



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 14, 2025

Administrator
Ebenezer Integrated Care & Rehab
45 West 10th Street
Saint Paul, MN 55102

RE: CCN: 245587
Cycle Start Date: February 27, 2025

Dear Administrator:

On February 27, 2025, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 26, 2025, the situation of immediate jeopardy to potential health and safety cited at F806 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 29, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective March 29, 2025 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 29, 2025 (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 29, 2025 the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Ebenezer Integrated Care & Rehab will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 29, 2025. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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 August 27, 2025 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, 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 (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER EBENEZER INTEGRATED CARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 45 WEST 10TH STREET SAINT PAUL, MN 55102		
(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
E 000	Initial Comments On 2/24/25 to 2/27/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 2/24/25 through 2/27/25, a standard recertification survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F806 began on 12/14/24, when the facility failed to ensure residents with food allergies received the appropriate tray for 1 of 1 resident (R23) reviewed who had a listed anaphylactic reaction (a severe, potentially life threatening allergic response) to ginger. This resulted in an immediate jeopardy (IJ) situation. The administrator, and director of nursing (DON) were notified of the IJ on 2/25/25 at 3:46 p.m. The IJ was removed on 2/26/25 at 7:20 p.m. The following complaints were reviewed:	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2025

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.

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

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FORM APPROVED
OMB NO. 0938-0391

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F 000	Continued From page 1 H55878391C/MN105364/MN105569 H55878390C/MN105579 H55878389C/MN109472 H55878388C/MN106465 H55877981C/MN110792 H55878392C/MN106720 H55878387C/MN108799 H55877842C/MN110743 . The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550			3/27/25

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F 550	Continued From page 2 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained during cares for 1 of 2 residents (R35) reviewed for dignity. Findings include: R35's quarterly Minimum Data Set (MDS) dated 1/23/25, indicated she was dependent on staff for toileting and personal hygiene cares as well as			F 550	F000 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously		

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F 550	Continued From page 3 mobility and transfers. The MDS identified R35's diagnoses of dementia and indicated she was unable to complete the mental status assessment interview. R35's care plan dated 2/5/25, identified impaired cognitive function or impaired thought processes related to dementia. Furthermore, the care plan indicated R35 had a communication problem related to finding the right words to say and directed staff to anticipate and meet R35's needs. Finally, the care plan identified activities of daily living (ADL) self-deficit related to dementia (a loss of memory, language, problem-solving and other thinking abilities) diagnosis and indicated R35 required staff assistance for dressing, personal hygiene, and toilet use. During continuous observation of evening cares on 2/26/25 between 5:56 p.m. and 6:26 p.m., nursing assistant (NA)-C and NA-D used a mechanical body lift to assist R35 into the bed at 5:58 p.m. and assisted to lay down. R35 began to call out, "get out of here" repetitively while NA-C pulled her pants down, removed her socks and unfastened the front tabs of her incontinence brief. NA-C told R35 they would be "quick" while they cleaned her up and NA-D held R35's hand and told her, "It's okay." At 6:00 p.m., R35 was uncovered and exposed from the waist down and the NAs worked together to remove her top. NA-C turned her back towards NA-D and R35 and turned on the water at the sink and let the water run while R35 was completely nude and exposed on the bed. At 6:01 p.m., NA-C returned to the bedside. NA-D pulled R35's legs apart while she continued to call out, "get out of here assholes." NA-C first washed her face, then they assisted R35 to turn onto her right side and	F 550	improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facilities allegation of compliance. F 550 Resident Rights Corrective Action: Staff caring for R35 were re-educated on providing cares in a dignified manner. Corrective Action as it applies to other residents: Nursing Staff will be re-educated on how to provide cares in a dignified manner. The dignity policy was reviewed and revised. Reoccurrence will be prevented by: Random observational audits, 2 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month for dignity will be completed across the 24-hour day by the Director of Nursing or designee. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. Date of completion: March 27, 2025 The correction will be monitored by: The Director of Nursing or Designee		

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F 550	Continued From page 4 began to wash her backside. NA-C stated, "she's just going" and she used cleansing wipes to clean feces from R35's buttocks. R35 continued to call out, "get out of here." NA-C reported a new area to R35's buttock to the surveyor, calling the surveyor over to assess. NA-C changed soiled gloves and R35 remained nude, and her exposed backside faced the door. At 6:08 p.m., there was a knock at the door and registered nurse (RN)-C opened the door to R35's fully exposed buttocks. RN-C walked over to the bedside and draped the hospital gown over R35's neck, covering her front side and began to rub her back gently. RN-C stated this was done to promote her dignity and they wouldn't want their family members to be laying like that naked. RN-C expected staff to protect a resident's dignity during cares by covering them up with blankets or clothing when it would not impede cares. RN-C also stated it may help provide comfort since being naked might make the resident cold. During interview on 2/26/25 at 6:37 p.m., NA-C verified they had not provided for R35's dignity during cares. NA-C stated it was something they didn't think about and was grateful to be reminded "especially for those residents who cannot speak for themselves." NA-C stated covering her also may have provided warmth, which could have promoted comfort during their cares. Per interview on 2/27/25 at 2:22 p.m., RN-D expected staff to only expose what needs to be exposed during cares. RN-D provided the example of covering the chest if perform peri-cares and keeping a resident's bottom covered if performing upper body cares.			F 550			

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F 550	Continued From page 5 Per interview on 2/27/25 at 3:13 p.m., the director of nursing (DON) expected staff to try and maintain dignity to the highest level as possible during cares. The DON stated staff should shut the door, pull a privacy curtain if able, explain the task they are about to perform, and ask the resident how they could keep them comfortable. The DON stated staff should maintain privacy as much as they are able to in order to promote a resident's dignity.	F 550			
F 554 SS=D	A policy pertaining to dignity was requested but not received. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 1 of 1 residents (R44) observed with medications at bedside. Findings include: R44's annual Minimum Data Set (MDS) dated 12/31/24, indicated he had intact cognition, was dependent on staff for personal hygiene and mobility, and required setup or clean-up assistance with eating. The MDS reported diagnoses of a stroke (when blood flow to a part	F 554	F554- Self Administration of Medications Corrective Action: R44- the Tums were removed from the room. An assessment for Self- administration was completed for R44. Corrective Action as it applies to other residents: All resident rooms were audited for medications left at bedside. Residents that wish to self-administer medications will be assessed for their ability to self-administer. Medication kept at bedside must be stored in a locked box that is attached to something that can't be easily moved or locked bedside drawer. The self-administration of medication	3/27/25	

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F 554	Continued From page 6 of the brain is disrupted, causing a lack of oxygen and brain cell death), aphasia (a language disorder affecting a person's ability to communicate), dementia (loss of memory, language, problem-solving and other thinking abilities), and hemiplegia or hemiparesis (one-sided muscle weakness or paralysis). Additionally, the MDS identified he had a mechanically altered diet and did not exhibit signs or symptoms of a possible swallowing disorder. R44's order summary report dated 12/25/24, were reviewed on 2/24/25 and lacked documentation of an order for self-administration of medications. Additionally, his order summary report lacked an order for Tums, an antacid medication. R44's medication administration record (MAR) dated 2/25/25, was reviewed on 2/24/25 and lacked documentation of an order for self-administration of medications as well as an order for Tums. R44's electronic health record (EHR) was reviewed on 2/24/25 at 9:19 a.m. and lacked documentation of an assessment to self-administer medications. During observation on 2/24/25 at 9:19 a.m., R44 was in bed with his bedside table over the bed, and on the bedside table was a bottle with the label "Smoothies-flavored Tums". During observation on 2/25/25 at 10:05 a.m., the bottle of Tums remained unchanged on the bedside table. During observation on 2/27/25 at 10:02 a.m., the	F 554	policy was reviewed and remains current. All nursing staff were re-educated on medications left at bedside. All licensed staff were re-educated on the process for completion of Self administration of medications assessments. Reoccurrence will be prevented by: Random observational audits, 2 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month of rooms for medications left at bedside will be completed by the Director of Nursing or designee. Residents will then be assessed for ability to Self-administer medications. Random chart audits 2 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month will be completed by Director of Nursing or designee to ensure completion of an assessment to self-administer. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. Date of completion: March 27, 2025 The correction will be monitored by: The Director of Nursing or Designee		

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

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F 554	Continued From page 7 bottle of Tums remained unchanged on the bedside table. During interview on 2/27/25 at 10:08 a.m., registered nurse (RN)-C stated a resident wishing to administer their own medications should have an assessment for self-administration. RN-C stated the assessments were completed by nursing staff and then the provider would be updated. RN-C reviewed R44's EHR and confirmed he did not have a self-administration assessment or an order to self-administer medications. RN-C stated "we did see it; we were asking our manager" about the medications noted at his bedside table, and stated "he has very high anxiety, he would get really upset about it" if staff took the bottle away from him. RN-C walked into R44's room and confirmed there was a bottle of Tums on his bedside table and asked him where it came from. He responded, "my family," and RN-C told him the bottle would not be removed "right now" but it would be discussed with the nurse manager. During interview on 2/27/25 at 10:16 a.m., licensed practical nurse (LPN)-B reviewed R44's physician orders and confirmed he did not have an order for Tums or a generic equivalent. LPN-B further verified he should have a self-administration assessment and order to have the Tums at his bedside and stated, "I feel like he would be able to self-administer" the Tums because of his pureed diet and the Tums being chewable or dissolvable. LPN-B stated, "I will update the provider and the nurse manager." Per interview on 2/27/25 at 2:39 p.m., RN-D expected staff to complete a self-administration assessment first, then get an order from the			F 554			

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F 554	Continued From page 8 provider with the okay to self-administer medications. RN-D also expected staff to remove medications from a resident's room "the second someone noticed it." RN-D stated the risks could include possible medication contraindications or interactions, indications for use, safety implications and stated, "we need to get the provider involved to make that decision." Per interview on 2/27/25 at 3:34 p.m., the director of nursing (DON) expected staff complete a self-administration assessment and obtain a provider order. The DON stated if a family member brought in a medication from home, staff should question why there was a need for that medication and get the provider involved. The DON indicated the risks included polypharmacy and interactions with other medications. Per facility policy titled Self Administration of Medications (SAM) revised 9/24, a self-administration of medications assessment would be completed for any resident requesting to administer any medication without the direct supervision of a nurse and the interdisciplinary team would review the recommendation to determine if the resident was safe to do so. The resident's physician would need to write an order for the resident to self-administer medications and only the medications permitted for self-administration would be left at the bedside. The resident's care plan should be updated to reflect self-administration of medications.	F 554			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609			3/27/25

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F 609	Continued From page 9 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of potential harm was reported to the State Agency (SA) in the required timeframe for 1 of 1 residents (R23) reviewed for anaphylactic reaction. Findings include: R23's admission Minimum Data Set (MDS) dated 12/5/24, indicated R23 was cognitively intact and required setup assistance for eating. R23's	F 609	F609 Reporting Alleged Violations Corrective Action: A VA report was made on 2/25/25 for R 23. Corrective Action as it applies to other residents: Nursing leaders and Administrator were re- educated to the Vulnerable adult policy on 3/11/25. All staff were re-educated on the VA policy for reporting alleged violations of abuse, neglect, exploitation or mistreatment. The		

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F 609	Continued From page 10 diagnoses included acute ischemia of small intestine (decrease in blood flow), type 2 diabetes, and Prader-Willi syndrome [a condition affecting appetite and causing one to always feel hungry). R23's diet order/dietary communication dated 11/29/24, indicated food allergies, "ginger, bee pollen." R23's allergy list printed 2/25/25, indicated the following food allergens: ginger, bee pollen/royal jelly. R23's physician order history indicated the following: -Epinephrine injection solution auto-injector 0.3mg/0.3ml. Inject 0.3 mg intramuscularly as needed for anaphylaxis, allergy to ginger, daily - start date 11/29/24 at 5:00 p.m. -11/29/24 at 9:29 p.m. on hold, "insurance does not cover." -12/18/24 at 3:19 p.m. resume, "ordered per provider." -Date received-12/23/24, "on hand." During interview on 2/24/25 at 11:51 a.m., R23 stated a few months ago she was provided a meal consisting of a piece of chicken and stir fry vegetables. R23 stated her meal ticket did not indicate chicken; therefore, did not know what type of chicken was provided. R23 asked several unidentified staff members if the food items contained ginger, and all said no. After a couple bites, R23 stated she thought she bit into a piece of ginger and within a few seconds her lips started tingling and she felt her throat beginning to tighten. R23 notified staff she was having anaphylactic reaction and requested epinephrine.	F 609	Vulnerable Adult- abuse prohibition plan was reviewed and remains current. Reoccurrence will be prevented by: Nursing leadership is reviewing all Risk Management incidents and progress notes that are completed to ensure reports to OHFC are made when needed. Random chart audits 1 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month will be completed by the Director of Nursing or designee to ensure reports are being made timely. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. Date of completion: March 27, 2025 The correction will be monitored by: The Administrator or Designee		

