan of care (R19, R21) reviewed for ing. I dental care as directed in the 2/13, at 4:40 p.m. revealed eith on the lower jaw that were When interviewed on n. R19 was asked if he had his mouth. R19 replied that he in the lower jaw that need said he sometimes had said, "I need to get those 4/13, at 7:59 a.m. R19 was at a facial expression of hing, ate the soft oatmeal toast and hardboiled egg. If assisted R19 back to room. Iffered. Itered nurse (RN)-A asked R19 is replied yes and he denied aled the resident was in dining sof pain.		qualified persons in accordance with each residents written placare. R19's care plan is updated an current. With coordination of the attending NP and dentist, a plain place for additional visit(s) to dentist per NP recommendation. The facility continues to maintant R19's daily oral care and montreat pain as necessary. R21's nails were cleaned and effective 12/4/13. R21's care pupdated and current. All licensed staff were educated about checking for referral return dentists and proper resid hygiene effective 12/19/13. Audits for dental referrals and resident hygiene began 12/16/ and will continue for 3 months until ongoing compliance is achieved with oversight by the	d is he an is the ons. ain itor/ olan is ed urns ent	
٧	resident was in the asked if he had any	5/13, at 10:00 a.m. the room in bed resting. When mouth pain at that time he o get to the Veteran's		director of nursing.		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245587	B. WING		12/	05/2013	
	PROVIDER OR SUPPLIER ER CARE CENTER		S 2 N		,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 282		nge 7 as they know him there. ted 4/17/13, included 2%	F 282				
	Lidocaine solution of effected teeth/gums. The doctor's orders Brush teeth after m	a topical anesthetic) 15cc to s every four hours as needed. dated 8/27/13, included: eals, put toothpaste on lower ly) and PRN (as needed) for					
	assessment dated admitted with obvious natural teeth. The G date 4/18/13, noted	imum Data Set (MDS) 4/18/13, indicated R19 was ous or likely cavity or broken Care Area Assessment (CAA) I R19 triggered for dental care dentition. Staff was to arrange ded.					
	self-care deficit rela has own teeth but I missing teeth. Inter	of care dated, 10/10/13, listed ated to cognitive impairment, has poor dentition and some ventions included staff to hall cares twice daily and needed.					
		note dated 10/31/13, indicated ol daily for pain and had not not recently.					
	medical doctor (ME fairly glum, compla Has had multiple dhad persisted. The tooth or teeth (prim seems intractable vextensive work up.	ted 11/3/13, by the residents b) noted resident was quiet, ining of teeth bothering him. ental visits and the problem MD impression was "pain in a ary encounter diagnosis) without cause found despite " The plan was to continue (a mild analgesic) and oral					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245587	B. WING		•	121	05/2013
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404		00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 282	,		F:	282			
	R19 was assessed				·		
	medication adminis 2013. R19 had not the PRN Lidocaine also said R19 has i	on usage was reviewed in the stration record for December received the PRN Tylenol or in December of 2013. RN-B not asked for the topical they used that more in the first rer last summer.					
	When requested, n	o documentation of a dental ne medical record.					
	nursing assistant (I complain of mouth	on 12/4/13, at 9:00 a.m. NA)-A said that R19 did pain occasionally. She also up his toothbrush for him and		:			
	family member (F)- dad to the dentist we dentist extracted to the direction for foll supposed to return problems. FM-A did R19 still complaine	on 12/4/13, at 10:55 a.m. A stated that he had taken his with in the last six months. The wo teeth at that time. FM-A said low up was that he was if he had any further d say that he was aware that d of occasional mild mouth was more related to dementia.					
	stated that R19 red	on 12/4/13, at 11:14 a.m. RN-B eived Tylenol three times daily. order for additional Tylenol if					
	RN-A said that R19	on 12/4/13, at 11:31 a.m. the b's son had taken him to the round date of admission. RN-A				,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245587	B. WING			12/0	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	was unable to find a the dental visit. RN health unit coordina appointments, the s referral and it's alway getting information to the dentist, why won it I don't know." When interviewed on urse practitioner (I him get those rotter went on to explain to the dentist some facility and that their within the family dyagreed it would be dentist and have the for R19 in regards to NP confirmed R19 pain. The NP confirmed R19 has referred to find the confirmed R19 pain. The NP confirmed R19 has referred to find the confirmed R19 pain. The NP confirmed R19 has referred to find the confirmed R19 pain. The NP confirmed R19 has referred to find the confirmed R19 pain.	any documentation related to A said, "I am betting the stor did not set up those son did. We likely sent a says a fifty-fifty chance of back. I know he has been out we don't have any paperwork on 12/4/13, at 2:50 p.m. R19's NP) said," I would I like to see a teeth pulled, yes." The NP that the family had taken R19 time around admission to the re was some dysfunction namics. The NP and RN-A a good idea to contact the em fax over recommendations to his dental/oral health. The had intermittent mild mouth med R19 was on scheduled d not been used the PRN ut had used the PRN Tylenol	F2	282			
	A progress note dar R19 was comfort or inner turmoil. The for highly focused on so was assessed by the intermittent mild mo and much better the dental pain was und son. Not medically resident, addressed seemed to need bro	nt on 12/4/13, in the afternoon. Ited same indicated the goal for are and that the family had amily power of attorney was aving money. The resident the NP as having chronic buth pain, repetitive in nature, an when admitted. R19's changed by dental visits per opposed to dental follow up for d in past with them, family eak, suspect some caregiver family to escort, preferable to					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245587	B. WING	·	·	12/	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER		:	2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404	· ·	30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			(X5) COMPLETION DATE
F 282	When interviewed of said she had containformed that the rethe last visit. RN-A indicated to her that them in the future of last appointment. Redentistry to obtain a The facility policy tit October 2011, indice policy to assist the achieving dental he was to ensure reside best possible dentained R21 was not provided R21 was observed during the evening subsequent days of 12/4/13. On 12/2/13, at 3:15 on the bed and was approximately a has soiled nails to both matter underneath On 12/3/13, 10:08 a observed still long a and soiled R21 was approximated and soiled R21 was	on 12/5/13, at 2:00 p.m. RN-A cted the dentist and was esident had two extractions at also said the dentist had to R19 would not be treated by live to resident agitation at the RN-A said she would call senior an appointment for R19. Ited, Dental Policy, dated sated that it was the facility residents in maintaining and salth. The purpose of the policy dents maintain and achieve the all health. Ited assistance with nail care. Ited assistance with nail care.	F	282	DEFICIENCY)		
	bed with head of be RN-G observed add medications in pude	p.m. observed R21 lying in ed elevated at 60 degrees ministering resident ding. After she completed cations wipe R21's mouth but			*		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245587	B. WING _		12/	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICE OF THE	LD BE	(X5) COMPLETION DATE
F 282	never offered to trin On 12/4/13, at 7:22 bed all dressed and completed providing explained to survey assisted R21 with a resistive but would a cares to a certain e would attempt to sh still observed to hav nails to both hands. On 12/4/13, at 8:34 dining room RN-F s never offered to ren breakfast On 12/4/13, at 9:32 observations R21 ly uneven, jagged edg -At 2:30 p.m. obser watching TV R21 al Nails remain soiled The ADL care plan R21had self-care de	a.m. observed R21 lying in I NA-C stated he had just g morning cares. NA-C or all the cares he had and that R21 was mostly allow staff at times to do the extent. NA-C further stated he have R21 after breakfast. R21 we long uneven jagged soiled a.m. observed R21 at the citting next to him feeding him move R21's long nails after a.m. during random ving in his bed with nails still	F 28	82		
	plan also identified cares also. Care plate dressed with physic directed staff to proof staff to do nail can NA assignment she directed R21 requirements. The annual MDS da required extensive to the care of the	R21 can be resistive with an goal "Will be appropriately all assist of staff." Care plan vide R21 with physical assist are after bath and PRN. The ets for all three shifts undated, ed total assistance with ADL's. ated 9/17/13, identified R21 to total physical assist of one ADLs including personal				

