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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PGJS
Facility ID: 00191

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

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

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

4. TYPE OF ACTION: 7 (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2012**

6. DATE OF SURVEY **11/25/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **127** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34	93		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 11/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/06/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245587

November 25, 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 November 10, 2014 the above facility is certified for:

34 - Skilled Nursing Facility/Nursing Facility Beds

93 - Nursing Facility II 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
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

November 25, 2014

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

RE: Project Number S5587024

Dear Mr. Prevost:

On October 13, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 2, 2014. 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 November 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 13, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 2, 2014, effective November 10, 2014 and therefore remedies outlined in our letter to you dated October 13, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. 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
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245587	A. Building B. Wing	11/25/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	**11/10/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	**11/10/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**11/10/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**11/10/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**11/10/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**11/10/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**11/10/2014**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	**11/10/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	11/25/2014	32982	11/25/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/2/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245587	01 - MAIN BUILDING 01	11/13/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0012	10/07/2014	ID Prefix Reg. # NFPA 101 LSC K0038	10/07/2014	ID Prefix Reg. # NFPA 101 LSC K0040	10/07/2014
ID Prefix Reg. # NFPA 101 LSC K0050	11/10/2014	ID Prefix Reg. # NFPA 101 LSC K0052	11/10/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/AK	11/25/2014	28120	11/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/30/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245587	A. Building 02 - BLDG TWO B. Wing	11/13/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	11/10/2014	ID Prefix Reg. # NFPA 101 LSC K0052	11/10/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	11/25/2014	28120	11/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/30/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PGJS
Facility ID: 00191

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **05/01/2012**

6. DATE OF SURVEY **10/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **127** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34	93		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lou Anne Page, HFE NE II 10/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4837

October 13, 2014

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

RE: Project Number S5587024

Dear Mr. Prevost:

On October 2, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
> **<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

Email: gloria.derfus@state.mn.us
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 November 11, 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 November 11, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates

must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original

deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 2, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

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
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

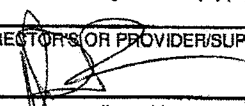
PRINTED: 10/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING ____ B. WING ____	10/02/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	The facility will immediately inform the resident, consult with the resident's physician; and if known notify the resident's legal representative or an interested family of accidents resulting in injury or one which requires physician intervention; a significant change in physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility or to a different room or roommate assignment	11/10/14

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



TITLE: Campus Administrator

(X6) DATE: 10/24/14

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

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R123) representative and power of attorney (POA) had been notified timely of the results from a procedure reviewed for notification of change. Findings include: On 9/29/14, at 4:51 p.m. when family member (F)-A was asked if R123 had a change in condition within the past several months F-A stated she had brought up to the facility attention a few weeks prior that she had noted R123 was not able to recognize her. F-A stated the provider had ordered R123 to be sent to the hospital for evaluation which F-A took R123 to and R123 had a computed tomography (CT) scan. F-A further stated after the procedure had been completed the facility had not called to notify her of the findings as when she was at the hospital after the procedure "I was sort of surprised when doctor told me that they were to notify the facility and never told me anything until today no one has called me on the results." R123's diagnoses included senile dementia with delusional features and anxiety state obtained from the Order Summary Report dated 9/8/14.	F 157	Family member of R123 was notified of the change and CT scan that was conducted for R123. Effective 10/20/14 all nursing staff and the attending NP were educated regarding the requirement to immediately notify families for such changes. Audits are being conducted to ensure compliance & will continue for 3 months or until ongoing compliance is achieved. Oversight of this process is being managed by the Director of Nursing. Audit results will be reviewed in the facility's quality assurance meeting.	

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F 157	Continued From page 2 R123's quarterly Minimum Data Set (MDS) dated 7/3/14, indicated R123 had moderately impaired cognition. In addition the Cognitive Loss/Dementia Care Area Assessment (CAA) dated 1/3/14, identified R123 had a diagnosis of dementia and had impaired long and short term memory impairment and had impaired decision making. The CAA indicated the daughter was involved and assisted as needed. R123's cognitive and Communication care plan dated 4/25/14, identified R123 with problems related to altered thought process, had dementia and had short and long term memory problems. Difficulty finding words to finish thoughts. During document review, the following was revealed: -On 9/2/14, a telephone order had been obtained "Send resident to FVS [Fairview Southdale] hospital for eval [evaluation]." -Referral Form dated 9/2/14, indicated R123 had been sent to Fairview Southdale for a CT scan and the form had been noted on the bottom on the same date. -Nurse practitioner Progress Notes dated 9/3/14, indicated "Patient appear near baseline today, she states she is aware she has a daughter. She does have trouble recalling her daughter's name. CT head negative for recent stroke yesterday, neuros within normal limits..." -Review of interdisciplinary Progress Notes dated 8/1/14, through 9/30/14, lacked documentation daughter had been notified of the CT scan results. Although the facility staff and the nurse practitioner knew of the results from the daughter had not been notified for over a month. When interviewed on 10/1/14, at 7:54 a.m.	F 157		