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F 609	Continued From page 11 R23 was told her epinephrine order was on hold due to insurance not covering it and staff did not have epinephrine in the emergency medication kit (e-kit). Review of facility week 2 menu for Saturday was Honey Ginger chicken thighs and Asian Stir fry vegetable mix. R23's progress note dated 12/14/24 at 10:56 p.m., indicated R23 reported to staff of having a food allergy after eating part of her dinner and on assessment discovered R23 "having a stick [sic] throat, and does not feel well." R23 started having shortness of breath and was put on oxygen at 4 liters/min. Resident had an order for epinephrine but it was on hold and the medication was not available. Staff called 911 and resident was sent to the hospital. R23's progress noted dated 12/14/24 at 11:05 p.m., indicated, "This writer re email [sic] resident diet order to kitchen because one of the dietary stated that they don't have the food allergy in their file." R23's emergency department after visit summary (AVS) dated 12/14/24, indicated, "Reason for Visit ALLERGIC REACTION Diagnoses -Shortness of breath - Anaphylaxis, initial encounter." The AVS instructed, "You were seen today for an allergic reaction. Your symptoms improved after an epi pen. Return to the emergency department with any new or worsening symptoms." Review of facility risk management lacked evidence facility completed an investigation or safety incident report for R23's anaphylactic reaction event.	F 609			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 609	Continued From page 12 During interview on 2/27/25 at 2:29 p/m., director of nursing stated expectation for staff to initiate a safety event or risk management entry, both process include the required report of the event to the administrator and DON regardless of date, time or shift. DON stated either herself or the administrator would then file a report with the SA and initiate an investigation. DON confirmed that this did not happen following R23's anaphylactic reaction. During interview on 2/27/25 at 3:13 p.m., administrator stated expectation of any adverse event would be reported via a group text which included herself, the DON, unit managers and the manager on call. Administrator stated either herself or DON would submit a report to the SA and initiate an investigation. Administrator confirmed that the event involving R23's anaphylactic reaction that occurred on 12/14/24, was not reported to the SA until 2/26/25. Facility policy Incident/Accident Reports dated 1/24, indicated, "When the incident/accident involves a resident, nursing is responsible for notation in the medical record Risk Management and progress note describing the incident /accident, as well as, prompt follow-up action, intervention and notification of family and physician." The policy further indicated, DON or designee would review and ensure documentation was complete and when appropriate ensure incidents were reported in accordance with state and federal law. Facility policy Vulnerable Adult-Abuse Prohibition Plan dated 10/24, indicated all incidents involving abuse, neglect, exploitation or mistreatment			F 609			

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F 609	Continued From page 13			F 609			
F 610 SS=D	would be reported immediately to the SA. The policy defined neglect as the failure "to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." The policy further indicated, "All incidents requiring medical intervention or follow-up are documented in the resident record" and DON, Administrator or other designee would "immediately institute an internal investigation of the reported allegation or incident." Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate an incident of anaphylactice reaction and need for emergency services for 1 of 1 residents (R23) reviewed for			F 610			3/27/25
					F610 Investigation, Prevention and Correction of Alleged Violations Corrective Action: A VA report was made on 2/25/25 for R 23. A thorough		

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F 610	Continued From page 14 anaphylactic reaction. Findings include: R23's admission Minimum Data Set (MDS) dated 12/5/24, indicated R23 was cognitively intact and required setup assistance for eating. R23's diagnoses included acute ischemia of small intestine (decrease in blood flow), type 2 diabetes, and Prader-Willi syndrome [a condition affecting appetite and causing one to always feel hungry). R23's diet order/dietary communication dated 11/29/24, indicated food allergies, "ginger, bee pollen." R23's allergy list printed 2/25/25, indicated the following food allergens: ginger, bee pollen/royal jelly. R23's physician order history indicated the following: -Epinephrine injection solution auto-injector 0.3mg/0.3ml. Inject 0.3 mg intramuscularly as needed for anaphylaxis, allergy to ginger, daily - start date 11/29/24 at 5:00 p.m. -11/29/24 at 9:29 p.m. on hold, "insurance does not cover." -12/18/24 at 3:19 p.m. resume, "ordered per provider." -Date received-12/23/24, "on hand." During interview on 2/24/25 at 11:51 a.m., R23 stated a few months ago she was provided a meal consisting of a piece of chicken and stir fry vegetables. R23 stated her meal ticket did not indicate chicken; therefore, did not know what type of chicken was provided. R23 asked several			F 610	investigation was completed, and processes put into place for prevention and correction. Corrective Action as it applies to other residents: Nursing leaders and Administrator were re-educated to the Vulnerable adult policy on 3/11/25. All staff were re-educated on the VA policy for reporting alleged violations of abuse, neglect, exploitation or mistreatment. The Vulnerable Adult- abuse prohibition plan was reviewed and remains current. Reoccurrence will be prevented by: Random audits 1 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month of reports of alleged violations surrounding abuse, neglect, exploitation and mistreatment will be completed by the Director of Nursing or designee to ensure they are investigated thoroughly and interventions for prevention and correction are in place. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. Date of completion: March 27, 2025 The correction will be monitored by: The Administrator or Designee		

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F 610	Continued From page 15 unidentified staff members if the food items contained ginger, and all said no. After a couple bites, R23 stated she thought she bit into a piece of ginger and within a few seconds her lips started tingling and she felt her throat beginning to tighten. R23 notified staff she was having anaphylactic reaction and requested epinephrine. R23 was told her epinephrine order was on hold due to insurance not covering it and staff did not have epinephrine in the emergency medication kit (e-kit). Review of facility week 2 menu for Saturday was Honey Ginger chicken thighs and Asian Stir fry vegetable mix. R23's progress note dated 12/14/24 at 10:56 p.m., indicated R23 reported to staff of having a food allergy after eating part of her dinner and on assessment discovered R23 "having a stick [sic] throat, and does not feel well." R23 started having shortness of breath and was put on oxygen at 4 liters/min. Resident had an order for epinephrine but it was on hold and the medication was not available. Staff called 911 and resident was sent to the hospital. R23's progress noted dated 12/14/24 at 11:05 p.m., indicated, "This writer re email [sic] resident diet order to kitchen because one of the dietary stated that they don't have the food allergy in their file." R23's emergency department after visit summary (AVS) dated 12/14/24, indicated, "Reason for Visit ALLERGIC REACTION Diagnoses -Shortness of breath - Anaphylaxis, initial encounter." The AVS instructed, "You were seen today for an allergic reaction. Your symptoms improved after an epi			F 610			

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F 610	Continued From page 16 pen. Return to the emergency department with any new or worsening symptoms." Review of facility risk management lacked evidence facility completed an investigation or safety incident report for R23's anaphylactic reaction event. During interview on 2/27/25 at 2:29 p/m., director of nursing stated expectation for staff to initiate a safety event or risk management entry, both process include the required report of the event to the administrator and DON regardless of date, time or shift. DON stated either herself or the administrator would then file a report with the SA and initiate an investigation. DON confirmed that this did not happen following R23's anaphylactic reaction. During interview on 2/27/25 at 3:13 p.m., administrator stated expectation of any adverse event would be reported via a group text which included herself, the DON, unit managers and the manager on call. Administrator stated either herself or DON would submit a report to the SA and initiate an investigation. Administrator confirmed that the event involving R23's anaphylactic reaction that occurred on 12/14/24, was not reported to the SA until 2/26/25. Facility policy Incident/Accident Reports dated 1/24, indicated, "When the incident/accident involves a resident, nursing is responsible for notation in the medical record Risk Management and progress note describing the incident /accident, as well as, prompt follow-up action, intervention and notification of family and physician." The policy further indicated, DON or designee would review and ensure	F 610			

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F 610	Continued From page 17 documentation was complete and when appropriate ensure incidents were reported in accordance with state and federal law. The policy further indicated, "Designated staff member [designated by the administrator or DON] will initiate an internal investigation as needed to determine the root cause of the incident." Facility policy Vulnerable Adult-Abuse Prohibition Plan dated 10/24, indicated all incidents involving abuse, neglect, exploitation or mistreatment would be reported immediately to the SA. The policy defined neglect as the failure "to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." The policy further indicated, "All incidents requiring medical intervention or follow-up are documented in the resident record" and DON, Administrator or other designee would "immediately institute an internal investigation of the reported allegation or incident." The policy indicated the investigation may include but not limited to the following: -Interviews and written statements with staff and any witnesses -Resident and resident representative interviews -Care observations -Environmental review -Resident health status and medical record review.			F 610			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure			F 684			3/27/25

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

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F 684	Continued From page 18 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of a change in condition for 1 of 1 resident with congestive heart failure (CHF) and a significant weight gain. The facility further failed to ensure appropriate wound care orders were followed for 1 of 1 resident (R35) reviewed for wound care. Findings include: R40 R40's discharge Minimum Data Set (MDS) dated 2/12/25, indicated intact cognition and diagnoses of CHF, acute and chronic respiratory failure with hypoxia, acute kidney disease, and fluid overload. It further indicated R40 required partial/moderate assistance with most activities of daily living (ADL) and mobility. R40's physician's orders dated 1/20/2025, indicated daily weights and to update the provider of a weight gain of 2 pounds (lbs.) in one day and/or 5 lbs. in one week, every shift. R40's care plan dated 1/3/25, indicated R40 had CHF, peripheral heart disease (PAD), and hyperlipidemia (HLD). Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles while breathing. Notify provider of abnormalities. It further indicated the following	F 684	F 684- Quality of Care Corrective Action: The provider was updated on 3/17/25 regarding R40s weight changes. The appropriate wound care dressing was applied to R35. Corrective Action as it applies to other residents: All licensed nursing staff will be re-educated regarding the facility's policies related to notification of changes in condition in relation to weight gains and Dressing Change to a wound ☐ Clean. The policies on change in condition, weights and heights, and Dressing Change to a wound ☐ Clean were reviewed and remains current. Reoccurrence will be prevented by: Random audits 2 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month of resident with changes of condition related to weight changes that require provider update will be completed by the Director of Nursing or designee to ensure the provider and family have been properly and timely notified of changes related to weight gains. Random observational audits 2 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month of dressing changes will be completed by the Director of Nursing or designee to ensure they are completed as		

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F 684	Continued From page 19 interventions: -Daily weights, call medical doctor (MD)/nurse practioner (NP) for weight gain of more than 2 pounds per day and/or 5 pounds per week. -Encourage adequate nutrition. Offer small frequent feedings. -Give cardiac medications as ordered. -Monitor lab work; potassium (K+), sodium (NA), blood urea nitrogen (BUN), and creatinine. -Monitor/document sleeping pattern. Inform physician of any insomnia or anxiety. Give sedatives as ordered. Monitor/document/report (as needed) any signs or symptoms of CHF: dependent edema of legs and feet, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation. Report to provider as indicated. R40's treatment administration record (TAR) for January and February of 2025 indicated, during the week of 1/20/25-1/26/25 R40 had a weight gain of 11.4 lbs., from 1/25/25-1/26/25 a weight gain of 8.8 lbs., and from 2/6/25-2/27/25 a weight gain of 13 lbs. as evidenced by the weights below: -1/20/25 443.4 lbs. -1/24/25 443.8 lbs. -1/25/25 446.0 lbs. -1/26/25 454.8 lbs. -1/27/25 445.6 lbs. -2/6/25 433.0 lbs. -2/7/25 446.0 lbs. -2/10/25 442.0 lbs. -2/11/25 448.0 lbs.	F 684	ordered. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. Date of completion: March 27, 2025 The correction will be monitored by: The Director of Nursing or Designee		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 20 R40's progress notes for the month of January and February of 2025, lacked any indication the doctor had been notified of a change in condition regarding weight gain During interview on 2/26/25 at 4:40 p.m., RN-F verified R40's weights on her January and February TAR were more than 2 lbs. in one day and 5 lbs. in one week (as referenced above) and stated the physician should have been notified and documentation should have occurred. During interview on 2/26/25 at 4:46 p.m., RN-G verified R40's weight gain of more than 2 lbs. in one day and 5 lbs. in one week (as referenced above) and stated the nurses were responsible for calling the provider and documenting in the progress notes. RN-G further stated if a resident needed to be re-weighed, they should document it in the progress notes. During interview on 2/27/25 at 9:45 a.m. the nurse practioner (NP) stated the only time she had been notified of R40's weight gain was when she sent her to the hospital for hypervolemia on 2/12/25. The NP further stated she was in the facility 4 days per week and reviewed the weights of the patients she planned to see that day. She didn't see every resident every time she was there, therefore the order indicated to notify the physician and that's what the nursing staff were expected to do. The nurses were responsible for re-weighing a resident if there was an issue with the weight. The NP also verified the order was intended to be for a 7 day period typically from Monday to Sunday. During interview on 2/27/25 at 12:45 p.m. the			F 684			

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F 684	Continued From page 21 director of nursing (DON) stated the nurses were responsible for notifying the provider of a change in condition and the provider should have been notified regarding R40's weight gain. This was important because R40 had CHF and was at risk for fluid overload which could have negative effects on her cardiac health. The facility's policy regarding weight and height dated 10/2021, indicated to document resident weight in PCC and update the provider of weight increases or decreases as needed and per physician's orders. R35 R35's quarterly Minimum Data Set (MDS) dated 1/23/25, indicated she was dependent on staff for toileting and personal hygiene cares as well as mobility and transfers. The MDS identified R35's diagnoses of dementia (a loss of memory, language, problem-solving and other thinking abilities) and indicated she was unable to complete the mental status assessment interview. Additionally, the MDS identified she was at risk for developing a pressure injury and had moisture-associated skin damage (MASD, or skin irritation or breakdown caused by prolonged exposure to moisture such as urine, saliva, sweat, or wound drainage). R35's Care Area Assessment (CAA) for pressure ulcer/injury dated 10/31/24, identified her "MASD to left gluteal fold with treatment." The CAA directed staff to the care plan for goals and			F 684			