	OF DEFICIENCIES OF CORRECTION			SURVEY LETED			
		245587	B. WING		12/0	5/2013	
	PROVIDER OR SUPPLIER ER CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		312010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			
F 282	dated 9/18/13, indic deficit and required	ge 12 Functional/Rehabilitation CAA cated R21 had a self-care staff assistance for dressing, ng, bathing and toileting.	F 282				
	Sheet and Weekly I from 5/14/13, through been documented a	eview of the Skin/Bath Flow Bath Skin and Pain Sheet gh 11/26/13, nail care had as completed once on 7/30/13, d been documented "Refused"					
	the Progress notes medications and for	ment review it was revealed in R21 had refused cares, od five times between 5/6/13, with documentation specifically e on 10/12/13.					
	who stated he had nail care during the nails were soiled, u	p.m. interviewed the NA-C not offered or attempt to do shift but acknowledged the neven and jagged. NA-C was resistive with cares		-			
	nails were long, une	p.m. RN-F verified R21's even and jagged then left the ame back with a clipper and a					
	applied gloves and RN-F and started to observation R21 all	p.m. both RN-F and NA-C NA-C took the clipper from trim R21's nails. During owed NA-C trim all his nails the nails and was never	,				
_		p.m. RN-C was interviewed tation was R21 and all other					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATI COM	ATE SURVEY OMPLETED	
	**	245587	B, WING	, , , , , , , , , , , , , , , , , , ,		12/	05/2013	
	PROVIDER OR SUPPLIER ER CARE CENTER	•		STREET ADDRESS, C 2545 PORTLAND AV MINNEAPOLIS, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COR	R'S PLAN OF CORRECT RECTIVE ACTION SHOU RENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 282	residents had to be residents who were supposed to let the attempt to see if re done and if not the During interview or stated her expectar inform the nurse or nurse would attempt the nurse to provid if still not successful on refusal and let herefusal of cares wo next shift to attempt more familiar with or successful and let herefusal of cares wo next shift to attempt more familiar with or successful and let herefusal of cares wo next shift to attempt more familiar with or successful and let herefusal of cares wo next shift to attempt more familiar with or successful and let herefusal of cares wo next shift to attempt more familiar with or successful and let herefusal of cares wo next shift to attempt more familiar with or successful and let herefusal of cares wo next shift to attempt more familiar with or successful and let herefusal of cares wo next shift to attempt more familiar with or successful and let herefusal and let herefus	e well groomed and for a resistive to cares the NA was a nurse know for the nurse to sident would allow cares to be in to document the refusal. In 12/4/13, at 3:11 p.m. RN-E tion was the NA's were to in refusal of cares and then the pot to see if resident would allow the cares being a new face and cull the nurse then to document there know. RN-E further stated and be communicated to the pot cares as some residents are other staff and would let the cares. RN-E verified R21	F2	82				
F 311 SS=D	The facility Nail-Ca directed both finge residents are to be podiatrist respective information on who nail care for other roversee/check to rocomplete with reside weekly and as nee 483.25(a)(2) TREA IMPROVE/MAINTA	re policy dated 1/2009, rnails and toenails for diabetic cut by the licensed nurse and ely. The policy lacked was responsible to complete residents and who would nake sure nail care was dent bath per the plan of care ded.	F	311			¥	
	This REQUIREME by:	NT is not met as evidenced			•			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		245587	B. WING			12/0	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	review, the facility fraction of daily living (ADL) Findings include: R45 had not brusher 7/13/13 (six months 7/13/13 (six months 7/13/13 (six months 7/13/13) (six months 7/13/1	ion, interview and document ailed to provide assistance for 15, R21) reviewed for activities of this teeth since admit, and the since admit, and the since admit, and the since admit, and the since are since at the since and the since are was never offered a coaste and never asked for a teeth with his fingers once in the had especially good teeth in his whole life. In 12/4/13, at 7:30 a.m. IA)-B said R45 was rooming and oral hygiene but are. In 12/4/13, at 1:00 p.m. nurse id residents are given a bag of uding toothbrushes and mission. I's room on 12/4/13, at 1:15 was no toothbrush or om. RN-A looked in R45's med there was no toothpaste 5's room. RN-A confirmed oral to an individual's overall be sure to get him a toothbrush		311	The facility will ensure that all residents are given the appropring treatment and services to mai or improve his or her abilities specifically with respect to ora R45 was provided a toothbrustoothpaste on 12/4/13. All stafeducated about oral care and need to provide necessary assistance with each resident described in their plan of care effective. 12/19/13. R21's nails were cleaned and effective 12/4/13. R21's care pupdated and current. All licensed staff were educated about checking for referral retifrom dentists and proper residently in the form of the staff will continue for 3 months until ongoing compliance is achieved with oversight by the director of nursing.	oriate ntain al care. sh and ff were the as olan is ed urns lent /13	12/30/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245587	B. WING			12/	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			25	REET ADDRESS, CITY, STATE, ZIP CODE 45 PORTLAND AVENUE SOUTH NNEAPOLIS, MN 55404	1 121	03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 311	Document review of to the nursing facility cerebral infarct (stradmission Minimur dated 7/23/13, indicand one person phygiene. The MDS believed R45 was condependence in at area assessment (colored for the plan of care dated to the plan also including t	evealed that R45 was admitted ty on 7/13/13, following a oke) with partial paralysis. The n Data Set (MDS) assessment cated R45 required supervision ysical assist with personal also indicated direct care staff capable of increased least some ADL's. The care CAA) worksheet dated hat R45 triggered for ADL ding supervision and assist with ADL's related to self-care ass, stroke with right sided all paralysis), and cognitive ns include assist of one with showers, dressing, and to m cares. The care plan also sive and easily frustrated. The ided cognitive problems all long term memory loss with ve reminders to maintain n. The care plan lacked ds to oral hygiene.	F3	311			
	director of nursing that residents recei hygiene needs. Wh ensured residents toothpaste she said	on 12/5/13, at 1:00 p.m. the (DON) said it was expected we assistance with oral nen asked how the facility have toothbrushes and droom checks would need to sident to ensure he had the			•		The second secon