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F 157	Continued From page 3	F 157		

Continued From page 3

registered nurse (RN)-B nurse manager stated following the CT scan as far as he knew it was negative. RN-B verified after looking through the calendar he was not able to locate the date R123 had gone for the appointment and also verified neither the nurse practitioner (NP) nor nursing progress notes had indicated daughter had been notified of the findings from the CT scan procedure done on 9/2/14. RN-B further stated medical records coordinator would know when R123 had been to the appointment.

When interviewed on 10/1/14, at 8:04 a.m. medical records information director looked through the chart was able to locate the Referral Form dated 9/2/14, from when R123 had gone to the appointment and verified the results were not in the chart. When asked how the facility knew about the results she stated " The primary doctor, nurse practitioner and only some nurses have access to Epic. " She acknowledged the medical record was not complete.

On 10/1/14, at 8:27 a.m. medical records information director approached surveyor with a copy of the CT scan results indicated she had called and requested a copy. When asked who was responsible to ensure a copy had been obtained to ensure R123's medical record was complete and accurate she indicated the nurse practitioner was supposed to have printed a copy for the chart and if nursing had noticed it was not in the chart they could have let her know to get one. She further stated "It is quicker if the nurse practitioner can go in and print it for us. This nurse practitioner is new and we have to ask her."

On 10/1/14, at 9:04 a.m. via a telephone call NP stated she expected the daughter to have been

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F 157	Continued From page 4 notified at the hospital when R123 had been by the doctor and was under the impression she had been informed of the results. NP stated if she had known she had not been informed of the findings she would have called the daughter to let her know. NP further stated she was going to call R123's daughter sometime that day with the results. When interviewed on 10/2/14, at 10:59 a.m. the director of nursing (DON) acknowledged the facility should have notified the family. DON further stated after talking to the NP, the NP had indicated the doctor at the hospital should have let the daughter know of the results. DON acknowledged there was a problem in who was supposed to update the family but the facility had the ultimate responsibility to do so. Undated Family/Responsible Party Notification policy indicated the family and/or responsible party was to be notified anytime there was a change in a resident's condition or plan of care. The policy lacked to indicate who was responsible to notify the responsible party of test and results that had been completed outside the facility to ensure timely notification.	F 157		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	The facility will ensure that the residents have the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	

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F 246	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the call light was within reach for 1 of 5 residents (R150) who was identified as being at risk for falls. Findings include: On 9/30/14, at 9:15 a.m. during staff interview the registered nurse (RN)-D stated R150 had a fall on 9/28/14. On 9/30/14, at 10:39 a.m. p.m. the call light for R150 was observed to be on the floor under the bed. R150 was interviewed with the help of a translator at that time, and stated he often used the call light to ask for help. RN-C entered the room at 10:41 a.m. and verified the call light was out of reach for R150. Medical record review noted R150 was newly admitted to the facility per the Entry Tracking Record dated 9/27/14. When interviewed on 10/2/14, at 10:29 a.m. the director of nursing stated call lights needed to be within reach for residents all the time. The facility Call Light Response policy dated revised on 12/13, directed staff to "10. Be sure call lights are placed within resident reach at all times, never on the floor or bedside stand."	F 246	The care plan for Resident 150 was updated on 9/30/14 and is current including new interventions for call light placement. All staff were educated effective 10/20/14 regarding the requirement to keep call lights within reach for all residents who use them for requesting assistance. Audits are in place for call light placement with over sight from the Director of Nursing. Audits will continue for 3 months or until ongoing compliance is achieved. Results will be reviewed at the facility's quality assurance meeting.	11/10/14
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