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F 684	Continued From page 22 interventions. R35's care plan revised on 2/5/25, identified her impaired skin integrity and risk for further breakdown as evidenced by MSAD to her buttocks. The care plan directed staff to provide treatment and wound care as ordered. R35's signed order summary dated 1/6/25, included the wound order: - "wound care 1. Facility staff to perform every other day and as needed 2. Cleanse open areas to buttocks and upper thigh. Allow to dry. Apply Mepilex over open areas every day shift every other day for MASD," dated 12/17/24. R35's TAR dated 2/25, reflected the following wound care orders: - "wound care to buttocks: cleanse open areas with wound cleanser. Pat dry. Cover with Mepilex dressing," change every evening shift every other day for MASD, dated 2/26/25 at 7:08 p.m. - "wound care for left heel: cleanse with wound cleanser. Pat dry. Apply Medihoney and cover with Mepilex dressing. Change daily and PRN" (as needed) every evening shift, dated 1/23/25. During observation on 2/26/25 at 6:14 p.m., registered nurse (RN)-C and RN-D were at R35's bedside during evening cares. RN-D stood at the head of the bed and talked to R35 while RN-C performed wound cares. RN-C sprayed a wound cleanser over R35's buttocks to cleanse the area before patting it dry with gauze. RN-C applied a dark, honey-colored gel from a tube to her gloved fingertips and dabbed it onto each of the opened			F 684			

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F 684	Continued From page 23 and red areas on her buttocks, and then applied more from the tube to her fingertips and dabbed it onto the fluid-filled sacs on R35's buttocks. RN-C then applied foam dressings to cover the areas and dated each dressing. During interview on 2/26/25 at 6:42 p.m., RN-C reviewed R35's wound care orders and TAR dated 2/25 and was unable to find current or active wound treatment orders for her. RN-C verified the wound treatment orders for R35's pressure ulcer to her left heel, which included "Medihoney", and confirmed applying it to R35's buttock during wound cares. During interview on 2/27/25 at 2:26 p.m., RN-D verified the MSAD treatment order should have been cleanse with a wound cleanser, pat dry with gauze and cover with a "Mepilex". RN-D confirmed witnessing RN-C applying the Medihoney to R35's MSAD on her buttocks and stated, "I thought I saw RN-C doing that." RN-D expected staff to verify and "double check" orders before applying treatments if staff were unsure. Per interview on 2/27/25 at 3:13 p.m. with the director of nursing (DON), staff were expected to review treatment orders if they were unsure of an order before administering the treatment or order. Per facility policy titled Management of Skin Alterations dated 9/11/24, residents with wounds would have at minimum weekly monitoring for appropriateness of treatment/care plan, signs of healing and would report to the provider as needed. Education would be provided to staff as needed on alterations in skin integrity.			F 684			
F 806 SS=J	Resident Allergies, Preferences, Substitutes			F 806			3/27/25

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F 806	Continued From page 24 CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents with food allergies received the appropriate tray for 1 of 1 resident (R23) reviewed who had a listed anaphylactic reaction (a severe, potentially life threatening allergic response) to ginger. This resulted in an immediate jeopardy (IJ). The IJ began on 12/14/24, when R23 was served a meal tray which included honey ginger chicken and after a few bites experienced an anaphylactic reaction. R23 had an order for epinephrine to be used in the case of an anaphylactic reaction however, R23 was not given the epinephrine. This resulted in R23 requiring transfer to the emergency department for treatment. The administrator and director of nursing (DON) were informed of the IJ on 2/25/25 at 3:46 p.m. The facility implemented corrective action and the IJ was removed on 2/26/25 at 7:20 p.m. However, non-compliance remained at the lower scope and severity of D, isolated, no actual harm, with potential for more than minimal harm that is not immediate jeopardy.			F 806	F806 - Resident Allergies Corrective Action: The allergen for the affected resident has been added to the "tray note" section of their "Health Touch" Software profile. This ensures that the allergen is printed at the bottom of the paper meal ticket. Additionally, the allergen has been added to the "dislikes" section of the resident's profile in the "Health Touch" Software, which will discourage culinary staff from ordering anything with a recipe that contains the resident's allergen. These additional steps were necessary because the resident's allergen was not listed in the software's predefined allergen list. Corrective Action as it Applies to Other Residents: A facility-wide audit of resident and patient allergens was conducted. This audit involved cross-referencing all resident allergens listed in their H&P paperwork with the allergens in both their "Point Click Care" and "Health Touch" profiles. Any missing allergens were		

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F 806	Continued From page 25 Findings include: R23's admission Minimum Data Set (MDS) dated 12/5/24, indicated R23 was cognitively intact and required setup assistance for eating. R23's diagnoses included acute ischemia of small intestine (decrease in blood flow), type 2 diabetes, and Prader-Willi syndrome [a condition affecting appetite and causing one to always feel hungry). R23's care plan dated 12/9/24, indicated set up assistance to eat, diet as ordered, monitor food intake at meals, and offer alternatives for meals if refusing. R23's care plan lacked evidence of any food allergies. R23's diet order/dietary communication dated 11/29/24, indicated food allergies, "ginger, bee pollen." R23's allergy list printed 2/25/25, indicated the following food allergens: ginger, bee pollen/royal jelly. R23's admission nutrition assessment dated 12/3/24, indicated, "Allergies ...Diclofenac, metformin, Bee pollen/royal jelly, Ginger." R23's physician order history indicated the following: -Epinephrine injection solution auto-injector 0.3mg/0.3ml. Inject 0.3 mg intramuscularly as needed - for anaphylaxis, allergy to ginger, daily - start date 11/29/24 at 5:00 p.m. -11/29/24 at 9:29 p.m. on hold, "insurance does not cover." -12/18/24 at 3:19 p.m. resume, "ordered per			F 806	added to both systems. For allergens not included in the "defined" allergen list of the "Health Touch" Software (which automatically prevents staff from ordering any dish with these allergens as an ingredient), the allergens were entered into the "tray notes" and "dislikes" sections of the resident's profile. Prevention of Reoccurrence: Every weekday, the culinary and nursing/administration leadership teams meets in person. During these meetings, allergens and diet orders for new admissions are discussed and cross-referenced. Any changes to the diet or allergens of long-term residents from the past 24 to 72 hours are also reviewed. In addition, the facility's dietitian and culinary director are conducting a whole house comparison between the allergens listed in the "Point Click Care" software and those in the "Health Touch" software. These audits will be conducted two times per month for all Transitional Care beds and one time per month for the Long-Term care beds. The culinary director will also check that any undefined allergens are entered into both the tray note and dislike sections of the software during this audit. Education has been provided to all lead culinary staff regarding the new process for entering undefined allergens into the "Health Touch" Software. All staff have been trained to complete a final check when serving a meal to a resident. This final check involves reviewing the meal		

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F 806	Continued From page 26 provider." -Date received-12/23/24, "on hand." R23's December 2024 medication administration record (MAR) indicated, "EPINEPHrine Injection Solution Auto-Injector 0.3 MG/0.3ML (Epinephrine [Anaphylaxis] Inject 0.3 mg intramuscularly as needed for anaphylaxis, Allergy to ginger. Daily - Order Date- 07/27/2014 ...-Hold Date-from 12/01/2024 ...to 12/18/2024." R23's MAR indicated "H" from 12/1/24 through 12/17/24, and did not indicate any epinephrine administration. During interview on 2/24/25 at 11:51 a.m., R23 stated a few months ago she was provided a meal consisting of a piece of chicken and stir fry vegetables. R23 stated her meal ticket did not indicate chicken; therefore, did not know what type of chicken was provided. R23 asked several unidentified staff members if the food items contained ginger, and all said no. After a couple bites, R23 stated she thought she bit into a piece of ginger and within a few seconds her lips started tingling and she felt her throat beginning to tighten. R23 notified staff she was having an anaphylactic reaction and requested epinephrine. R23 was told her epinephrine order was on hold due to insurance not covering it and staff did not have epinephrine in the emergency medication kit (E-kit). Review of facility week 2 menu for Saturday was honey ginger chicken thighs and Asian stir fry vegetable mix. R23's progress note dated (Saturday) 12/14/24 at 10:56 p.m., indicated R23 reported to staff of having a food allergy after eating part of her dinner and on assessment discovered R23	F 806	ticket for any allergens or special notes and inspecting the tray for the listed allergens. If a staff member is unsure whether an allergen is present, they are instructed to return the tray to the kitchen for clarification. All staff have also been educated on the signs and symptoms of anaphylactic shock and allergic reactions. Nurses have been educated on the contents and appropriate use of Emergency Kit medications, as well as the process for administering these medications. Date of Completion: March 27, 2025 The correction will be monitored by: The Director of Culinary Services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025	
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F 806	Continued From page 27 "having a stick [sic] throat, and does not feel well." R23 started having shortness of breath and was put on oxygen at 4 liters/min. Resident had an order for epinephrine but it was on hold and the medication was not available. Staff called 911 and resident was sent to the hospital. R23's progress noted dated 12/14/24 at 11:05 p.m., indicated, "This writer re email [sic] resident diet order to kitchen because one of the dietary stated that they don't have the food allergy in their file." R23's emergency department after visit summary (AVS) dated 12/14/24, indicated, "Reason for Visit ALLERGIC REACTION Diagnoses -Shortness of breath - Anaphylaxis, initial encounter." The AVS instructed, "You were seen today for an allergic reaction. Your symptoms improved after an epi pen. Return to the emergency department with any new or worsening symptoms." During observation on 2/25/25 at 9:00 a.m., R23's meal tray ticket lacked evidence of any food allergies. During interview on 2/25/25 at 9:21 a.m., dietary staff (DS)-A stated each resident had diet orders and allergies uploaded to the nutrition program. DS-A stated dietary staff would go room to room and enter residents' requests for all three meals for the following day. The nutrition program would identify a contraindication due to an allergy and would not allow the specific food item to be ordered. DS-A further stated resident allergies should also print out on the meal tray ticket and staff should check ticket prior to providing resident their meal.			F 806			

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F 806	Continued From page 28 During interview on 2/25/25 at 9:41 a.m., licensed practical nurse (LPN)-A stated all resident allergies should be listed in the nutrition program and should display on the resident's meal tray ticket. LPN-A further stated epinephrine was stocked in the E-kit and available to be used in emergency situations. LPN-A further stated if a resident had epinephrine ordered for an anaphylactic reaction and did not have the medication available in their medications, the epinephrine in the E-kit should be used in the case of an allergic reaction. During interview on 2/25/25 at 10:06 a.m., kitchen manager (KM) and director of nutrition services (DNS) stated nursing communicates diet orders and allergies to dietary services using a specific communication form which was completed then scanned and emailed to nutrition. KM stated the information was then uploaded into the nutrition program (Healthtouch) and the system had safety measures built in to not allow a resident to order a food item that was listed as an allergy. During interview on 2/25/25 at 10:34 a.m., registered nurse (RN)-A stated would expect dietary services would have the correct allergy information for each resident and that they would not provide a meal containing food that a resident was allergic to. RN-A stated each resident's meal tray ticket should indicate any food allergies. RN-A further stated if a resident had an order for an emergency medication and it was not covered by insurance, that the facility would purchase the medication within 24 hours of denial and preferably before their first meal in the case of a food allergen. During follow up interview on 2/25/25 at 11:37	F 806			

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

PRINTED: 04/01/2025
FORM APPROVED
OMB NO. 0938-0391

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F 806	Continued From page 29 a.m., DNS provided list of all available allergies in the nutrition program and confirmed ginger was not included. DNS stated an undefined allergy could be added to the comments area but that did not display on the meal tray ticket. During interview on 2/25/25 at 10:55 a.m., director of nursing (DON) stated expectation that the process would correctly identify a resident's food allergies, and that information would be communicated to nutrition services. DON stated the food allergy should print on the meal tray ticket. DON further stated in a situation of a non-covered emergency medication the facility would purchase the medication to have on hand. DON stated the facility E-kit does contain epinephrine, but was not sure it was the corrected dosage. DON could not explain why there was not a change of condition, safety event or risk management completed on this event and stated lack of such report did not allow for proper follow up, education or resolution. During interview on 2/25/25 at 11:25 a.m., consultant pharmacist (CP) stated epinephrine was stocked in the facility E-kit and was unaware of any shortage around 12/14/24. CP stated if a resident was experiencing an anaphylactic reaction due to a food allergen ingestion, should be given epinephrine if ordered as anaphylaxis is a medical emergency. CP stated a resident in anaphylaxis who does not receive epinephrine could experience inability to breathe and would need emergency services. Facility policy Patient Meal Service Procedure dated 8/8/23, indicated, food allergies would be entered appropriately into HealthTouch and "HealthTouch computer system will automatically	F 806			

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

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F 806	Continued From page 30 omit designated allergens from the patient's menu choices. All foods listed as allergen in the HealthTouch system will not be served to the patient...If the patient has an allergy that is not identifiable in Health Touch the menu will be hand checked by the diet clerk or designee." The policy further indicated, "A designated Nutrition Aide will check each meal tray for accuracy before the tray leaves the department. This check includes, but it [sic] not limited to: confirming all items are in place and all quality standards are met." The immediate jeopardy that began on 12/14/24, was removed on 2/26/25 at 7:20 p.m., when it could be verified through observation and interview that the facility had implemented a process to ensure residents would receive appropriate food items and not receive identified food allergens. A whole house audit was conducted by nutrition services and verified all residents' allergies listed in the medical record was accurately listed in the nutrition system and that those allergies would accurately print on the residents' meal tray ticket. Meal service observation identified staff confirmed the meal served matched the meal tray ticket and any food allergies listed on the meal ticket were not served. In addition, R23's orders and stocked medication included epinephrine. The E-kit contents were reviewed and included epinephrine as well. Nutrition staff education started on 2/25/25 included allergy information communication and entry into the nutrition system, meal service, meal ticket and allergy review and tray assembly. Nursing staff education started on 2/25/25 included verification that the meal delivered matched the tray ticket and did not contain any food allergens. Nursing education further included E-kit contents, use of epinephrine			F 806			