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		245587	B. WING			121	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			254	EET ADDRESS, CITY, STATE, ZIP CODE 5 PORTLAND AVENUE SOUTH INEAPOLIS, MN 55404	, tar	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 311	The facility policy til January 2009, instr hygiene before brea	ge 16 I. The DON confirmed that the al hygiene interventions. tled, Oral Hygiene, dated ucted staff to offer oral akfast and at bedtime or per	F3	311			
	during the evening subsequent days of	to have long, soiled fingernails on 12/2/13, and during f the survey 12/3/13, and ernails remained long, jagged					
	in his bed and was approximately a ha soiled nails to both matter underneath - At 10:08 a.m. R21 long and untrimmed R21 was in his roor - At 3:55 p.m. obse head of bed elevate observed administer pudding. After she	If (1/2) inch long, jagged and hands with dark brown/black them. I's nails were observed still to both hands and soiled					
	shut, knocked the completed providing explained to survey assisted R21 with resistive but would cares to a certain expound attempt to should be should sh	a.m. observed door to room door went in saw R21 lying in d NA-C stated he had just g morning cares. NA-C for all the cares he had and that R21 is mostly allow staff at times to do the extent. NA-C further stated he have R21 after breakfast. R21 we long uneven jagged soiled					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245587	B. WING			12/	05/2013	
	PROVIDER OR SUPPLIER ER CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404	1 7 847	0012013	
(X4) ID PREFIX TAG				X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 311	RN-F sitting next to offered to remove F - At 9:32 a.m. durin- lying in his bed with edged and soiled. - At 2:30 p.m. obse- watching TV R21 al	-	F:	311				
	accident (CVA), der contracture to elbov and hemiplegia obt dated 9/17/13. The annual MDS da required extensive to two staff with all A hygiene. The ADL F	cluded cerebrovascular mentia, hearing loss, w, seizure disorder, aphasia, ained from the annual MDS ated 9/17/13, identified R21 to total physical assist of one ADLs including personal functional/Rehabilitation CAA eated R21 had a self-care						
	deficit and required undressing, groomi The ADL care plan had self-care deficit Hemiplegia, and mu also identified R21 also. Care plan goad dressed with physic directed to provide staff to do nail care (PRN). The NA ass	staff assistance for dressing, ng, bathing and toileting. dated 12/19/12, identified R21 tin ADL's related to CVA, uscle spasm. The care plan can be resistive with cares il "Will be appropriately al assist of staff." Care plan R21 with physical assist of after bath and as needed ignment sheets undated for all R21 required total assistance						
	During document re Sheet and Weekly	eview of the Skin/Bath Flow Bath Skin and Pain Sheet						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245587	B. WING			12/0	05/2013	
	PROVIDER OR SUPPLIER ER CARE CENTER			25	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 311	been documented a and on 6/18/13, had once.	gh 11/26/13, nail care had as completed once on 7/30/13, d been documented "Refused"	F3	311				
	the Progress notes medications and fo	Iment review it was revealed in R21 had refused cares, od five times between 5/6/13, vith documentation specifically e on 10/12/13.						
	who stated he had nail care during the nails were soiled, u	p.m. interviewed the NA-C not offered or attempt to do shift but acknowledged the neven and jagged. NA-C was resistive with cares.						
·	nails were long, und	2 p.m. RN-F verified R21's even and jagged then left the ame back with a clipper and a						
	applied gloves and RN-F and started to observation R21 all	P.m. both RN-F and NA-C NA-C took the clipper from trim R21's nails. During lowed NA-C trim all his nails the nails and was never						
	he stated his expective residents had to be residents who were supposed to let the attempt to see if residents.	p.m. RN-C was interviewed ctation was R21 and all other well groomed and for eresistive to cares the NA was nurse know for the nurse to sident would allow cares to be n to document the refusal.						
	During interview on stated her expectal	n 12/4/13, at 3:11 p.m. RN-E tion was the NA's were to						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		245587	B. WING_	· ·	12/	05/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
F 311	nurse would attemp	refusal of cares and then the of to see if resident would allow	F 31	1		
	if still not successfu on refusal and let h refusal of cares wo next shift to attemp more familiar with o	e cares being a new face and at the nurse then to document er know. RN-E further stated uld be communicated to the t cares as some residents are other staff and would let the cares. RN-E verified R21 Tuesday day shift.				
	directed both fingeresidents are to be podiatrist respective information on who nail care for other roversee/check to not the control of the	are policy dated 1/2009, rnails and toenails for diabetic cut by the licensed nurse and ely. The policy lacked was responsible to complete esidents and who would nake sure nail care was lent bath per the plan of care ded.				
F 371 SS=E	483.35(i) FOOD PI STORE/PREPARE	ROCURE, //SERVE - SANITARY	F 37	71		
	considered satisfact authorities; and	om sources approved or ctory by Federal, State or local distribute and serve food ditions				
			3			
	by: Based on observa	NT is not met as evidenced tion, interview, and document failed to ensure the juice	-			