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F 329	Continued From page 6 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the consultant pharmacist identified and report the potential adverse side effect(s) for the use of antipsychotic medication for 1 of 5 residents (R87), reviewed for unnecessary medications. Findings include: On 10/1/14, at 7:39 a.m. R87 was observed in room awake, and seated in the wheelchair. No behaviors were noted.	F 329		

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F 329	Continued From page 7 R87's Significant Minimum Data Set (MDS) dated 12/16/13, identified R87 as being at risk for falls and interventions to minimize falls would be care planned. The care plan dated 9/2/14, indicated the facility would monitor for side effects of the antipsychotic medications by obtaining orthostatic blood pressure monthly. The physician's Order Summary Report (OSR) dated 9/2/14, indicated R87 had diagnoses which included obsessive-compulsive personality disorder and depressive disorder. The OSR directed facility staff to give R87 medications as follows: Zyprexa (anti-psychotic) 2.5 milligram (mg) tablet by mouth at bedtime; Lexapro (anti-depressant) 10 mg tablet by mouth at bedtime; Haldol (anti-psychotic) 0.5 mg tablet every six hours as needed for nausea/agitation; and Ativan (anti-anxiety) 0.5 mg tablet every four hours as needed for anxiety/restlessness. In addition, the OSR directed staff to obtain monthly orthostatic blood pressure for R87, and the start date of the order was on 11/12/13. There was lack of evidence that original order for monthly orthostatic BP monitoring was discontinued, thus, remained an active order until surveyor's review date on 10/1/14. An interview with RN-E on 9/29/14, at 4:00 p.m. revealed R87 had fallen on 9/23/14, at 4:50 p.m. No injury was noted. A review of R87's medical records on 10/1/14, revealed lacked evidence to indicate orthostatic blood pressures were obtained since the order was given on 11/12/13 to 8/14.	F 329	The facility will ensure residents are free of unnecessary drugs. R87's medications were reviewed 10/8/14 by the facility's licensed pharmacist.R87's medication management plan is current. A house-wide audit of all residents was conducted by the facility's licensed pharmacist on 10/8/14. The consultant pharmacist will continue to do thorough medication reviews to ensure all medications are necessary and appropriate, including comprehensive medication monitoring at least monthly. All staff were educated requirement to keep residents free of unnecessary medications including antipsychotics effective 10/20/14 Audits will be conducted for 3 months or until ongoing compliance is achieved. Oversight will be done by the Director of Nursing. Audit reports will be reviewed at the quality assurance meeting.	11/10/14

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F 329	Continued From page 8 On 10/1/14, at 9:35 a.m. registered nurse (RN)-E stated orthostatic blood pressures should have been recorded in the vitals section of R87's electronic medical record. RN-E reviewed the medical record and verified the medical record lacked evidence of any orthostatic BP results recorded for R87. -At 2:15 p.m. the director of nursing (DON) stated orthostatic blood pressures for R87 were never scheduled. DON added that was the reason why the orthostatic blood pressures were missed and were " not done." -At 3:05 p.m. the nurse manager, RN-A stated she "looked everywhere" and could not find orthostatic BP for R87. RN-A added she was putting in a new OSR for 10/14, and had the orthostatic BP scheduled for 10/2/14. The facility's policy on Psychopharmacologic Drug Use revised on 12/12, directed the pharmacy consultant to review medication records monthly for documentation/justification of the drug use and make appropriate recommendations.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356	The facility will post necessary staffing information daily. The staffing coordinator was educated on the requirement to post all accurate staffing information daily effective 10/20/14. Audits of posted staffing information will be conducted for 3 months with oversight by the Director of Nursing. Audits will be reviewed at the quality assurance meeting	11/10/14

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F 356	Continued From page 9 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required posted nurse staffing information reflected the correct number of licensed nursing staff and the correct actual hours worked by each category of licensed staff responsible for direct care at the facility. This had the potential to affect all 119 residents residing in the facility as well as family and visitors. Findings Include: Upon review of the facilities form titled, Ebenezer Daily Nursing Hours dated 9/29/14, with the facilities actual nursing schedule dated 9/29/14, revealed the actual number of registered nurses (RN) and licensed practical nurses (LPN) on the	F 356		

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F 356	Continued From page 10	F 356		

p.m. shift and p.m. shift were not what were identified on the required posted nurse staffing information. Review of the facilities actual schedule 9/29/14, revealed three LPN's and three RN's on a.m. shift: daily nursing hours revealed six LPN's and two RN's on a.m. shift. The actual schedule for the p.m. shift revealed four LPN's one RN, however the daily nurse posting revealed six LPN's and two RN's for the p.m. shift.