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

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F 806	Continued From page 31 via a vial, standing house orders, signs and symptoms of anaphylactic reaction, procedure for allergic and anaphylactic reactions, and incident reporting. The plan was to educate all staff prior to their next shift. Continued compliance monitored via meal service audits completed daily for two weeks, then weekly for four weeks and monthly thereafter. Audit results would be reviewed by the quality committee.	F 806			
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure adaptive equipment was used for 1 of 1 residents reviewed for adaptive equipment. Findings include: R9's quarterly Minimum Data Set (MDS) dated 12/12/24, indicated R9 had cognitive impairment and diagnoses of dementia, stroke, and dysphasia (difficulties swallowing). R9 had was dependent for eating, had difficulty swallowing and required a mechanically altered diet. R9's nutritional assessment dated 12/10/24, indicated R9 required varying level of assistance with meals and required a nosey cup for drink.	F 810	F810- Adaptive equipment- mealtime Corrective Action: R9 was provided a nosey cup starting on 2/26 for the evening meal. Corrective Action as it applies to other residents: All nursing and dietary staff were re-educated on the need to provide adaptive equipment. The policy for adaptive equipment at meals was reviewed and remains current. Reoccurrence will be prevented by: Random observational audits 2 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month for adaptive equipment at meals will be completed by the Director of		3/27/25

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F 810	Continued From page 32 R9's Kardex printed 2/25/25, indicated R9 required honey thick liquids and adaptive equipment of a nose cup. (cup that assists resident with drinking fluids) R9's care plan revised 12/13/24, indicated R9 had severe nutrition deficit related to demean, dysphasia and history of weight loss. Interventions included honey thick liquids and use of nose cup. R9's meal tickets dated 2/24/25 and 2/26/25, directed staff to provide a nose cup with meals. An observation on 2/24/25 at 11:47 a.m., lunch started to be served. R9's tray had three cups of juice, however did not have a nose cup. Nursing assistant (NA)-B placed R9's tray in front of him and set it up before delivering other resident trays. R9 was able feed self with spoon a few bites of pureed diet. R9 reached for cup, but did not pick up. After delivering trays, NA-B sat down and assisted R9 with lunch. NA-B assisted with the juice and NA-B had not obtained a nose cup. R9 was not able to tip head back to drink all the juice and NA-B poured juices together. When interviewed on 2/24/25 at 12:24 p.m., NA-B stated R9 was dependent with eating and was not able to do eat or drink on their own. NA-B verified R9's meal ticket indicated R9 required a nose cup however R9 liked to hold the normal cup and sometimes refused it. The cup would be sent up from the kitchen and NA-B stated there were not any on the unit. When interviewed on 2/24/25 at 12:24 p.m., dietary aide (DA)-A verified if adaptive equipment was listed on the ticket, the kitchen would send it up on the tray.			F 810	Culinary Services or designee. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. A higher par level for adaptive equipment has also been established to ensure proper equipment is readily available at mealtimes. Date of completion: March 27, 2025 The correction will be monitored by: The Director of Culinary Services		

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

PRINTED: 04/01/2025
FORM APPROVED
OMB NO. 0938-0391

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F 810	Continued From page 33 When observed on 2/26/25 at 12:16 p.m., NA-E assisted R9 with lunch. R9's tray did not have a nosey cup. When interviewed on 2/26/25 at 12:30 p.m., NA-E verified R9's meal ticket indicated R9 required a nosey cup, however, did not use one during lunch. NA-E stated the cups do not always come on the trays from the kitchen. When the cup was not available, NA-E would see how R9 was doing with drinking out of a normal cup and if there was not a lot of coughing, then the normal cup would be used. If R9 wasn't doing well with the normal cup, then the kitchen would be notified to bring a nosey cup. When interviewed on 2/27/25 at 8:30 a.m., kitchen manager (KM)-B expected adaptive equipment that was included on the meal ticket to be sent with the residents tray. KM-B further stated if it was not, nursing staff should reach out. When interviewed on 2/27/25 at 10:55 a.m., registered nurse (RN)-D stated if adaptive equipment was needed, it should be available and used. RN-D stated the nosey cup was needed to assist with fluid intake and make it easier to swallow. When interviewed on 2/27/25 at 11:55 a.m., the Director of Nursing (DON) expected resident adaptive equipment to be provided by the dietary staff. If the equipment was not provided, nursing staff should reach out to the kitchen to obtain what was needed. A facility policy titled Adaptive Equipment effective 4/5/23, directed staff to assure all residents were			F 810			

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F 810	Continued From page 34	F 810			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880			3/27/25

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

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F 880	Continued From page 35 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure hand hygiene was completed during incontinent cares for 2 of 4 residents (R31 and R9) who were observed for cares. Furthermore, the facility failed to ensure urine was cleaned in a manner to prevent			F 880	F880 Infection Control Corrective Action: Staff caring for R 31 and R9 were re-educated on the hand hygiene policy. Staff caring for R31 were re-educated on the procedure for cleaning bodily fluids.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 36 infection for 1 of 1 residents (R31) reviewed for clean environment. Findings include: R31 R31's quarterly Minimum Data Set (MDS) dated 11/21/24, indicated R31 had cognitive impairment and diagnoses of dementia and heart failure. R31's care plan revised 11/27/24, indicated R31 was had bladder incontinence and tended to void in available garbage cans or receptacles. R31 requires assist of one staff to find the bathroom and assist with incontinent cares. Furthermore R31's care plan indicated R31 would urinate in inappropriate places. An observation on 2/25/25, at 7:07 a.m., R31's door was open with the commode moved away from the wall and placed in front of the R31's door. R31 was laying in bed and then started getting up from bed. R31 walked to the bathroom doorway, stood there for a moment before returning to bed. At 7:33 a.m., nursing assistant (NA)-B entered the room and asked R31 if wanted to go down for breakfast. R31 declined. NA-B then took the commode bucket out of the commode and went into the bathroom and rinsed it out. NA-B then took the commode bucket, now filled with soap and water and poured the soapy water onto R31's floor. NA-B placed the commode bucket back into the commode and then took towels and using their feet, wiped up the soapy water from the floor. A disposable pad and towel were placed on the floor and NA-B then put the commode on top of them. At 7:42 a.m., writer entered the room as R31 was now getting	F 880	Corrective Action as it applies to other residents: All nursing staff were re-educated on the policy for hand hygiene and the procedure for cleaning bodily fluids. The policy for hand hygiene was reviewed and remains current. The policy for cleaning bodily fluids was reviewed and remains current. Reoccurrence will be prevented by: Random observational audits 2 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month for hand hygiene will be completed by the Director of Nursing or designee. Random environmental audits 1 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month r/t cleaning of bodily fluids will be completed by the Director of Environmental Services. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. Date of completion: March 27, 2025 The correction will be monitored by: The Director of Nursing or Designee		

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

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F 880	Continued From page 37 out of bed. Without glove exchange or hand hygiene, NA-B assisted R31 by the arm to the bathroom to urinate NA-B stated the floor may be wet as R31 "goes all over the place". After R31 urinated, NA-B obtained a wipe and wiped the toilet seat as R31 walked back to the room. NA-B moved clean towels from the sink in R31's room to his bed and asked R31 to come to the sink. Still without removing gloves or performing hand hygiene, NA-B took R31's toothbrush, added toothpaste and prompted R31 to brush their teeth. When R31 was done, NA-B took the toothbrush and rinsed it off in the sink, using a gloved thumb to rub the bristles. NA-B prompted R31 to wash their hands while NA-B took some clean towels from the bed and placed them back onto the sink. Without hand hygiene or glove exchange, NA-B placed body soap on the towel and got it wet. Assisted resident to wash face. NA-B placed towel in garbage bag. NA-B then lowered R31's soiled pants and took a clean towel placed soap on it and got it wet. NA-B cleaned R31's front groin side and with the same towel wiped down R31's legs to the knees before coming back up to wipe the backside. The wet towel was placed in the garbage bag before NA-B opened a drawer to obtain a dry towel and dried off R31. R31 sat down on the bed. Without hand hygiene or glove exchange, NA-B went to R31's closet and obtained clean clothing. NA-B assisted R31 with a clean sweatshirt and clean pants. R31 put on shoes and NA-B prompted R31 to walk down for breakfast. NA-B finished up with collecting the dirty linens and clothes before removing gloves and performing hand hygiene. When interviewed on 2/25/25 at 8:05 a.m., NA-B verified hand hygiene and glove exchange was			F 880			

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

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F 880	Continued From page 38 not completed after handling soiled towels and the commode bucket and before working with R31. NA-B further acknowledged hand hygiene and glove exchange was not completed in between cleaning soiled areas and working with clean areas. NA-B explained R31 would just get up an urinate anywhere in the room. NA-B used the soapy water from the commode bucket to help keep the smell of urine out of the room. NA-B verified the soap used in the water was a Dial men's 3 in 1 soap. When interviewed on 2/25/25 at 2:02 p.m., universal services staff (USS) stated all resident rooms were cleaned daily. USS stated they just started at one end to the next end. USS stated staff had not informed them of any room needing cleaning due to urine being spilled. USS stated they had not cleaned R31's room yet and left that one for last. USS said R31 urinates on the floor often so that room was saved for last as rooms were completed only once a day. When interviewed on 2/27/25 at 8:33 a.m., universal services manager stated nursing staff should clean up any bodily fluids and then environmental staff should be notified to sanitize the floor. It was expected the USS would clean the floor right away and after each occurrence. Furthermore, body soap would not properly disinfect the floor and would not be used and should not be dumped from a commode bucket. R9 R9's quarterly MDS dated 12/12/24, indicated R9 had cognitive impairment and diagnoses of dementia, stroke, and dysphagia (difficulties swallowing). Furthermore, R9 was dependent on	F 880			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 39 staff for toileting and bed mobility. R9's care plan revised 12/19/24, indicated R9 was incontinent of bowel and bladder and dependent on staff for toileting. An observation on 2/26/25 at 3:45 p.m., nursing assistant (NA)-E and NA- B assisted R9 back to bed with a lift. R9's was assisted with turning back and forth in bed to remove sling and pull down pants to change brief. NA-A tucked in the left side of brief and then turned R9 to the right. R9 has a small bowel movement. NA-E used a wipe to clean R9 and removed the soiled brief. NA-E then placed the soiled brief on the floor. NA-E then looked at their gloves and took an incontinent wipe and wiped their soiled gloved hands. Without hand hygiene or glove exchange, NA-E assisted with placing R9's clean brief. NA-E and NA-A then assisted with R9's pants. NA-E lowered R9's bed and placed the call light within reach. NA-E moved R9's wheelchair and then picked up R9's soiled brief from the floor and placed in the garbage. NA-E doffed the gloves, tied up the garbage and took to the soiled utility room where hand hygiene was then completed. When interviewed on 2/26/25 at 1:00 p.m., NA-E verified she had not performed hand hygiene or changed gloves after handling R9's soiled brief. NA-E stated since R9's brief was only a little dirty, glove change was not needed. NA-E further verified the soiled brief should not have been on the floor and should have been placed in the garbage right away. When interviewed on 2/27/25 at 10:00 a.m., the infection preventionist (IP) stated hand hygiene and glove exchange was required after handling	F 880			

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

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F 880	Continued From page 40 soiled or potentially dirty items and moving to clean areas during resident cares. IP further stated nursing staff were responsible to clean up any bodily fluids that were on the floor and notify the universal workers to come disinfect the floor. The floors can be cleaned as often as needed. When interviewed on 2/27/25 at 11:49 a.m., the Director of Nursing (DON) expected staff to change gloves and perform hand hygiene when moving from soiled cares to clean cares. Dirty briefs should not be placed on the floor and should be placed in the garbage right away. DON further expected staff to clean up any bodily fluids from the floors and then seek out environmental services to clean or disinfect the floor. All of these were important to prevent infection. A facility policy titled Environmental Cleaning revised 3/2024, was received and did not outline cleaning procedures for bodily fluids. A facility policy for hand hygiene was requested however not received.	F 880			
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 883			3/27/25

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F 883	Continued From page 41 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the			F 883			

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F 883	Continued From page 42 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 4 of 4 residents (R15, R33, R54, R110) were offered and/or provided updated vaccinations for pneumococcal disease and 2 of 5 residents (R33, R110) for influenza in accordance with the Centers for Disease Control (CDC) vaccinations. Findings include: R15 R15's discharge Minimum Data Set (MDS) dated 1/27/25, indicated R15 was admitted on 10/5/24, was currently 57 years old, had intact cognition and diagnosis of diabetes which puts him at higher risk for pneumococcal diseases. R15's Minnesota Immunization report dated 2/7/25, indicated R15 received the pneumococcal polysaccharide vaccine (PPSV23) on 7/17/12 and the pneumococcal conjugate vaccine (PCV13) on 4/26/19. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/26/25, identified based on R15's age and vaccine history: Give one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Regardless of which vaccine is used (PCV20 or PCV21), their pneumococcal vaccinations are complete. R15's medical record lacked documentation of a discussion of shared clinical decision making			F 883	F883 Resident Vaccines- Influenza and Pneumococcal Corrective Action: R 15- the provider was updated on qualifies for Prevnar 20. Provider wants to hold immunizing until off antibiotics. R33- offered and declined Prevnar and Influenza vaccine. R54 was discharged R110 was discharged Corrective Action as it applies to other residents: Will review all resident immunization records for pneumococcal and influenza vaccination status and will offer vaccines in accordance with CDC recommendations and document the acceptance or refusal in the EHR and documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines in the EHR. Resident pneumococcal and influenza immunization policies were reviewed and remain current. All licensed nursing staff re-educated on immunization administration. Reoccurrence will be prevented by: Director of Nursing or designee will conduct random chart audits 2 audits/week for 4 weeks, then 2 audits/month for 1 month and then 1 audit/month of immunization records to ensure vaccines are being offered per		