,	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION		SURVEY PLETED	
		245587	B. WING		·	12/	05/2013	
,	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404	1 0 21	30/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 371	dispenser in the kit manner and had th residents, families juices from the ma	chen was stored in a sanitary e potential to affect 113 of 124 and staff that would drink chine. In addition, the facility	F3	371	The facility will (1) Procure for from sources approved or considered satisfactory by F State or local authorities; and	ederal,	12/30/13	
		ed to ensure outdated milk was removed from of 2 nourishment refrigerators on the second or.				Store, prepare, distribute and food under sanitary condition All dietary staff were educated	e and serve	
	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				to clean juice dispenser guns nozzles properly with the use sanitizer and they are not to in the sink for any length of the effective 12/19/13. All outdated milk was discard immediately on 12/5/13. All cand nursing staff were educated discard all outdated food immediately upon discovery	s and e of be left ime ded dietary		
	manager (DM) startalked to the staff r dispensers in the s juice dispenser gurwater then got a boand placed the disholding trays next	O p.m. interviewed the dietary led "He knows better than that" not to wash hands with the juice link. Then DM rinsed all three has and hose contaminated with ottle of sanitizer sanitized then pensers in three different sliver to the juice dispenser.			effective 12/19/13. Audits for proper sanitation a properly dated food will be conducted for 3 months or u ongoing compliance is achie with oversight by the directonursing and dietary manage	ntil ved r of		
	he did not see the the sink when was	5 p.m. interviewed D-A stated juice dispensers guns inside hing his hands yet the DM had. if he had seen them he would		1	•			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245587	B. WING_				12	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			2	STREET ADDRESS, CITY 1545 PORTLAND AVEN MINNEAPOLIS, MN	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRE CROSS-REFERE	S PLAN OF CORRE CTIVE ACTION SHI NCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	Continued From pa	-	F 3	71				
	with facility Supervi report dated 12/4/1 indicating he had be maker and had gon water over his hand clarified with DM th	p.m. DM provided surveyor sor's Report Of Accident 3, that D-A had filed a report urned himself from the coffee ie over to the sink to run cold d. During this time surveyor at this had not been what D-A uring interview right at the time ade.						
	Food Service Depa "Sanitary conditions the food service de transmission of dis- mean storing, preparations food properly to pre-	ral Infection Control In The ortment policy directed is will be maintained throughout partment in order to prevent ease. Sanitary conditions aring, distributing, and serving event foodborne illness in ederal, State, and local health ions."						
	Outdated milk was North nourishment	observed in the 2 South and 2 refrigerators.						
	was observed to he container of thicker one quarter of the container of th	erator in the nurse's station ave stored in it an open ned milk. The container had contents remaining and the te was 9/2/13, (should have						
	the date and agree immediately. RN-B	RN)-B was present, confirmed d it needed to be discarded added that dietary staff was ough the refrigerator daily to						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
-		245587	B. WING			12/0	5/2013
	ROVIDER OR SUPPLIER			25	REET ADDRESS, CITY, STATE, ZIP CODE 45 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	contained opened s that were undated. the unfinished open	The refrigerator also ingle use half pints of milk RN-B stated that they re-use and half pints of milk at the infirmed they should have	F3	71			
	refrigerator in the n have stored in it an percent milk with a (should have been The clinical nurse n the milk was old an	a.m. the 2 North nourishment urse's station was observed to unopened half pint of one use by date of 10/21/13, discarded six weeks prior). nanager (RN)-A confirmed that d discarded it immediately on 12/5/13, at 9:20 a.m. RN-A					
	indicated that the d assuming that the r outdated milk. The facility policy tir Microwave Daily CI staff to thoroughly of	ietary staff may have been nursing staff was checking for staff. Refrigerator and eaning Flow Sheet directed clean refrigerators every					
F 411 SS=D	older than one wee 483.55(a) ROUTIN SERVICES IN SNF		F	411			
		sist residents in obtaining r emergency dental care.					
	resource, in accord part, routine and er meet the needs of Medicare resident a routine and emerge	de or obtain from an outside ance with §483.75(h) of this nergency dental services to each resident; may charge a an additional amount for ency dental services; must if ne resident in making					