Upon review of the required posted nurse staffing information for the facility from 7/1/14 to 10/1/14, and the facilities actual nursing schedule revealed the actual licensed staff of LPN's and RN's for a.m. and p.m. shifts were not congruent with the licensed staff identified as working on the facilities nursing schedule on a daily basis.

On 10/1/14, at 2:40 p.m. the director of nursing (DON) confirmed the facilities schedule for nursing indicated the correct number of licensed staff worked each shift. The DON further verified the actual schedule for the facility and the posted daily nursing hours did not match. She confirmed the required posted nurse staffing information was incorrect. The DON revealed the facility was training a new staffing coordinator, stating, "We haven't gotten everything fine-tuned yet". The DON also verified her awareness of the discrepancies between the required staff posting and the actual nursing schedules from 7/1/14 to 10/1/14.

Review of the facility policy titled, Posting Hours, revised Sept 2003 Staffing policy directed the facility staff to post the "daily nursing hours" report in a clear and accessible location for residents and visitors to view, Policy interpretation and implementation:

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F 356	Continued From page 11 1. "The facility staffer, or designee will post the projected "Daily Nursing Hours" report for that day at the Resident Care Office by 8 a.m. M-F and 9 a.m. S-S 2. The staffer or building supervisor will make changes to the projected information posted as they happen and initial the changes 3. The staffer will take the old "Daily Nursing Hours" reports and keep them in a binder for 18 months."	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hotel pans used for the steam table were dried prior storage and failed to ensure potentially hazardous food containers were labeled and dated as to when they were opened. This had the potential to affect all 119 residents who were served from the dietary department. Findings include: During the initial tour of the kitchen on 9/29/14, at	F 371	The facility will (1) prcure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. All food found to be without proper dates were discarded at the time of survey. All staff were educated on proper dating of food when opened and the requirement to fully air-dry utensils before placing them in their storage space effective 10/21/14 Audits are being conducted for 3 months or until ongoing compliance is achieved. Audits are overseen by the food services director and are reviewed at the quality assurance meeting.	11/10/14

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	245587	A. BUILDING ______ B. WING ______	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 12 12:01 p.m. with the director of food services (DFS) the following food items were observed in the milk/juice refrigerator opened but not labeled with the date as to when they were opened: three cartons of 46 ounce (oz) thickened dairy drinks, two cartons of 46 oz 100 percent (%) prune juice, and a carton of half gallon lactose free milk. The DFS verified the above and stated staff was expected to date all opened containers and discard it after three days. During the full kitchen tour on completed on 10/1/14, at 1:35 p.m. with DFS the following were observed. The milk/ juice cooler had two cartons of 46 oz thickened dairy drink, one carton of 100% prune juice and a half gallon carton of lactose free milk, all opened, but not labeled with the date when they were opened. In the pots and pans storage area there were five hotel pans for the steam table ready for use that were visibly wet. When the DFS picked up the pans and turned them over for observation, water ran on the bottom of the pans. When interviewed at the time of the observation the DFS stated pots and pans supposed to be air dried before storing them on the shelf, and further explained the kitchen was challenging due to the small space, and "there just was not enough shelf area to dry the pans properly. " The DFS also stated this deficient practice had the potential to affect everybody in the facility since all residents in the facility ate from the kitchen. The facility's Dishwashing Procedures undated policy indicated "Dishes and utensils must be air-dried" and that "All items are to be air-dried. No moisture can be found on any stacked items." The policy also indicated "Pots, pans, and utensils will be air-dried before stored or will be	F 371		

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F 371	Continued From page 13 stored in a self-draining position on suitably located hooks or racks constructed of corrosion resistant material." The facility's Date Marking Ready-to-eat, Potentially Hazardous Food policy undated indicated "Label and date ready-to-eat, potentially hazardous food that is prepared onsite and held more than 24 hours". Per the policy staff supposed to serve or discard refrigerated, ready-to-eat, potentially hazardous foods within seven (7) day calendar days or less from the day of preparation. The DSD stated on 9/2/14, at 11:30 a.m. that this policy was applicable to the cartons of milk, juices.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the consultant pharmacist identified and report the potential adverse side effect(s) for the use of antipsychotic medication for 1 of 5 residents (R87), reviewed for unnecessary medications.	F 428	The facility will ensure the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. A house-wide audit of all resident drug regimen including R87 was conducted by the facility's licensed pharmacist effective 10/8/14. The consultant pharmacist will continue to do thorough medication reviews to ensure all medications are necessary and appropriate, including comprehensive medication monitoring at least monthly. Pharmacy audits will be reviewed at the quality assurance meeting on-going indefinitely with oversight by the director of nursing and administrator.	11/10/14