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F 883	Continued From page 43 regarding additional pneumococcal vaccines. It further lacked a declination or documentation of risk and benefits regarding the pneumococcal vaccination. R33 R33's admission Minimum Data Set (MDS) dated 1/16/25, indicated R33 was admitted on 1/10/25, was currently 73 years old, had intact cognition and diagnosis of diabetes which puts her at higher risk for pneumococcal diseases. It further indicated her pneumococcal vaccinations were up to date. R33's Minnesota Immunization report dated 1/10/25, indicated R33 received the pneumococcal polysaccharide vaccine (PPSV23) on 10/10/19 and the pneumococcal conjugate vaccine (PCV13) on 11/21/16. It further indicated R33's most recent influenza vaccination was administered on 10/1/2020. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/26/25, identified based on R33's age and vaccine history: though the vaccines were considered complete, based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 or 21 is administered, their pneumococcal vaccinations are complete. R33's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. It further lacked a declination or documentation of risk and benefits regarding the pneumococcal	F 883	CDC guidelines and documented of acceptance or refusal in the EHR and documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines in the EHR. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. Date of completion: March 27, 2025 The correction will be monitored by: The Director of Nursing or Designee		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 883	Continued From page 44 and/or influenza vaccination. R54 R54's quarterly Minimum Data Set (MDS) dated 2/19/25, indicated R54 was admitted on 11/20/24, was currently 76 years old, had intact cognition and diagnosis of intracerebral hemorrhage (brain bleed). R54's Minnesota Immunization report dated 11/20/24, indicated R54 received the pneumococcal polysaccharide vaccine (PPSV23) on 9/19/19 and the pneumococcal conjugate vaccine (PCV13) on 10/28/15. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/26/25, identified based on R54's age and vaccine history: though the vaccines were considered complete, based on shared or clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 or PCV21 was administered, their pneumococcal vaccinations are complete. R54's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. It further lacked a declination or documentation of risk and benefits regarding the pneumococcal vaccination. R110 R110's discharge Minimum Data Set (MDS) dated 12/20/24, indicated R15 was admitted on 2/20/25, was currently 77 years old, had			F 883			

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F 883	Continued From page 45 moderately impaired cognition and of diagnosis of hepatic encephalopathy and alcoholic cirrohosis of the liver (with ascites). It further indicated his pneumococcal vaccinations were up to date. R110's Minnesota Immunization report dated 2/20/25, indicated R110 received the pneumococcal conjugate vaccine (PCV13) on 4/30/1997. It further indicated R110's last influenza vaccine was administered on 4/30/1956. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/26/25, identified based on R110's age and vaccine history: Give one dose of PCV15, PCV20 or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year. The minimum interval is 8 weeks and can be considered in adults with immunocompromising conditions, cochlear implants, or cerebrospinal fluid leaks. R110's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. It further lacked a declination or documentation of risk and benefits regarding the pneumococcal and/or influenza vaccination. During interview on 2/27/25 at 10:00 a.m. the infection preventionist (IP) stated the process regarding vaccinations for new admissions was to print of their Minnesota Immunization Information Connection report (MIIC) in order to determine what vaccinations the resident had already	F 883			

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F 883	Continued From page 46 received and which ones they needed. Then the facility would ask the resident if they are interested in receiving those vaccines and give them a Vaccine Information Sheet (VIS), and request a physician's order. If the resident refused, they sign a declination form, were educated on the risk versus (vs) benefits, and it was documented in their medical record. The facility offered COVID, influenza, RSV, and pneumococcal vaccinations. The IP verified R15, R33, R54, R110 lacked documentation of vaccines being offered, refused, or educated on risk vs. benefits and was still following up on those residents. The nursing staff try to offer the residents vaccinations in the first day or two following admission. The IP also stated influenza vaccinations are offered from October 1st-March 31st each year. During interview on 2/27/25 at 12:49 p.m., the director of nursing (DON) stated when there was a new admission, the nursing staff were responsible for putting in an order set which would populate the vaccinations and schedule a Tuberculin blood test at the lab. Then the results would be documented. The nursing staff and IP were responsible for following up and ensuring the residents were offered and/or received the vaccinations. Documentation for refusals was not put in Point Click Care (computer program) it was tracked internally. The facility's policy regarding influenza (11/7/24) and pneumococcal vaccinations (11/5/24) indicated, all patients including those admitted during the influenza season, will be offered an influenza immunization, September 1st through March 31st annually, unless the immunization is medically contraindicated, or the resident had	F 883			

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F 883	Continued From page 47 already been immunized during this time period. All residents or resident representative will receive information regarding the benefits and potential side effects of immunization prior to a vaccine being offered. In the case of a refusal, staff will discuss the risk and benefits of the influenza vaccine and return later to re-offer, preferably having another nurse offer, and if the resident refuses, document the refusal in the medical record. In regards to the pneumococcal vaccination the policy indicated all residents are encouraged to receive a pneumococcal vaccine as defined by the Minnesota Department of Health or CDC unless medically contraindicated, refused, or already immunized or due to circumstances outside the facility's control. The resident will be give the opportunity to refuse the vaccine and refusals will be documented in the medical record. All residents or legal representatives will receive information regarding the benefits and potential side effects of the immunization prior to a vaccine being offered. In the case of a refusal, the staff will discuss risks and benefits of the pneumococcal vaccine, return later to re-offer (preferably having another nurse offer), if the resident refuses, it will then be documented in the resident's medical record.	F 883			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

Administrator
Ebenezer Integrated Care & Rehab
45 West 10th Street
Saint Paul, MN 55102

Re: State Nursing Home Licensing Orders
Event ID: S35P11

Dear Administrator:

The above facility was surveyed on February 24, 2025 through February 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/24/25 through 2/27/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

03/20/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: no citations were issued. H55878391C/MN105364/MN105569 H55878390C/MN105579 H55878389C/MN109472 H55878388C/MN106465 H55877981C/MN110792 H55878392C/MN106720 H55878387C/MN108799 H55877842C/MN110743 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER EBENEZER INTEGRATED CARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 45 WEST 10TH STREET SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From page 2 enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 1 of 2 (R35) residents reviewed for MDS accuracy. Findings include: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 1 of 2 (R35) residents reviewed for MDS accuracy.	2 550	Corrected	3/27/25	

Minnesota Department of Health

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2 550	Continued From page 3 Findings include: R35's quarterly Minimum Data Set (MDS) dated 1/23/25, indicated she was dependent on staff for toileting and personal hygiene cares as well as mobility and transfers. The MDS identified R35's diagnoses of dementia (a loss of memory, language, problem-solving and other thinking abilities) and indicated she was unable to complete the mental status assessment interview. Additionally, the MDS identified she was at risk for developing a pressure ulcer and had an unstageable pressure ulcer. The MDS indicated she was not receiving pressure ulcer care. R35's Care Area Assessment (CAA) for pressure ulcer/injury dated 10/31/24, identified her risk for pressure ulcers and indicated "she currently has a deep tissue injury to left heel." The CAA directed staff to the care plan for goals and interventions. R35's care plan revised on 2/5/25, identified her impaired skin integrity and risk for further breakdown as evidenced by an unstageable pressure ulcer and included interventions of heel protectors, elevating heels off of the bed, air-mattress on bed and "antithrust cushion" on wheelchair, treatment as ordered, turn and reposition every two hours in bed and every hour when in wheelchair, reposition off buttocks, and wound care per orders. A skin and wound evaluation dated 1/23/25, assessed the pressure ulcer to her left medial heel and indicated treatment included a generic wound cleanser and foam dressing.	2 550			

Minnesota Department of Health

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2 550	Continued From page 4 R35's treatment administration record dated 1/25, reflected the following administered wound care orders: - "wound care cleanse left heel with wound cleanser 3 times a week and cover with Mepilex in the evening" every Monday, Wednesday, and Friday, dated 12/19/24 and discontinued 1/17/25. - "wound care: cleanse left heel with wound cleanser (pat dry) - cover with Mepilex dressing. Change daily", dated 1/17/25 and discontinued 1/20/25. - "wound care: cleanse left heel with wound cleanser (pat dry). Cover with Mepilex dressing 4x4. Change daily, continue until healed," dated 1/20/25 and discontinued 1/23/25. - "wound care for left heel: cleanse with wound cleanser. Pat dry. Apply Medihoney and cover with Mepilex dressing. Change daily and PRN" (as needed) every evening shift, dated 1/23/25. R35's TAR dated 2/25, reflected the following administered wound care orders: - "wound care for left heel: cleanse with wound cleanser. Pat dry. Apply Medihoney and cover with Mepilex dressing. Change daily and PRN" (as needed) every evening shift, dated 1/23/25. During observation on 2/26/25 at 6:21 p.m., registered nurse (RN)-C was at R35's bedside during evening cares and removed the old foam dressing from her left heel. RN-C spray the heel with wound cleanser and patted the heel dry with gauze. Next, RN-C applied a dark golden-colored gel to the heel before putting a foam bandage on it and dating the bandage.	2 550			

Minnesota Department of Health

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2 550	Continued From page 5 Per interview on 2/26/25 at 6:42 p.m., RN-C confirmed R35's left heel pressure ulcer and verified the administered treatment against her orders on the TAR. During interview on 2/27/25 at 10:52 a.m., registered nurse (RN)-E verified the answer for R35's pressure ulcer/injury treatment for her MDS dated 1/23/25 was no. RN-E confirmed the deficient practice after reviewing R35's TAR dated 1/25. RN-E stated, "there are a lot of wound orders here, I see it now. This answer should be yes." RN-E stated it was important to have accurate MDS information because it reflected what was going on with the resident and provided a good care plan for staff to take care of the resident. Per facility policy titled MDS/Care Plan Process/Resident Assessment dated 2/21/25, accuracy of assessment meant the appropriate health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, psychosocial status using the appropriate Resident Assessment Instrument (RAI). Furthermore, the policy stated whether MDS assessments were completed manually or computer-generated following data entry, each individual assessor was responsible for certifying the accuracy of responses relative to the resident's condition. The policy directed when MDS forms were completed directly on the facility's computer, each individual assessor should sign and date the computer-generated hard copy, or provide an electronic signature, after it was reviewed for accuracy of the portion(s) they completed.	2 550			

Minnesota Department of Health

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2 550	Continued From page 6 R35's Care Area Assessment (CAA) for pressure ulcer/injury dated 10/31/24, identified her "MASD to left gluteal fold with treatment." The CAA directed staff to the care plan for goals and interventions. R35's care plan revised on 2/5/25, identified her impaired skin integrity and risk for further breakdown as evidenced by an unstageable pressure ulcer and included interventions of heel protectors, elevating heels off of the bed, air-mattress on bed and "antithrust cushion" on wheelchair, treatment as ordered, turn and reposition every two hours in bed and every hour when in wheelchair, reposition off buttocks, and wound care per orders. A skin and wound evaluation dated 1/23/25, assessed the pressure ulcer to her left medial heel and indicated treatment included a generic wound cleanser and foam dressing. R35's treatment administration record dated 1/25, reflected the following administered wound care orders: - "wound care cleanse left heel with wound cleanser 3 times a week and cover with Mepilex in the evening" every Monday, Wednesday, and Friday, dated 12/19/24 and discontinued 1/17/25. - "wound care: cleanse left heel with wound cleanser (pat dry) - cover with Mepilex dressing. Change daily", dated 1/17/25 and discontinued 1/20/25. - "wound care: cleanse left heel with wound cleanser (pat dry). Cover with Mepilex dressing 4x4. Change daily, continue until healed," dated	2 550			

Minnesota Department of Health

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2 550	Continued From page 7 1/20/25 and discontinued 1/23/25. - "wound care for left heel: cleanse with wound cleanser. Pat dry. Apply Medihoney and cover with Mepilex dressing. Change daily and PRN" (as needed) every evening shift, dated 1/23/25. R35's TAR dated 2/25, reflected the following administered wound care orders: - "wound care for left heel: cleanse with wound cleanser. Pat dry. Apply Medihoney and cover with Mepilex dressing. Change daily and PRN" (as needed) every evening shift, dated 1/23/25. During observation on 2/26/25 at 6:21 p.m., registered nurse (RN)-C was at R35's bedside during evening cares and removed the old foam dressing from her left heel. RN-C spray the heel with wound cleanser and patted the heel dry with gauze. Next, RN-C applied a dark golden-colored gel to the heel before putting a foam bandage on it and dating the bandage. Per interview on 2/26/25 at 6:42 p.m., RN-C confirmed R35's left heel pressure ulcer and verified the administered treatment against her orders on the TAR. During interview on 2/27/25 at 10:52 a.m., registered nurse (RN)-E verified the answer for R35's pressure ulcer/injury treatment for her MDS dated 1/23/25 was no. RN-E confirmed the deficient practice after reviewing R35's TAR dated 1/25. RN-E stated, "there are a lot of wound orders here, I see it now. This answer should be yes." RN-E stated it was important to have accurate MDS information because it reflected what was going on with the resident and provided a good care plan for staff to take care of the	2 550			

Minnesota Department of Health

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2 550	Continued From page 8 resident. Per facility policy titled MDS/Care Plan Process/Resident Assessment dated 2/21/25, accuracy of assessment meant the appropriate health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, psychosocial status using the appropriate Resident Assessment Instrument (RAI). Furthermore, the policy stated whether MDS assessments were completed manually or computer-generated following data entry, each individual assessor was responsible for certifying the accuracy of responses relative to the resident's condition. The policy directed when MDS forms were completed directly on the facility's computer, each individual assessor should sign and date the computer-generated hard copy, or provide an electronic signature, after it was reviewed for accuracy of the portion(s) they completed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure policies are up to date, staff training has been completed, implemented and monitored to assure Minimum Data Set (MDS) are completed accurately and timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550			
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining	2 835			3/27/25