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245587	B. WING		12/0	5/2013
	PROVIDER OR SUPPLIER ER CARE CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	<u> IZN</u>	10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BF [(X5) COMPLETION DATE
F 411	to and from the den residents with lost of dentist.	ge 23 by arranging for transportation itist's office; and promptly refer or damaged dentures to a	F 411	The facility will assist resident obtaining routine and 24-hour emergency dental care. R19's care plan is updated are current. With coordination of	nd is	12/30/13
	by: Based on observat review, the facility fa	ion, interview and document ailed to ensure dental services residents (R19) reviewed for		attending NP and dentist, a p in place for additional visit(s) dentist per NP recommendati The facility continues to main	lan is to the ons.	
	Findings include: R19 did not receive	dental care		R19's daily oral care and mor treat pain as necessary.	nitor/	
	Observation on 12/2 R19 had several teclose and decayed. 12/2/13, at 4:55 p.n any problems with I had several teeth of extraction. He also	2/13, at 4:40 p.m. revealed eth on the lower jaw that were . When interviewed on n. R19 was asked if he had nis mouth. R19 replied that he n the lower jaw that need said he sometimes had said, "I need to get those		Audits will be completed for 3 months or until ongoing comp is achieved with oversight by director of nursing.	liance	
Ä	breakfast and with sadness, was frown cereal and half the After breakfast staff Oral care was not c - At 1:30 p.m. regis if he was OK and he pain at that time.	tered nurse (RN)-A asked R19 e replied yes and he denied aled the resident was in dining				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
	245587 B. WING		12/05/2013					
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404					
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 411	resident was in the asked if he had any said no but wants to Administration (VA) A doctor's order dat Lidocaine solution (effected teeth/gums The doctor's orders Brush teeth after m tooth bid (twice dail mouth pain. The admission Min assessment dated was admitted with cobroken natural teet (CAA) dated 4/18/1 dental care due to the was to arrange dental said no vanished to a said of the color of the colo	ge 24 5/13, at 10:00 a.m. the room in bed resting. When mouth pain at that time he get to the Veteran's as they know him there. ted 4/17/13, included 2% a topical anesthetic) 15cc to severy four hours as needed. I dated 8/27/13, included: eals, put toothpaste on lower y) and PRN (as needed) for imum Data Set (MDS) 4/18/13, indicated that R19 obvious or likely cavity or in. The Care Area Assessment 3, noted R19 triggered for naving poor dentition. Staff tal visits as needed.	F	411				
	self-care deficit relahas own teeth but himissing teeth. Inter assist of one with ordental services as in A care conference in R19 received Tylen received prin Tylend A progress note dail medical doctor (ME)	ated to cognitive impairment, has poor dentition and some ventions included staff to ral cares twice daily and needed. note dated 10/31/13, indicated of daily for pain and had not						
· /	Has had multiple de had persisted. The	ental visits and the problem MD impression was "pain in a ary encounter diagnosis)					,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED 12/05/2013		
		B. WING		12/0			
	PROVIDER OR SUPPLIER ER CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 411	extensive work up.' scheduled Tylenol (Lidocaine solution. A weekly pain asse R19 was assessed	vithout cause found despite The plan was to continue a mild analgesic) and oral ssment dated 11/16/13, noted to have no pain.	F 4	111			
	medication adminis 2013. R19 had not the PRN Lidocaine also said that R19 I Lidocaine and said months of admit ov	o documentation of a dental					
	When interviewed on ursing assistant (I complain of mouth said the aides set uhe brushes himself When interviewed family member (F)dad to the dentist when the dentist extracted the complete of the complete of the dentist extracted the complete of the dentist extracted the complete of t	on 12/4/13, at 9:00 a.m. NA)-A said that R19 did pain occasionally. She also up his toothbrush for him and on 12/4/13, at 10:55 a.m. A stated that he had taken his vith in the last six months. The vo teeth at that time. FM-A said					
	supposed to return problems. FM-A did R19 still complaine pain and thought it When interviewed registered nurse (F	ow up was that he was if he had any further if say that he was aware that d of occasional mild mouth was more related to dementia. On 12/4/13, at 11:14 a.m. IN-B) stated that R19 received daily. There was also an order of if needed.			•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245587	B. WING			12/0	15/2013
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 411	nurse manager (RN taken him to the de admission. RN-A w documentation rela said, "I am betting to not set up those ap likely sent a referra chance of getting in been out to the deripaperwork on it I downwell."	on 12/4/13, at 11:31 a.m. the N)-A said that R19's son had entist sometime around date of as unable to find any atted to the dental visit. RN-A the health unit coordinator did pointments, the son did. We I and it's always a fifty-fifty afformation back. I know he has attist, why we don't have any on't know."	F	411			
	him get those rotter went on to explain to the dentist some facility and that there within the family dy agreed it would be dentist and have the for R19 in regards INP confirmed R19 pain. The NP confir scheduled Tylenol a	NP) said," I would I like to see in teeth pulled, yes." The NP that the family had taken R19 time around admission to the re was some dysfunction namics. The NP and RN-A a good idea to contact the em fax over recommendations to his dental/oral health. The had intermittent mild mouth remed that R19 was on and that R19 had not been al Lidocaine but had used the the recent past.					
	A progress note da R19 was comfort of inner turmoil. The fi highly focused on s was assessed by the intermittent mild mo- and much better the dental pain was und	ent on 12/4/13, in the afternoon. ted same indicated the goal for are and that the family had amily power of attorney was saving money. The resident ne NP as having chronic buth pain, repetitive in nature, an when admitted. R19's changed by dental visits per opposed to dental follow up for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245587	B. WING		12/05/2013
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 1545 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)		PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 411	Continued From pa	ge 27	F 411		
	seemed to need bro	I in past with them, family eak, suspect some caregiver family to escort, preferable to			
	said she had containformed that the re	on 12/5/13, at 2:00 p.m. RN-A cted the dentist and was esident had two extractions at also said the dentist had			
	them in the future of last appointment. R	t R19 would not be treated by lue to resident agitation at the N-A said she would call senior an appointment for R19.			
	October 2011, indic policy to assist the achieving dental he	tled, Dental Policy, dated cated that it was the facility residents in maintaining and calth. The purpose of the policy dents maintain and achieve the			
F 431 SS=E	483.60(b), (d), (e) [F 431		
	a licensed pharmad of records of receip controlled drugs in accurate reconcilia records are in orde	inploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically			
	labeled in accordar professional princip appropriate access	als used in the facility must be nce with currently accepted bles, and include the sory and cautionary e expiration date when		*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245587		B. WING			12/05/2013		
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		00/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 431	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.				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.		12/30/13
	by: Based on observareview, the facility facility facility facility from the safter opening and control of the safter opening and the safter opening and the safter of	NT is not met as evidenced tion, interview and document ailed to ensure medications dates were properly dated discarded when expired on 2 of e potential to affect 2 of 22 to who used insulin pens for n, the facility failed to properly n 1 of 5 nursing unit e facility failed to ensure eye properly for 1 of 5 residents of units were found to be ned and not discarded when the p.m. during the medication n three south, the licensed N)-A prepared Humalog insulin			All licensed nurses were eductive regarding the proper storage at labeling of medications and biological effective 12/19/13. Audits will be completed for 3 months or until ongoing complis achieved with oversight by the director of nursing.	and	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
245587		B. WING			12/05/2013			
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404					
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	included a date open Humalog insulin ex opened and disposed on 12/2/13, at 5:15 first floor north med Humalog for R15 with when it was opened from the pharmacy the insulin pen was insulin pen was insulin pen was under the pharmacy would when interviewed director of nursing (needed to be dated the nurse should us pharmacy as the optime insulin pen for Fine facility Insulin Station (undated) revealed days after being optime insulin station refrigerator to be unlocked. The contained a bottle or efflux disease) and for neuropathy) for refrigerator also conpudding, yogurt, an Registered nurse (Fine were stored on the refrigerator and station the medication station interviewed of the contained of the medication station interviewed of the medication inter	stes) for R32. The insulin penered of 10/7/13. LPN-A stated pired 28 days after it was ead of the expired insulin. p.m. during observation of the lication cart, an insulin pen of as found not to have a date d. The delivery date on the penwas 10/22/13. LPN-B verified not dated and stated if an lated; the delivery date from d be used as the open date. on 12/5/13, at 10:32 a.m. the DON) stated insulin pens when opened and if not dated se the delivery date from the bened date. The DON stated R15 was discarded. Storage Recommendations Humalog was good for 28 ened.		131				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245587	B. WING			12/	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			254	REET ADDRESS, CITY, STATE, ZIP C 45 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	a.m. and stated me with food on the ref The facility Storage January 2011, direct stored safely, secul medication supply licensed nursing peor staff lawfully allowedications.	rator with food. viewed on 12/5/13, at 10:32 dications should not be stored rigerator door. of Medication policy dated ted medications would be rely and properly. The vas to be accessible only to rsonnel, pharmacy personnel, wed to administer	F	1331			
	compartment. On 12/2/13, at 3:30	stored in a safe locked p.m. during interview with R7, eye drops was observed on ser.					
	room observed the of the bedside dres "It was not suppose stated R7 received as she had an as n nurse forgot to take stated it was the far medications at bed	p.m. LPN-B went to R7's bottle of eye drops still on top ser. LPN-B grabbed it stated do to be left here." She further the eye drops in the morning eeded order and maybe the drops out of room. LPN-A cility policy to not leave side when resident has no hister medication (SAM).					
	cataract, contractur hemiplegia, trauma obtained from quar dated 10/16/13. The required extensive	uded encephalopathy, nuclear re of hand joint, left side tic brain injury and depression terly Minimum Data Set (MDS) as MDS also indicated R7 physical assist of one to two of daily living (ADL's).					A