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F 428	Continued From page 14 Findings include: On 10/1/14, at 7:39 a.m. R87 was observed in room awake, and seated in the wheelchair. No behaviors were noted. R87's Significant Minimum Data Set (MDS) dated 12/16/13, identified R87 as being at risk for falls and interventions to minimize falls would be care planned. The care plan dated 9/2/14, indicated the facility would monitor for side effects of the antipsychotic medications by obtaining orthostatic blood pressure monthly. The physician's Order Summary Report (OSR) dated 9/2/14, indicated R87 had diagnoses which included obsessive-compulsive personality disorder and depressive disorder. The OSR directed facility staff to give R87 medications as follows: Zyprexa (anti-psychotic) 2.5 milligram (mg) tablet by mouth at bedtime; Lexapro (anti-depressant) 10 mg tablet by mouth at bedtime; Haldol (anti-psychotic) 0.5 mg tablet every six hours as needed for nausea/agitation; and Ativan (anti-anxiety) 0.5 mg tablet every four hours as needed for anxiety/restlessness. In addition, the OSR directed staff to obtain monthly orthostatic blood pressure for R87, and the start date of the order was on 11/12/13. There was lack of evidence that original order for monthly orthostatic BP monitoring was discontinued, thus, remained an active order until surveyor's review date on 10/1/14. An interview with RN-E on 9/29/14, at 4:00 p.m. revealed R87 had fallen on 9/23/14, at 4:50 p.m. No injury was noted.	F 428		

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F 428	Continued From page 15 A review of R87's medical records on 10/1/14, revealed lacked evidence to indicate orthostatic blood pressures were obtained since the order was given on 11/12/13 to 8/14. On 10/1/14, at 9:35 a.m. registered nurse (RN)-E stated orthostatic blood pressures should have been recorded in the vitals section of R87's electronic medical record. RN-E reviewed the medical record and verified the medical record lacked evidence of any orthostatic BP results recorded for R87. -At 2:15 p.m. the director of nursing (DON) stated orthostatic blood pressures for R87 were never scheduled. DON added that was the reason why the orthostatic blood pressures were missed and were " not done." -At 2:16 p.m. during a telephone interview, the consultant pharmacist (CP) stated she expected orthostatic blood pressures to be completed for R87, who was on psychotropic medications. When asked if CP was able to identify the lack of orthostatic blood pressure, CP could only state the orthostatic BP result obtained as a post fall intervention, during R87's fall on 9/23/14, as follows: "lying: 120/62, sitting: 118/74, and standing: 110/64." The CP failed to provide any orthostatic BP recorded for R87 since the physician's order on 11/12/13 to 8/14. -At 3:05 p.m. the nurse manager, RN-A stated she "looked everywhere" and could not find orthostatic BP for R87. RN-A added she was putting in a new OSR for 10/14, and had the orthostatic BP scheduled for 10/2/14. The facility's policy on Psychopharmacologic Drug Use revised on 12/12, directed the pharmacy consultant to review medication	F 428		

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F 428	Continued From page 16 records monthly for documentation/justification of the drug use and make appropriate recommendations.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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.	F 431	The facility will ensure drugs and biologicals are stored appropriately including locked in storage when not being accessed for medication administration. All nurse staff were educated about proper medication storage including the requirement to lock med carts. Mediation cart audits will be conducted for 3 months or until ongoing compliance is achieved. Audits will be overseen by the director of nursing and results will be reviewed at the quality assurance meeting.	11/10/14

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F 431	Continued From page 17	F 431		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 4 medication and treatment carts was locked on 3 South which held biologicals and medications such as anti-depressants, anti-psychotropic, blood pressure medication, supplements/vitamins among other prescribed medication) during a random observation. This had the potential to affect 12 of 24 residents who physically were able to access the unsecured medication cart.