Minnesota Department of Health

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2 835	Continued From page 9 adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of a change in condition for 1 of 1 resident with congestive heart failure (CHF) and a significant weight gain. The facility further failed to ensure appropriate wound care orders were followed for 1 of 1 resident (R35) reviewed for wound care. Findings include: R40 R40's discharge Minimum Data Set (MDS) dated 2/12/25, indicated intact cognition and diagnoses of CHF, acute and chronic respiratory failure with hypoxia, acute kidney disease, and fluid overload. It further indicated R40 required partial/moderate assistance with most activities of daily living (ADL) and mobility. R40's physician's orders dated 1/20/2025, indicated daily weights and to update the provider of a weight gain of 2 pounds (lbs.) in one day and/or 5 lbs. in one week, every shift. R40's care plan dated 1/3/25, indicated R40 had CHF, peripheral heart disease (PAD), and hyperlipidemia (HLD). Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles while breathing. Notify provider of	2 835	Corrected		

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2 835	Continued From page 10 abnormalities. It further indicated the following interventions: -Daily weights, call medical doctor (MD)/nurse practioner (NP) for weight gain of more than 2 pounds per day and/or 5 pounds per week. -Encourage adequate nutrition. Offer small frequent feedings. -Give cardiac medications as ordered. -Monitor lab work; potassium (K+), sodium (NA), blood urea nitrogen (BUN), and creatinine. -Monitor/document sleeping pattern. Inform physician of any insomnia or anxiety. Give sedatives as ordered. Monitor/document/report (as needed) any signs or symptoms of CHF: dependent edema of legs and feet, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation. Report to provider as indicated. R40's treatment administration record (TAR) for January and February of 2025 indicated, during the week of 1/20/25-1/26/25 R40 had a weight gain of 11.4 lbs., from 1/25/25-1/26/25 a weight gain of 8.8 lbs., and from 2/6/25-2/27/25 a weight gain of 13 lbs. as evidenced by the weights below: -1/20/25 443.4 lbs. -1/24/25 443.8 lbs. -1/25/25 446.0 lbs. -1/26/25 454.8 lbs. -1/27/25 445.6 lbs. -2/6/25 433.0 lbs. -2/7/25 446.0 lbs. -2/10/25 442.0 lbs. -2/11/25 448.0 lbs.	2 835			

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2 835	Continued From page 11 R40's progress notes for the month of January and February of 2025, lacked any indication the doctor had been notified of a change in condition regarding weight gain During interview on 2/26/25 at 4:40 p.m., RN-F verified R40's weights on her January and February TAR were more than 2 lbs. in one day and 5 lbs. in one week (as referenced above) and stated the physician should have been notified and documentation should have occurred. During interview on 2/26/25 at 4:46 p.m., RN-G verified R40's weight gain of more than 2 lbs. in one day and 5 lbs. in one week (as referenced above) and stated the nurses were responsible for calling the provider and documenting in the progress notes. RN-G further stated if a resident needed to be re-weighed, they should document it in the progress notes. During interview on 2/27/25 at 9:45 a.m. the nurse practioner (NP) stated the only time she had been notified of R40's weight gain was when she sent her to the hospital for hypervolemia on 2/12/25. The NP further stated she was in the facility 4 days per week and reviewed the weights of the patients she planned to see that day. She didn't see every resident every time she was there, therefore the order indicated to notify the physician and that's what the nursing staff were expected to do. The nurses were responsible for re-weighing a resident if there was an issue with the weight. The NP also verified the order was intended to be for a 7 day period typically from Monday to Sunday. During interview on 2/27/25 at 12:45 p.m. the director of nursing (DON) stated the nurses were	2 835			

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2 835	Continued From page 12 responsible for notifying the provider of a change in condition and the provider should have been notified regarding R40's weight gain. This was important because R40 had CHF and was at risk for fluid overload which could have negative effects on her cardiac health. The facility's policy regarding weight and height dated 10/2021, indicated to document resident weight in PCC and update the provider of weight increases or decreases as needed and per physician's orders. R35 R35's quarterly Minimum Data Set (MDS) dated 1/23/25, indicated she was dependent on staff for toileting and personal hygiene cares as well as mobility and transfers. The MDS identified R35's diagnoses of dementia (a loss of memory, language, problem-solving and other thinking abilities) and indicated she was unable to complete the mental status assessment interview. Additionally, the MDS identified she was at risk for developing a pressure injury and had moisture-associated skin damage (MASD, or skin irritation or breakdown caused by prolonged exposure to moisture such as urine, saliva, sweat, or wound drainage). R35's Care Area Assessment (CAA) for pressure ulcer/injury dated 10/31/24, identified her "MASD to left gluteal fold with treatment." The CAA directed staff to the care plan for goals and interventions. R35's care plan revised on 2/5/25, identified her impaired skin integrity and risk for further breakdown as evidenced by MSAD to her	2 835			

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2 835	Continued From page 13 buttocks. The care plan directed staff to provide treatment and wound care as ordered. R35's signed order summary dated 1/6/25, included the wound order: - "wound care 1. Facility staff to perform every other day and as needed 2. Cleanse open areas to buttocks and upper thigh. Allow to dry. Apply Mepilex over open areas every day shift every other day for MASD," dated 12/17/24. R35's TAR dated 2/25, reflected the following wound care orders: - "wound care to buttocks: cleanse open areas with wound cleanser. Pat dry. Cover with Mepilex dressing," change every evening shift every other day for MASD, dated 2/26/25 at 7:08 p.m. - "wound care for left heel: cleanse with wound cleanser. Pat dry. Apply Medihoney and cover with Mepilex dressing. Change daily and PRN" (as needed) every evening shift, dated 1/23/25. During observation on 2/26/25 at 6:14 p.m., registered nurse (RN)-C and RN-D were at R35's bedside during evening cares. RN-D stood at the head of the bed and talked to R35 while RN-C performed wound cares. RN-C sprayed a wound cleanser over R35's buttocks to cleanse the area before patting it dry with gauze. RN-C applied a dark, honey-colored gel from a tube to her gloved fingertips and dabbed it onto each of the opened and red areas on her buttocks, and then applied more from the tube to her fingertips and dabbed it onto the fluid-filled sacs on R35's buttocks. RN-C then applied foam dressings to cover the areas and dated each dressing.	2 835			

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2 835	Continued From page 14 During interview on 2/26/25 at 6:42 p.m., RN-C reviewed R35's wound care orders and TAR dated 2/25 and was unable to find current or active wound treatment orders for her. RN-C verified the wound treatment orders for R35's pressure ulcer to her left heel, which included "Medihoney", and confirmed applying it to R35's buttock during wound cares. During interview on 2/27/25 at 2:26 p.m., RN-D verified the MSAD treatment order should have been cleanse with a wound cleanser, pat dry with gauze and cover with a "Mepilex". RN-D confirmed witnessing RN-C applying the Medihoney to R35's MSAD on her buttocks and stated, "I thought I saw RN-C doing that." RN-D expected staff to verify and "double check" orders before applying treatments if staff were unsure. Per interview on 2/27/25 at 3:13 p.m. with the director of nursing (DON), staff were expected to review treatment orders if they were unsure of an order before administering the treatment or order. Per facility policy titled Management of Skin Alterations dated 9/11/24, residents with wounds would have at minimum weekly monitoring for appropriateness of treatment/care plan, signs of healing and would report to the provider as needed. Education would be provided to staff as needed on alterations in skin integrity. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review policies, procedures related to wound care and educate staff. The DON or designee could conduct routine audits to ensure appropriate care and services were implemented. The results of those audits should be taken to the QAPI committee for a determined amount of time to	2 835			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER EBENEZER INTEGRATED CARE & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 45 WEST 10TH STREET SAINT PAUL, MN 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 835	Continued From page 15 ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	2 835			3/27/25
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure adaptive equipment was used for 1 of 1 residents reviewed for adaptive equipment. Findings include:	2 945			

Minnesota Department of Health

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2 945	Continued From page 16 R9's quarterly Minimum Data Set (MDS) dated 12/12/24, indicated R9 had cognitive impairment and diagnoses of dementia, stroke, and dysphasia (difficulties swallowing). R9 had was dependent for eating, had difficulty swallowing and required a mechanically altered diet. R9's nutritional assessment dated 12/10/24, indicated R9 required varying level of assistance with meals and required a nosey cup for drink. R9's Kardex printed 2/25/25, indicated R9 required honey thick liquids and adaptive equipment of a nosey cup. (cup that assists resident with drinking fluids) R9's care plan revised 12/13/24, indicated R9 had severe nutrition deficit related to demean, dysphasia and history of weight loss. Interventions included honey thick liquids and use of nosey cup. R9's meal tickets dated 2/24/25 and 2/26/25, directed staff to provide a nosey cup with meals. An observation on 2/24/25 at 11:47 a.m., lunch started to be served. R9's tray had three cups of juice, however did not have a nosey cup. Nursing assistant (NA)-B placed R9's tray in front of him and set it up before delivering other resident trays. R9 was able feed self with spoon a few bites of pureed diet. R9 reached for cup, but did not pick up. After delivering trays, NA-B sat down and assisted R9 with lunch. NA-B assisted with the juice and NA-B had not obtained a nosey cup. R9 was not able to tip head back to drink all the juice and NA-B poured juices together. When interviewed on 2/24/25 at 12:24 p.m., NA-B stated R9 was dependent with eating and was not able to do eat or drink on their own. NA-B	2 945			

Minnesota Department of Health

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2 945	Continued From page 17 verified R9's meal ticket indicated R9 required a nosey cup however R9 liked to hold the normal cup and sometimes refused it. The cup would be sent up from the kitchen and NA-B stated there were not any on the unit. When interviewed on 2/24/25 at 12:24 p.m., dietary aide (DA)-A verified if adaptive equipment was listed on the ticket, the kitchen would send it up on the tray. When observed on 2/26/25 at 12:16 p.m., NA-E assisted R9 with lunch. R9's tray did not have a nosey cup. When interviewed on 2/26/25 at 12:30 p.m., NA-E verified R9's meal ticket indicated R9 required a nosey cup, however, did not use one during lunch. NA-E stated the cups do not always come on the trays from the kitchen. When the cup was not available, NA-E would see how R9 was doing with drinking out of a normal cup and if there was not a lot of coughing, then the normal cup would be used. If R9 wasn't doing well with the normal cup, then the kitchen would be notified to bring a nosey cup. When interviewed on 2/27/25 at 8:30 a.m., kitchen manager (KM)-B expected adaptive equipment that was included on the meal ticket to be sent with the residents tray. KM-B further stated if it was not, nursing staff should reach out. When interviewed on 2/27/25 at 10:55 a.m., registered nurse (RN)-D stated if adaptive equipment was needed, it should be available and used. RN-D stated the nosey cup was needed to assist with fluid intake and make it easier to swallow.	2 945			

Minnesota Department of Health

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2 945	Continued From page 18 When interviewed on 2/27/25 at 11:55 a.m., the Director of Nursing (DON) expected resident adaptive equipment to be provided by the dietary staff. If the equipment was not provided, nursing staff should reach out to the kitchen to obtain what was needed. A facility policy titled Adaptive Equipment effective 4/5/23, directed staff to assure all residents were assessed and provided the special equipment necessary for them to reach their highest level of functioning. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to ensuring residents have adaptive equipment with meals and following the care plan. The DON or designee could provide training for all nursing staff related to residents who need adaptive equipment with meals and following the care plan based on the assessment. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945			
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.	2 965			3/27/25

Minnesota Department of Health

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2 965	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents with food allergies received the appropriate tray for 1 of 1 resident (R23) reviewed who had a listed anaphylactic reaction (a severe, potentially life threatening allergic response) to ginger. This resulted in an immediate jeopardy (IJ). The IJ began on 12/14/24, when R23 was served a meal tray which included honey ginger chicken and after a few bites experienced an anaphylactic reaction. R23 had an order for epinephrine to be used in the case of an anaphylactic reaction however, R23 was not given the epinephrine. This resulted in R23 requiring transfer to the emergency department for treatment. The administrator and director of nursing (DON) were informed of the IJ on 2/25/25 at 3:46 p.m. The facility implemented corrective action and the IJ was removed on 2/26/25 at 7:20 p.m. However, non-compliance remained at the lower scope and severity of D, isolated, no actual harm, with potential for more than minimal harm that is not immediate jeopardy. Findings include: R23's admission Minimum Data Set (MDS) dated 12/5/24, indicated R23 was cognitively intact and required setup assistance for eating. R23's diagnoses included acute ischemia of small intestine (decrease in blood flow), type 2 diabetes, and Prader-Willi syndrome [a condition affecting appetite and causing one to always feel	2 965	Corrected		

Minnesota Department of Health

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2 965	Continued From page 20 hungry). R23's care plan dated 12/9/24, indicated set up assistance to eat, diet as ordered, monitor food intake at meals, and offer alternatives for meals if refusing. R23's care plan lacked evidence of any food allergies. R23's diet order/dietary communication dated 11/29/24, indicated food allergies, "ginger, bee pollen." R23's allergy list printed 2/25/25, indicated the following food allergens: ginger, bee pollen/royal jelly. R23's admission nutrition assessment dated 12/3/24, indicated, "Allergies ...Diclofenac, metformin, Bee pollen/royal jelly, Ginger." R23's physician order history indicated the following: -Epinephrine injection solution auto-injector 0.3mg/0.3ml. Inject 0.3 mg intramuscularly as needed - for anaphylaxis, allergy to ginger, daily - start date 11/29/24 at 5:00 p.m. -11/29/24 at 9:29 p.m. on hold, "insurance does not cover." -12/18/24 at 3:19 p.m. resume, "ordered per provider." -Date received-12/23/24, "on hand." R23's December 2024 medication administration record (MAR) indicated, "EPINEPHrine Injection Solution Auto-Injector 0.3 MG/0.3ML (Epinephrine [Anaphylaxis] Inject 0.3 mg intramuscularly as needed for anaphylaxis, Allergy to ginger. Daily - Order Date- 07/27/2014 ...-Hold Date-from 12/01/2024 ...to 12/18/2024." R23's MAR	2 965			