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245587	B. WING			12/	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			25	REET ADDRESS, CITY, STATE, ZIP CODE 45 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 31	F4	31			
	care plan dated 10/ memory loss and m	gnitive and communication 23/09, identified R7 had noderately impaired decision idary to encephalopathy.					
	an order dated 2/3/	ment review, revealed R7 had 11, for Artificial Tears 1.4% two every hour as needed for dry					
	did not wish to self-	t dated 10/10/13, indicated R7 administer medications, had that may affect SAM which brain injury.					
	stated all residents determine that they self-administer med be discussed with t RN-B further stated	a.m. interviewed the RN-B have to be assessed to are appropriate to dications and in addition has to he interdisciplinary team (IDT). If the nurse may have forgotten make sure it does not happen.					
F 441 SS=E	not have a SAM an have been left at be 483.65 INFECTION	p.m. the DON stated R7 does d the eye drops should not edside. I CONTROL, PREVENT	F4	141			
	Infection Control Pr safe, sanitary and o	tablish and maintain an cogram designed to provide a comfortable environment and development and transmission ction.					
	(a) Infection Contro The facility must es	l Program tablish an Infection Control					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		SURVEY PLETED
		245587	B. WING		12/0	05/2013
	PROVIDER OR SUPPLIER ER CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	1 1201	70,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Program under which (1) Investigates, con in the facility; (2) Decides what proshould be applied to (3) Maintains a reconductions related to in (b) Preventing Spree (1) When the Infect determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will troop (3) The facility must hands after each dispand washing is incorposessional practice. (c) Linens Personnel must hand	ch it - ntrols, and prevents infections recedures, such as isolation, an individual resident; and ord of incidents and corrective fections. ad of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which licated by accepted		The facility maintains an infection provide a safe, sanitary and comfortable environment to puthe development and transmis of disease and infection. All ice packs were removed frunit refrigerators effective 12/6 Facility practice is to no longe store ice packs on the units. All staff were educated regard the proper storage of ice pack effective 12/30/13. Audits will be completed for 3 months or until ongoing comp is achieved with oversight by director of nursing.	revent ssion om 6/13. r ling ss	12/30/13
, , , , , , , , , , , , , , , , , , ,	by: Based on observative review, the facility for packs in a sanitary nourishment/medic medical use, reusal containers. This ha	NT is not met as evidenced tion, interview and document ailed to store reusable ice manner. Four of five ation freezers contained ble ice packs and ice cream d the potential to affect 97 of use ice packs or consume erators.				

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245587	B. WING			12/0	5/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			25	REET ADDRESS, CITY, STATE, ZIP CODE 45 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404	1270	1012013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 33	F4	41			
	Findings include:		,				
	station nourishmen reusable ice packs cream. Registered packs were stored	a.m. the first floor nursing t freezer contained six and nine containers of ice nurse (RN)-C verified the ice with the ice cream and stated at the ice packs were used					
	RN-B verified the ic	on 12/5/13, at 10:05 a.m. e packs were used for were cleaned and reused.				,	
	nursing station nou nine reusable ice pa cream. Licensed pr	2 a.m. the third floor south rishment freezer contained acks and ten containers of ice actical nurse (LPN)-C verified used for resident injuries and					
		12/5/13, at 10:32 a.m. the (DON) stated ice packs and ed separately.					·
	was observed on 1. The freezer held six fourteen individual ice packs were in c						
	said they do keep r	on 12/4/13, at 11:19 a.m. RN-A esident food in there and that om the medication container					

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		245587	B. WING	·		12	/05/2013
•	PROVIDER OR SUPPLIER ER CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		00.20
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	those in the freezer discarding them aft North: The two north refrig	are delivered. They just throw and staff should be er use on residents.	F	441			
	re-useable ice pack The facility Refriger 9/7/12, was reviewe	n. The freezer held ten as and 12 cups of ice cream. The freezer held ten ator Safety policy revised and did not include a of reusable ice packs with					
				-			
			7.				