Findings include:

3 South:
On 9/30/14, at 1:17 p.m. the key lock to the medication cart parked outside the nursing station glass window was observed to be fully extended in the unlocked position. During the observation R51 was seated across from the medication cart on a wheelchair adjusting her sweater as she attempted to stand up from her wheelchair.
-At 1:19 p.m. R29 was observed propelling his wheelchair down the hallway towards the nursing station went by the unlocked and unattended medication cart and continued to propel slowly past the cart towards the hallway where the elevator was located.
-At 1:20 p.m. nursing assistant (NA)-B came out of the tub room walked past the open unattended medication cart and went to the nursing station spoke briefly with licensed practical nurse (LPN)-A then came out.
-At 1:22 p.m. LPN-A came out stood by a bedside pull table outside the nursing station next to R51

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F 431	Continued From page 18 looked around. -At 1:23 p.m. LPN-A approached R51 briefly spoke with R51 then turned around walked towards the unlocked medication cart and pushed the extended knob inward quickly picked up two pitchers from the top of the same medication cart and retrieved back to the nursing station. R51's Minimum Data Set (MDS) dated 8/19/14, revealed R51 had impaired vision, had behaviors of hallucinations and delusions, and was cognitively impaired. When interviewed on 9/30/14, at 1:23 p.m. LPN-A stated she was supposed to lock the cart at all times "I know these things, Oops!" when she was asked the facility expectation on securing medications and the medication cart. When interviewed on 10/1/14, at 11:05 a.m. registered nurse (RN)-A stated her expectation was the medication cart was to be locked at all times when not being attended to. When interviewed on 10/1/14, at 11:18 a.m. the director of nursing (DON) stated the cart should have been locked even though the nurse was at the nursing station. Storage of Medication - Residential policy reviewed 1/24/2011, directed "Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access."	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		

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F 463	Continued From page 19 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a non-functioning call light for 1 of 5 residents (R122) reviewed for being at risk for accidents. Findings include: On 9/29/14, at 3:01 p.m. during R122's room observation, the call light at bedside seated on top of the bedding was noted not to be lighting up outside the room when the red button was pushed to activate the call light. -At 3:03 p.m. the nursing assistant (NA)-B verified the call light was not lighting up outside the room. He then pulled the call light from under the bed stated the cord was stack on the bed wheel and indicated that was probably why it was not working. -At 3:05 p.m. registered nurse (RN)-B who also was the nurse manager stated he was going to have the call light cord replaced and was going downstairs to get another cord. -At 3:16 p.m. the maintenance staff (M)-A was observed in R122's room attempting to fix the call light when asked what was wrong with the call light M-A stated he was going to replace the call light cord to see if that was the problem after he attempted to push the button but was still not lighting up neither on the box in the room nor outside. When asked how his department was	F 463	The facility will ensure the nurse call station is functioning properly for all call lights to enable residents to call for assistance. All maintenance staff were educated on the expectation to maintain the call light system in good working order effective 10/2/14. A preventative maintenance plan has been implemented. Audits of the preventative maintenance plan will be conducted for 3 months with oversight by the environmental services director. Results will be reviewed at the quality assurance meeting.	11/10/14

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F 463	Continued From page 20	F 463		

informed of malfunctioning call lights he stated nursing was to let his department know and they would come to fix it. When asked about how often call light audits were done to ensure they were properly functioning he stated his department director was new since December 2013 a lot was going to change which included checking to ensure the call lights were properly working.
-At 4:00 p.m. when asked if R122 used his call light NA-A indicated "Yes, he uses it at times but we go in also to check on him regularly."

On 10/1/14, at 2:32 p.m. when asked how was department found out about malfunctioning call light the director of environmental services (ESD) stated either a resident or staff who had identified the problem would notify his department and the nursing staff would write a pink work order slip for his department to fix it.

R122's quarterly Minimum Data Set (MDS) dated 7/10/14, indicated R122 had moderately impaired cognition and had two falls without injury since admission or prior to assessment. Fall care plan dated 7/15/14, identified R122 at risk for falls and had directed staff to "Place call light within reach and encourage to use."

When interviewed on 10/2/14, at 11:16 a.m. the director of nursing (DON) stated after the issue had been brought to the facility attention, the facility had identified there was no system in place to make sure the call lights were in proper functioning order. The plan was to have the maintenance department start performing audits and had actually done an audit during the survey.