Minnesota Department of Health

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2 965	Continued From page 21 indicated "H" from 12/1/24 through 12/17/24, and did not indicate any epinephrine administration. During interview on 2/24/25 at 11:51 a.m., R23 stated a few months ago she was provided a meal consisting of a piece of chicken and stir fry vegetables. R23 stated her meal ticket did not indicate chicken; therefore, did not know what type of chicken was provided. R23 asked several unidentified staff members if the food items contained ginger, and all said no. After a couple bites, R23 stated she thought she bit into a piece of ginger and within a few seconds her lips started tingling and she felt her throat beginning to tighten. R23 notified staff she was having an anaphylactic reaction and requested epinephrine. R23 was told her epinephrine order was on hold due to insurance not covering it and staff did not have epinephrine in the emergency medication kit (E-kit). Review of facility week 2 menu for Saturday was honey ginger chicken thighs and Asian stir fry vegetable mix. R23's progress note dated (Saturday) 12/14/24 at 10:56 p.m., indicated R23 reported to staff of having a food allergy after eating part of her dinner and on assessment discovered R23 "having a stick [sic] throat, and does not feel well." R23 started having shortness of breath and was put on oxygen at 4 liters/min. Resident had an order for epinephrine but it was on hold and the medication was not available. Staff called 911 and resident was sent to the hospital. R23's progress noted dated 12/14/24 at 11:05 p.m., indicated, "This writer re email [sic] resident diet order to kitchen because one of the dietary stated that they don't have the food allergy in their	2 965			

Minnesota Department of Health

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2 965	Continued From page 22 file." R23's emergency department after visit summary (AVS) dated 12/14/24, indicated, "Reason for Visit ALLERGIC REACTION Diagnoses -Shortness of breath - Anaphylaxis, initial encounter." The AVS instructed, "You were seen today for an allergic reaction. Your symptoms improved after an epi pen. Return to the emergency department with any new or worsening symptoms." During observation on 2/25/25 at 9:00 a.m., R23's meal tray ticket lacked evidence of any food allergies. During interview on 2/25/25 at 9:21 a.m., dietary staff (DS)-A stated each resident had diet orders and allergies uploaded to the nutrition program. DS-A stated dietary staff would go room to room and enter residents' requests for all three meals for the following day. The nutrition program would identify a contraindication due to an allergy and would not allow the specific food item to be ordered. DS-A further stated resident allergies should also print out on the meal tray ticket and staff should check ticket prior to providing resident their meal. During interview on 2/25/25 at 9:41 a.m., licensed practical nurse (LPN)-A stated all resident allergies should be listed in the nutrition program and should display on the resident's meal tray ticket. LPN-A further stated epinephrine was stocked in the E-kit and available to be used in emergency situations. LPN-A further stated if a resident had epinephrine ordered for an anaphylactic reaction and did not have the medication available in their medications, the epinephrine in the E-kit should be used in the case of an allergic reaction.	2 965			

Minnesota Department of Health

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2 965	Continued From page 23 During interview on 2/25/25 at 10:06 a.m., kitchen manager (KM) and director of nutrition services (DNS) stated nursing communicates diet orders and allergies to dietary services using a specific communication form which was completed then scanned and emailed to nutrition. KM stated the information was then uploaded into the nutrition program (Healthtouch) and the system had safety measures built in to not allow a resident to order a food item that was listed as an allergy. During interview on 2/25/25 at 10:34 a.m., registered nurse (RN)-A stated would expect dietary services would have the correct allergy information for each resident and that they would not provide a meal containing food that a resident was allergic to. RN-A stated each resident's meal tray ticket should indicate any food allergies. RN-A further stated if a resident had an order for an emergency medication and it was not covered by insurance, that the facility would purchase the medication within 24 hours of denial and preferably before their first meal in the case of a food allergen. During follow up interview on 2/25/25 at 11:37 a.m., DNS provided list of all available allergies in the nutrition program and confirmed ginger was not included. DNS stated an undefined allergy could be added to the comments area but that did not display on the meal tray ticket. During interview on 2/25/25 at 10:55 a.m., director of nursing (DON) stated expectation that the process would correctly identify a resident's food allergies, and that information would be communicated to nutrition services. DON stated the food allergy should print on the meal tray ticket. DON further stated in a situation of a	2 965			

Minnesota Department of Health

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2 965	Continued From page 24 non-covered emergency medication the facility would purchase the medication to have on hand. DON stated the facility E-kit does contain epinephrine, but was not sure it was the corrected dosage. DON could not explain why there was not a change of condition, safety event or risk management completed on this event and stated lack of such report did not allow for proper follow up, education or resolution. During interview on 2/25/25 at 11:25 a.m., consultant pharmacist (CP) stated epinephrine was stocked in the facility E-kit and was unaware of any shortage around 12/14/24. CP stated if a resident was experiencing an anaphylactic reaction due to a food allergen ingestion, should be given epinephrine if ordered as anaphylaxis is a medical emergency. CP stated a resident in anaphylaxis who does not receive epinephrine could experience inability to breathe and would need emergency services. Facility policy Patient Meal Service Procedure dated 8/8/23, indicated, food allergies would be entered appropriately into HealthTouch and "HealthTouch computer system will automatically omit designated allergens from the patient's menu choices. All foods listed as allergen in the HealthTouch system will not be served to the patient...If the patient has an allergy that is not identifiable in Health Touch the menu will be hand checked by the diet clerk or designee." The policy further indicated, "A designated Nutrition Aide will check each meal tray for accuracy before the tray leaves the department. This check includes, but it [sic] not limited to: confirming all items are in place and all quality standards are met." The immediate jeopardy that began on 12/14/24, was removed on 2/26/25 at 7:20 p.m., when it	2 965			

Minnesota Department of Health

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2 965	Continued From page 25 could be verified through observation and interview that the facility had implemented a process to ensure residents would receive appropriate food items and not receive identified food allergens. A whole house audit was conducted by nutrition services and verified all residents' allergies listed in the medical record was accurately listed in the nutrition system and that those allergies would accurately print on the residents' meal tray ticket. Meal service observation identified staff confirmed the meal served matched the meal tray ticket and any food allergies listed on the meal ticket were not served. In addition, R23's orders and stocked medication included epinephrine. The E-kit contents were reviewed and included epinephrine as well. Nutrition staff education started on 2/25/25 included allergy information communication and entry into the nutrition system, meal service, meal ticket and allergy review and tray assembly. Nursing staff education started on 2/25/25 included verification that the meal delivered matched the tray ticket and did not contain any food allergens. Nursing education further included E-kit contents, use of epinephrine via a vial, standing house orders, signs and symptoms of anaphylactic reaction, procedure for allergic and anaphylactic reactions, and incident reporting. The plan was to educate all staff prior to their next shift. Continued compliance monitored via meal service audits completed daily for two weeks, then weekly for four weeks and monthly thereafter. Audit results would be reviewed by the quality committee. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods given, offered, or consumed by residents reflect the nutritional needs and prevent potential food allergies of	2 965			

Minnesota Department of Health

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2 965	Continued From page 26 residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food allergies. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are appropriate. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965			
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure hand hygiene was completed during incontinent cares for 2 of 4 residents (R31 and R9) who were observed for cares. Furthermore, the facility failed to ensure urine was cleaned in a manner to prevent infection for 1 of 1 residents (R31) reviewed for clean environment.	21385	Corrected	3/27/25	

Minnesota Department of Health

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21385	Continued From page 27 Findings include: R31 R31's quarterly Minimum Data Set (MDS) dated 11/21/24, indicated R31 had cognitive impairment and diagnoses of dementia and heart failure. R31's care plan revised 11/27/24, indicated R31 was had bladder incontinence and tended to void in available garbage cans or receptacles. R31 requires assist of one staff to find the bathroom and assist with incontinent cares. Furthermore R31's care plan indicated R31 would urinate in inappropriate places. An observation on 2/25/25, at 7:07 a.m., R31's door was open with the commode moved away from the wall and placed in front of the R31's door. R31 was laying in bed and then started getting up from bed. R31 walked to the bathroom doorway, stood there for a moment before returning to bed. At 7:33 a.m., nursing assistant (NA)-B entered the room and asked R31 if wanted to go down for breakfast. R31 declined. NA-B then took the commode bucket out of the commode and went into the bathroom and rinsed it out. NA-B then took the commode bucket, now filled with soap and water and poured the soapy water onto R31's floor. NA-B placed the commode bucket back into the commode and then took towels and using their feet, wiped up the soapy water from the floor. A disposable pad and towel were placed on the floor and NA-B then put the commode on top of them. At 7:42 a.m., writer entered the room as R31 was now getting out of bed. Without glove exchange or hand hygiene, NA-B assisted R31 by the arm to the bathroom to urinate NA-B stated the floor may be wet as R31 "goes all over the place". After R31	21385			