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(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245587 12/10/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2645 PORTLAND AVENUE SOUTH **FBENEZER CARE CENTER** MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) INITIAL COMMENTS K 000 Submission of this credible K 000 allegation FIRE SAFETY of compliance is not a THE FACILITY'S POC WILL SERVE AS YOUR legal admission ALLEGATION OF COMPLIANCE UPON THE that a deficiency exist or DEPARTMENT'S ACCEPTANCE. YOUR that the SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE statement of deficiency was USED AS VERIFICATION OF COMPLIANCE. correctly UPON RECEIPT OF AN ACCEPTABLE POC. AN cited, and is also not to ONSITE REVISIT OF YOUR FACILITY MAY BE be construed as CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE an admission against the REGULATIONS HAS BEEN ATTAINED IN interest of the ACCORDANCE WITH YOUR VERIFICATION. facility, its administrator A Life Safety Code Survey was conducted by the or any employees, Minnesota Department of Public Safety. At the agents or other time of this survey, Ebenezer Care Center (Builiding 1) was found not in substantial individuals who draft or compliance with the requirements for participation may be discussed in this in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 credible allegation edition of National Fire Protection Association of compliance. In addition (NFPA) Standard 101, Life Safety Code (LSC). preparation and Chapter 19 Existing Health Care submission of this credible PLEASE RETURN THE PLAN OF allegation of compliance CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO does not constitute and DEC 3 0 2013 admission or agreement of Healthcare Fire Inspections any kind by this facility State Fire Marshal Division 445 Minnesota St., Suite 145 EPT. OF PUBLIC SAFETY of the truth of St. Paul, MN 55101-5145, OR IRE MARSHAL DIVISION By email to: LABORATORY-DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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.

ampus

12/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
		245587	B. WING		12/	10/2013
	PROVIDER OR SUPPLIER ER CARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO	RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done	K 000	any facts alleged or the correctness of a conclusions set fort in this allegation b survey agency.	h	***
	3. The name and/oresponsible for comprevent a reoccurre Ebenezer Care Cefull basement. The different times. The constructed in 1919 Type III(200) constructed to that was determine construction. In 192	rection and monitoring to ence of the deficiency. Inter is a 3-story building with a building was constructed at 3 e original building was and was determined to be of ruction. In 1924, an addition the North side of the building d to be of Type III(200) 28, another addition was South side of the building that				
	to this building are type, even though type does not meet buildings, this build building, but the entwo buildings under The building has a throughout. The fac system with smoke	al building and the 2 additions all of the same construction the Type III(200) construction the code for existing ing was surveyed as one tire facility was surveyed as two booklets. complete fire sprinkler system cility has a complete fire alarm detection in the corridors and corridor, that is monitored for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245587	B. WING			12/	10/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			25	REET ADDRESS, CITY, STATE, ZIP CODE 645 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	automatic fire depa	nge 2 ortment notification. The facility acity of 127 beds and had a e time of the survey.	K	000	<u>.</u>		
K 012 SS=F	NOT MET as evide NFPA 101 LIFE SA Building construction	42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD on type and height meets one 9.1.6.2, 19.1.6.3, 19.1.6.4,	K	012	The facility has achi a passing FSES score effective 12/19/13	.eved	12/19 /13
	Based on observations not meet the type and height.	s not met as evidenced by: tion and interview, this building requirement for construction ice could affect all residents.			*		
	on 12/10/2013, obs 3-story, wood frame construction does r	veen 10:00 AM and 12:00 PM servation revealed that this e facility of Type III(200) not meet the minimum ements for a building of this					
K 038	Administrator at the Note: This deficient FSES can establish level of fire safety of the Life Safety Cod	ice was verified by the time of the inspection. cy need not be corrected if an that the facility has an overall equivalent to that required by le. FETY CODE STANDARD		038			

Facility ID: 00191

TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY
		245587	B. WING			12/1	0/2013
	ROVIDER OR SUPPLIER ER CARE CENTER			25	REET ADDRESS, CITY, STATE, ZIP CODE 445 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404	10.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
K 038 SS=F	Continued From pa Exit access is arran accessible at all tin 7.1. 19.2.1	age 3 nged so that exits are readily nes in accordance with section	K	038	The facility has achieved a passing F score effective 12/19/13	SES	12/19 /13
	Based on observa facility failed to pro accordance with the	is not met as evidenced by: tion and staff interview, the vide means of egress in e following requirements of ection 7.2.1.5.4. The deficient ct all residents.					
	on 12/10/2013, obs south stairway doo floors swing agains	ween 10:00 AM and 12:00 PM servation revealed that the ars on the second and third st the path of egress travel.					
K 040 SS=F	Administrator at the Note: This deficient FSES can establis level of fire safety the Life Safety Coc NFPA 101 LIFE SA	AFETY CODE STANDARD		040	The facility has achia passing FSES score	ieved	12/19
	care occupants are	and exit doors used by health e of the swinging type and are in clear width. 19.2.3.5			effective 12/19/13		/13

PRINTED: 12/17/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245587	B. WING		12/1	0/2013
	ROVIDER OR SUPPLIER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 040	Continued From pa	age 4	K 040	z #/		4
	Based on observation doors do not requirement.	is not met as evidenced by: tion and interview, the resident meet the 32-inch clear width tice could affect all residents.			-	
	on 12/10/2013, obside doors in the 1919 of found to be only 29	ween 10:00 AM and 12:00 PM servation revealed that the construction year building were 0-30 inches in clear width. This 32-inch requirement for s doors.				
K 045	Note: This deficience FSES can establis level of fire safety the Life Safety Code	tice was verified by the etime of the inspection. Incomplete the inspection of the corrected if an high that the fire has an overall equivalent to that required by the corrected by the correct	K 045	The facility will er	nsure	
SS=F	Illumination of mea discharge, is arran lighting fixture (bul darkness. (This d	ans of egress, including exit ged so that failure of any single b) will not leave the area in oes not refer to emergency nce with section 7.8.) 19.2.8		there is illumination means of egress, income exit discharge. Corridor lighting was reconfigured to meet	on for cluding	12/19 /13
	Based on observation failed to provide a	is not met as evidenced by: ation and interview, the facility dequate emergency lighting in SC (00) 19.2.8. This deficient	= -	standard. An electric removed switches for critical lighting enthat they remain on situations.	cian r nsuring	II _