On 10/1/14, at 2:04 p.m. during the environmental tour with the ESD and Housekeeping Supervisor

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F 463	Continued From page 21 ESD indicated routine call light audits were not completed by Maintenance unless when his department had received a pink slip/s. ESD further stated the most recent call light audit had been completed on 9/29/14. Call Light Response revised 12/13, directed, "Check all call lights daily and report any defective call lights to environmental services immediately." Although the policy directed staff to check daily, the policy lacked information on who was responsible to oversee if resident call lights were being checked daily to ensure they were functioning daily.	F 463		

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

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	245587	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/30/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Ebenezer Care Center (Builidng 1) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok w/FSES for K12, K38, K46 10-29-14 RECEIVED OCT 27 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 11-11-14
Exit: 10-2-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Campus Administrator — (X6) DATE: 10/24/14

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ebenezer Care Center is a 3-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1919 and was determined to be of Type III(200) construction. In 1924, an addition was constructed to the North side of the building that was determined to be of Type III(200) construction. In 1928, another addition was constructed to the South side of the building that was determined to be of Type III(200) construction. Because the original building and the 2 additions to this builidng are all of the same construction type, even though the Type III(200) construction type does not meet the code for existing buildings, this building was surveyed as one building, but the entire facility was surveyed as two buildings under two booklets. The building has a complete fire sprinkler system throughout. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for	K 000		

PRINTED: 10/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/30/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 automatic fire department notification. The facility has a licensed capacity of 127 beds and had a census of 118 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirement for construction type and height. This deficient practice could affect all residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 09/30/2014, observation revealed that this 3-story, wood frame facility of Type III(200) construction does not meet the minimum construction requirements for a building of this height. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012	Correction not needed. The facility has achieved a passing FSES score.	10/7/14
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038 SS=F	Continued From page 3 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect all residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 09/30/2014, observation revealed that the south stairway doors on the second and third floors swing against the path of egress travel. These deficient practices were verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 038	Correction not needed. The facility has achieved a passing FSES score.	10/7/14
K 040 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5	K 040	Correction not needed. The facility has achieved a passing FSES score.	10/7/14

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K 040	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the resident room doors do not meet the 32-inch clear width requirement. This deficient practice could affect all residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 09/30/2014, observation revealed that the doors in the 1919 construction year building were found to be only 29-30 inches in clear width. This does not meet the 32-inch requirement for existing exit access doors. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 040		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	The facility's environmental services director has been re-educated on the importance of thorough completion of accurate fire drill reports effective 10/2/14. The environmental services director will be responsible for ensuring all fire drills are completely and accurately documented. The administrator will conduct random audits of the fire drill reports to ensure on-going compliance. Audits will be reviewed at the quality assurance meeting.	11/10/14

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

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OMB NO. 0938-0391

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	245587	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/30/2014

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EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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K 050	Continued From page 5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide quarterly drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect all residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 09/30/2014, record review revealed that the March and June 2014 fire drill reports were incomplete. The reports were missing information such as location, staff response, time and signatures. These deficient practices were verified by the maintenance director at the time of the inspection.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	The current and prior year's fire inspection reports have been located and have been placed in the facility's fire/life safety documentation binder. The facility's environmental services director has been re-educated on the importance of maintaining fire alarm inspection reports on-file and readily available for review upon request. Effective 10/2/14 The administrator will conduct random audits of the fire alarm inspection reports to ensure on-going compliance. Audits will be reviewed at the monthly quality assurance meeting.	11/10/14

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EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

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K 052	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect some residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 09/30/2014, record review revealed that the facility could not produce the current and prior year's fire alarm inspection reports. This deficienct practice was verified by the maintenance director at the time cf the inspection.	K 052		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **02 - BLDG TWO** B. WING	**09/30/2014**

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

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K 000	INITIAL COMMENTS	K 000	Poc ok TS 10-29-14	

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Ebenezer Care Center Building 2 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

RECEIVED
OCT 27 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Campus Administrator	10/24/14

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ebenezer Care Center Building 2 is a 3-story building with a full basement. The building was constructed in 1952 and was determined to be of Type I (332) construction. The building is fully fire sprinklered throughout. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 127 beds and had a census of 118 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are	K 050	The facility's environmental services director has been re-educated on the importance of thorough completion of accurate fire drill reports effective 10/2/14. The environmental services director will be responsible for ensuring all fire drills are completely and accurately documented. The administrator will conduct random audits of the fire drill reports to ensure on-going compliance. Audits will be reviewed at the quality assurance meeting.	11/10/14

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