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245587	B. WING		with the second second	12/1	0/2013
	PROVIDER OR SUPPLIER	c		26	REET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		3
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 045	Continued From pa	_	ΚO	45	Effective 12/19/13 Audits will be mainta for 3 months or until	ined	
-	PM on 12/10/2013, of the corridor light off by a light switch	between 10:00 AM and 12:00 observation revealed that all s have the ability to be turned . The emergency lighting th the same light switches.		92°	ongoing compliance is observed with oversign the plant supervisor.	ht by	, , , , , , , , , , , , , , , , , , ,
K 144 SS=D	administrator at the NFPA 101 LIFE SA Generators are ins	tice was verified by the etime of the inspection. FETY CODE STANDARD pected weekly and exercised ninutes per month in FPA 99. 3.4.4.1.	K 1	144	The facility will ins generators weekly and monthly as required. All maintenance emplo	9	12/19 /13
	2 No. 100	<u></u>			were educated regardi the requirement to maintain proper gener inspections and documentation. Effect 12/19/13	ator	I
	Based on observa facility's emergenc with NFPA 99 Heal edition) nor NFPA	is not met as evidenced by: tions and interview, the y generators do not comply th Care Facilities (1999 110 Standard for Standby 998 edition). This deficient ct all patients.			Weekly audits are in and will continue for months or until ongoi compliance is achieve with oversight by the	3 ng d	
ž.		ween 10:00 AM and 12:00 PM ecord review revealed that			environmental service supervisor.	S	

PRINTED: 12/17/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION 1 - MAIN BUILDING 01	COMF	LETED
		245587	B. WING			12/1	0/2013
	PROVIDER OR SUPPLIER ER CARE CENTER			254	REET ADDRESS, CITY, STATE, ZIP CODE 45 PORTLAND AVENUE SOUTH NNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 144	there was no docu during the first wee This deficient pract	mentation of weekly generator	1	144	i Si XX		
<i>y</i>	OK.				*		
		й Э			*1		
				a l	3e		< 2
						2	

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ D PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION 12 - BLDG TWO	(X3) ĐẠTE COMI	SURVEY PLETED
		245587	B. WING			12/10/2013	
	PROVIDER OR SUPPLIER	3		26	REET ADDRESS, CITY, STATE, ZIP CODE 45 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE
K 000	INITIAL COMMEN	TS	· K0	וטטו	Submission of this credible allegation		
	FIRE SAFETY			- 1	of compliance is not a legal admission	a	
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.			that a deficiency exist that the statement of deficiency was correctly		R
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.				cited, and is also not be construed as an admission against interest of the facility, its		lok	
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 CEVE CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 ORDEPT OF PUBLIC SASTATE FIRE MARSHAL DIVISION STATE FIRE MARSHAL DIVISION CARE CONTRIBUTE SASTATE FIRE MARSHAL DIVISION CARE CONTRIBUTE SASTATE FIRE MARSHAL DIVISION CARE CONTRIBUTE SASTATE FIRE MARSHAL DIVISION CARE CARE CARE CARE CARE CARE CARE CARE			administrator or any employees, agents or other individuals who draft may be discussed in the credible allegation of compliance. In	nis	31-6		
	PLEASE RETURN CORRECTION FOI DEFICIENCIES TO Healthcare Fire Ins State Fire Marshal	THE PLAN OF CEVE R THE FIRE SAFETY DEC 3 0 2013 Division Suite 145	FEIY		addition, preparation submission of this credible allegation of compliance does not constitute and admission or agreement any kind by this	of	
	By email to:	December 1		-	facility of the truth	of	

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 02 - BLDG TWO		COMPLETED		
	50	245587	B. WING_			12/1	0/2013
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2646 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	Marian.Whitney@s THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO 1. A description of value to correct the deficit 2. The actual, or proposed to correct the deficit 3. The name and/oresponsible for comprevent a reoccurrent and the constructed in 1952. Type I (332) constructed in 1952. Type I (332) constructed in the corridors and that is monitored for notification. The factoric property is the constructed for notification. The factoric property is the corridors and that is monitored for notification. The factoric property is the correct property of the corridors and that is monitored for notification. The factoric property is the correct property of the correct property	tate.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.	K 00		any facts alleged or the correctness of any conclusions set forth in this allegation by survey agency.		
K 045 SS=F	NOT MET as evide NFPA 101 LIFE SA Illumination of mea discharge, is arrang lighting fixture (bulk darkness, (This do	: 42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD ans of egress, including exit ged so that failure of any single by will not leave the area in less not refer to emergency are with section 7.8.) 19.2.8			The facility will ensuthere is illumination means of egress, incluexit discharge. Corridor lighting was reconfigured to meet to standard.	iding	12/19 /13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587			(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BLDG TWO		(X3) DATE SURVEY COMPLETED		
		B. WING			0/2013		
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 045	Continued From pa	ge 2	K 045	An electrician removed switches for critical			
K 144 SS=D	Based on observate failed to provide ad accordance with LS practice can effect. Findings include: During facility tour IPM on 12/10/2013, of the corridor light off by a light switch system runs throug. This deficient pract administrator at the NFPA 101 LIFE SA Generators are insunder load for 30 m accordance with NI Based on observations.	petween 10:00 AM and 12:00 observation revealed that all shave the ability to be turned. The emergency lighting he the same light switches. ice was verified by the time of the inspection. FETY CODE STANDARD pected weekly and exercised inutes per month in FPA 99. 3.4.4.1.	K 144	lighting ensuring that they remain on in all situations. Effective 12/19/13 Audits will be maintain for 3 months or until ongoing compliance is observed with oversight the environmental service supervisor. The facility will inspective monthly as required. All maintenance employ were educated regarding requirement to maintain proper generator inspections and documentation. Effecti 12/19/13	ined nt by rices ect rees ng the	12/19/13	
æ	Based on observa facility's emergency with NFPA 99 Heal edition) nor NFPA						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - BLDG TWO	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
	n .	245587	B. WING		12	10/2013
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP COD 545 PORTLAND AVENUE SOUTH IINNEAPOLIS, MN 55404		ū
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	(X5) COMPLETION DATE	
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 generato during the first week of July 2013.		K 144	Weekly audits are a place and will cont for 3 months or untongoing compliance achieved with overs by the environmental services supervisor		
		tice was verified by the e time of the inspection.				



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.

Ebenezer Care Center December 17, 2013 Page 2

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, Enforcement Specialist

Licensing and Certification Program Division of Compliance Monitoring

Minnesota Department of Health Telephone: (651) 201-4124

Dre Klegge

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File



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 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Ebenezer Care Center December 17, 2013 Page 2

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Sincerely,

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program Division of Compliance Monitoring

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Enclosure(s)

cc: Original - Facility

Licensing and Certification File