Minnesota Department of Health

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21385	Continued From page 28 urinated, NA-B obtained a wipe and wiped the toilet seat as R31 walked back to the room. NA-B moved clean towels from the sink in R31's room to his bed and asked R31 to come to the sink. Still without removing gloves or performing hand hygiene, NA-B took R31's toothbrush, added toothpaste and prompted R31 to brush their teeth. When R31 was done, NA-B took the toothbrush and rinsed it off in the sink, using a gloved thumb to rub the bristles. NA-B prompted R31 to wash their hands while NA-B took some clean towels from the bed and placed them back onto the sink. Without hand hygiene or glove exchange, NA-B placed body soap on the towel and got it wet. Assisted resident to wash face. NA-B placed towel in garbage bag. NA-B then lowered R31's soiled pants and took a clean towel placed soap on it and got it wet. NA-B cleaned R31's front groin side and with the same towel wiped down R31's legs to the knees before coming back up to wipe the backside. The wet towel was placed in the garbage bag before NA-B opened a drawer to obtain a dry towel and dried off R31. R31 sat down on the bed. Without hand hygiene or glove exchange, NA-B went to R31's closet and obtained clean clothing. NA-B assisted R31 with a clean sweatshirt and clean pants. R31 put on shoes and NA-B prompted R31 to walk down for breakfast. NA-B finished up with collecting the dirty linens and clothes before removing gloves and performing hand hygiene. When interviewed on 2/25/25 at 8:05 a.m., NA-B verified hand hygiene and glove exchange was not completed after handling soiled towels and the commode bucket and before working with R31. NA-B further acknowledged hand hygiene and glove exchange was not completed in between cleaning soiled areas and working with	21385			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21385	Continued From page 29 clean areas. NA-B explained R31 would just get up an urinate anywhere in the room. NA-B used the soapy water from the commode bucket to help keep the smell of urine out of the room. NA-B verified the soap used in the water was a Dial men's 3 in 1 soap. When interviewed on 2/25/25 at 2:02 p.m., universal services staff (USS) stated all resident rooms were cleaned daily. USS stated they just started at one end to the next end. USS stated staff had not informed them of any room needing cleaning due to urine being spilled. USS stated they had not cleaned R31's room yet and left that one for last. USS said R31 urinates on the floor often so that room was saved for last as rooms were completed only once a day. When interviewed on 2/27/25 at 8:33 a.m., universal services manager stated nursing staff should clean up any bodily fluids and then environmental staff should be notified to sanitize the floor. It was expected the USS would clean the floor right away and after each occurrence. Furthermore, body soap would not properly disinfect the floor and would not be used and should not be dumped from a commode bucket. R9 R9's quarterly MDS dated 12/12/24, indicated R9 had cognitive impairment and diagnoses of dementia, stroke, and dysphagia (difficulties swallowing). Furthermore, R9 was dependent on staff for toileting and bed mobility. R9's care plan revised 12/19/24, indicated R9 was incontinent of bowel and bladder and dependent on staff for toileting.	21385			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21385	Continued From page 30 An observation on 2/26/25 at 3:45 p.m., nursing assistant (NA)-E and NA- B assisted R9 back to bed with a lift. R9's was assisted with turning back and forth in bed to remove sling and pull down pants to change brief. NA-A tucked in the left side of brief and then turned R9 to the right. R9 has a small bowel movement. NA-E used a wipe to clean R9 and removed the soiled brief. NA-E then placed the soiled brief on the floor. NA-E then looked at their gloves and took an incontinent wipe and wiped their soiled gloved hands. Without hand hygiene or glove exchange, NA-E assisted with placing R9's clean brief. NA-E and NA-A then assisted with R9's pants. NA-E lowered R9's bed and placed the call light within reach. NA-E moved R9's wheelchair and then picked up R9's soiled brief from the floor and placed in the garbage. NA-E doffed the gloves, tied up the garbage and took to the soiled utility room where hand hygiene was then completed. When interviewed on 2/26/25 at 1:00 p.m., NA-E verified she had not performed hand hygiene or changed gloves after handling R9's soiled brief. NA-E stated since R9's brief was only a little dirty, glove change was not needed. NA-E further verified the soiled brief should not have been on the floor and should have been placed in the garbage right away. When interviewed on 2/27/25 at 10:00 a.m., the infection preventionist (IP) stated hand hygiene and glove exchange was required after handling soiled or potentially dirty items and moving to clean areas during resident cares. IP further stated nursing staff were responsible to clean up any bodily fluids that were on the floor and notify the universal workers to come disinfect the floor. The floors can be cleaned as often as needed.	21385			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21385	Continued From page 31 When interviewed on 2/27/25 at 11:49 a.m., the Director of Nursing (DON) expected staff to change gloves and perform hand hygiene when moving from soiled cares to clean cares. Dirty briefs should not be placed on the floor and should be placed in the garbage right away. DON further expected staff to clean up any bodily fluids from the floors and then seek out environmental services to clean or disinfect the floor. All of these were important to prevent infection. A facility policy titled Environmental Cleaning revised 3/2024, was received and did not outline cleaning procedures for bodily fluids. A facility policy for hand hygiene was requested however not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise infection control and room cleaning policy and procedures. The DON or designee could re-educate nursing staff on infection control policies and procedures. The DON or designee could complete an audit on staff hand hygiene to monitor ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385			
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426			3/27/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21426	Continued From page 32 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure residents received a Tuberculosis (TB) test within 72 hours of admission for 1 of 1 resident (R110) reviewed for TB. R110's discharge Minimum Data Set (MDS) dated 12/20/24, indicated R15 was admitted on 2/20/25, was currently 77 years old, had moderately impaired cognition and diagnosis of hepatic encephalopathy and alcoholic cirrhosis of the liver (with ascites). R110's Minnesota Immunization report dated 2/20/25, lacked documentation of a TB test. R110's lab report for TB dated 2/21/25, indicated R110's admission date was 2/20/25 and the results of the test were invalid.	21426	Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21426	Continued From page 33 The facility's TB risk assessment dated 6/13/24, indicated baseline TB screening of all residents was performed at the time of admission as required. During interview on 2/27/25 at 10:00 a.m., the infection preventionist (IP) stated the timeline for residents to receive a TB test was within 72 hours of admission and verified R110's medical record lacked test results stating she wasn't sure it had even been drawn. Sometimes it can take 2-3 days to get the results and she was still following up on it. The IP also verified there was no documentation of a refusal or that education had been provided. During interview on 2/27/25 at 12:49 p.m. the director of nursing (DON) stated when there was a new admission, the nursing staff should put in an order set which would populate the vaccinations and schedule a TB test with the lab. The nurses were responsible for ensuring the lab gets the information and the IP was responsible for following up and ensuring it had been completed. The DON further stated the timeline for drawing a TB test was 72 hours following admission. The facility's policy regarding TB screening dated 11/11/24, indicated all residents must receive baseline screening within 72 hours of admission or within 3 months prior to admission of coming from a hospital or other nursing home. TB screening must include an assessment of resident's symptoms and risk factors for TB and a 2 step TST (Tuberculin Skin Test) or Quantiferon TB-Gold blood test. Complete baseline TB screening tool for residents. All reports and documentation of the resident's TST, Quantiferon TB-Gold blood test, medical evaluation, and chest	21426			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21426	Continued From page 34 radiograph results must be maintained in the clinical records. The TST will be documented in the immunization record in point click care, include positive or negative and document millimeters (mm) of induration or Quantiferon TB-Gold blood test results in the lab results. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426			
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there	21565			3/27/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21565	Continued From page 35 is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 1 of 1 residents (R44) observed with medications at bedside. Findings include: R44's annual Minimum Data Set (MDS) dated 12/31/24, indicated he had intact cognition, was dependent on staff for personal hygiene and mobility, and required setup or clean-up assistance with eating. The MDS reported diagnoses of a stroke (when blood flow to a part of the brain is disrupted, causing a lack of oxygen and brain cell death), aphasia (a language disorder affecting a person's ability to communicate), dementia (loss of memory, language, problem-solving and other thinking abilities), and hemiplegia or hemiparesis (one-sided muscle weakness or paralysis). Additionally, the MDS identified he had a mechanically altered diet and did not exhibit signs or symptoms of a possible swallowing disorder. R44's order summary report dated 12/25/24, were reviewed on 2/24/25 and lacked documentation of an order for self-administration of medications. Additionally, his order summary report lacked an order for Tums, an antacid medication. R44's medication administration record (MAR) dated 2/2525, was reviewed on 2/24/25 and	21565	Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21565	Continued From page 36 lacked documentation of an order for self-administration of medications as well as an order for Tums. R44's electronic health record (EHR) was reviewed on 2/24/25 at 9:19 a.m. and lacked documentation of an assessment to self-administer medications. During observation on 2/24/25 at 9:19 a.m., R44 was in bed with his bedside table over the bed, and on the bedside table was a bottle with the label "Smoothies-flavored Tums". During observation on 2/25/25 at 10:05 a.m., the bottle of Tums remained unchanged on the bedside table. During observation on 2/27/25 at 10:02 a.m., the bottle of Tums remained unchanged on the bedside table. During interview on 2/27/25 at 10:08 a.m., registered nurse (RN)-C stated a resident wishing to administer their own medications should have an assessment for self-administration. RN-C stated the assessments were completed by nursing staff and then the provider would be updated. RN-C reviewed R44's EHR and confirmed he did not have a self-administration assessment or an order to self-administer medications. RN-C stated "we did see it; we were asking our manager" about the medications noted at his bedside table, and stated "he has very high anxiety, he would get really upset about it" if staff took the bottle away from him. RN-C walked into R44's room and confirmed there was a bottle of Tums on his bedside table and asked him where it came from. He responded, "my family," and RN-C told him the bottle would not be removed	21565			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21565	Continued From page 37 "right now" but it would be discussed with the nurse manager. During interview on 2/27/25 at 10:16 a.m., licensed practical nurse (LPN)-B reviewed R44's physician orders and confirmed he did not have an order for Tums or a generic equivalent. LPN-B further verified he should have a self-administration assessment and order to have the Tums at his bedside and stated, "I feel like he would be able to self-administer" the Tums because of his pureed diet and the Tums being chewable or dissolvable. LPN-B stated, "I will update the provider and the nurse manager." Per interview on 2/27/25 at 2:39 p.m., RN-D expected staff to complete a self-administration assessment first, then get an order from the provider with the okay to self-administer medications. RN-D also expected staff to remove medications from a resident's room "the second someone noticed it." RN-D stated the risks could include possible medication contraindications or interactions, indications for use, safety implications and stated, "we need to get the provider involved to make that decision." Per interview on 2/27/25 at 3:34 p.m., the director of nursing (DON) expected staff complete a self-administration assessment and obtain a provider order. The DON stated if a family member brought in a medication from home, staff should question why there was a need for that medication and get the provider involved. The DON indicated the risks included polypharmacy and interactions with other medications. Per facility policy titled Self Administration of Medications (SAM) revised 9/24, a self-administration of medications assessment	21565			

Minnesota Department of Health

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21565	Continued From page 38 would be completed for any resident requesting to administer any medication without the direct supervision of a nurse and the interdisciplinary team would review the recommendation to determine if the resident was safe to do so. The resident's physician would need to write an order for the resident to self-administer medications and only the medications permitted for self-administration would be left at the bedside. The resident's care plan should be updated to reflect self-administration of medications. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565			
21930	MN St. Statute 144.651 Subd. 30 Patients & Residents of HC Fac.Bill of Rights Subd. 30. Protection and advocacy services.	21930			3/27/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21930	Continued From page 39 Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained during cares for 1 of 2 residents (R35) reviewed for dignity. Findings include: R35's quarterly Minimum Data Set (MDS) dated 1/23/25, indicated she was dependent on staff for toileting and personal hygiene cares as well as mobility and transfers. The MDS identified R35's diagnoses of dementia and indicated she was unable to complete the mental status assessment interview. R35's care plan dated 2/5/25, identified her impaired cognitive function or impaired though processes related to her dementia. Furthermore, the care plan indicated R3 had a communication problem related to finding the right words to say and directed staff to anticipate and meet her needs. Finally, the care plan identified her activities of daily living (ADL) self-deficit related to her dementia (a loss of memory, language, problem-solving and other thinking abilities) diagnosis and indicated she required staff assistance for dressing, personal hygiene, and	21930	Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21930	Continued From page 40 toilet use. During continuous observation of evening cares on 2/26/25 between 5:56 p.m. and 6:26 p.m., nursing assistant (NA)-C and NA-D used a mechanical body lift to assist R35 into her bed at 5:58 p.m. and assisted her to lay down. R35 began to call out, "get out of here" repetitively while NA-C pulled her pants down, removed her socks and unfastened the front tabs of her incontinence brief. NA-C told R35 they would be "quick" while they cleaned her up and NA-D held R35's hand and told her, "It's okay." At 6:00 p.m., R35 was uncovered and exposed from the waist down and the NAs worked together to remove her top. NA-C turned her back towards NA-D and R35 and turned on the water at the sink and let the water run while R35 was completely nude and exposed on the bed. At 6:01 p.m., NA-C returned to the bedside. NA-D pulled R35's legs apart while she continued to call out, "get out of here assholes." NA-C first washed her face, then they assisted R35 to turn onto her right side and began to wash her backside. NA-C stated, "she's just going" and she used cleansing wipes to clean feces from R35's buttocks. R35 continued to call out, "get out of here." NA-C reported a new area to R35's buttock to the surveyor, calling the surveyor over to assess. NA-C changed soiled gloves and R35 remained nude, and her exposed backside faced the door. At 6:08 p.m., there was a knock at the door and registered nurse (RN)-C opened the door to R35's fully exposed buttocks. RN-C walked over to the bedside and draped the hospital gown over R35's neck, covering her front side and began to rub her back gently. RN-C stated this was done to promote her dignity and they wouldn't want their family members to be laying like that naked. RN-C expected staff to protect a resident's dignity during cares by	21930			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21930	Continued From page 41 covering them up with blankets or clothing when it would not impede cares. RN-C also stated it may help provide comfort since being naked might make the resident cold. During interview on 2/26/25 at 6:37 p.m., NA-C verified they had not provided for R35's dignity during cares. NA-C stated it was something they didn't think about and was grateful to be reminded "especially for those residents who cannot speak for themselves." NA-C stated covering her also may have provided warmth, which could have promoted comfort during their cares. Per interview on 2/27/25 at 2:22 p.m., RN-D expected staff to only expose what needs to be exposed during cares. RN-D provided the example of covering the chest if perform peri-cares and keeping a resident's bottom covered if performing upper body cares. Per interview on 2/27/25 at 3:13 p.m., the director of nursing (DON) expected staff to try and maintain dignity to the highest level as possible during cares. The DON stated staff should shut the door, pull a privacy curtain if able, explain the task they are about to perform, and ask the resident how they could keep them comfortable. The DON stated staff should maintain privacy as much as they are able to in order promote a resident's dignity. A policy pertaining to dignity was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related	21930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
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21930	Continued From page 42 resident dignity. The DON or designee could re-educate all staff on policies and procedures. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures. The results of those measurable audits could be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21930			

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

PRINTED: 03/20/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NEW LOCATION B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025	
NAME OF PROVIDER OR SUPPLIER EBENEZER INTEGRATED CARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 45 WEST 10TH STREET SAINT PAUL, MN 55102			
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on February 25, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Ebenezer Integrated Care & Rehab, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2025

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.

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Ebenezer Integrated Care & Rehab is an 5-story building with a basement. The original building was built in 2008 and was determined to be of Type I (332) construction. 4th and 5th floors are occupied by Ebenezer and was remodeled for this occupancy in 2016. A complete fire sprinkler system protects the building. The facility has a fire alarm system with entire corridor smoke detection and spaces open			K 000			

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K 000	Continued From page 2 to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 56 at the time of the survey.	K 000			
K 341 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to Maintain Fire Alarm System - Installation in accordance with NFPA 72. This deficient practice could have a widespread impact on the residents of this facility..	K 341		3/27/25	
			K341 – Fire Alarm System – Installation Correction: The area immediately surrounding the fire alarm pull station has been cleared. There is now a clearing of 36” in front of the pull station.		

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K 341	Continued From page 3 Findings include: In 02/25/2025, between 9:00 AM and 11:30 AM, it was revealed by observation that the manual pull station located at the nurses station across from Room 4012 was obstructed by a cabinet, books and a cart. An interview with the Director of Facilities verified this deficient finding at the time of the survey.	K 341	Recurrence will be prevented by: To ensure ongoing compliance, a framed sign indicating the required 36" of clearance has been posted below the pull station. Education has been provided to all staff about keeping this area free from clutter to ensure accessibility to the fire pull station at all times. Date of completion: March 27, 2025 The correction will be monitored by: The Regional Director of Facilities		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10	K 351		3/27/25	

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K 351	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/25/2025 between 9:00 AM and 11:30 AM, it was revealed by observation that there were wires in contact with the sprinkler system above the ceiling by room 5004. An interview with the Facility Director verified this deficient finding at the time of discovery.	K 351	K351 – Sprinkler System- Installation Correction: The wires that were touching the sprinkler system’s pipes have been secured so they no longer come in contact with the pipes. Recurrence will be prevented by: If there is any construction that could impact these secured wires, the director of facilities will review for proper placement. Date of completion: March 27, 2025 The correction will be monitored by: The Regional Director of Facilities		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by:	K 712		3/27/25	

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K 712	Continued From page 5 Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per 42 CFR 483.470(i). These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/25/2025, between 9:90 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that between the 4th quarter of 2024 and the 1st quarter of 2025, the fire drill for the 1st shift exceeded 3 months. An interview with the Facility Director verified these deficient findings at the time of discovery.			K 712	K712 – Fire Drills Correction: Education surrounding fire drill frequency has been provided to the safety committee participants. The team has been educated that a drill needs to be completed on each work shift within a 90-day window from the previous drill during the same shift. Recurrence will be prevented by: The safety committee will schedule fire drills 3 months in advance to ensure they are spaced appropriately from one another. Date of completion: March 27, 2025 The correction will be monitored by: The Regional Director of Facilities		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a			K 920			3/27/25

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K 920	Continued From page 6 substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/25/2025, between 9:00 AM and 11:30 AM, it was revealed by observation that in room 5143 B, a microwave and refrigerator was plugged into a power strip. An interview with the Facility Director verified these deficient findings at the time of discovery.	K 920	K920 – Electrical Equipment – Power Cords and Extension Cords Correction: The power strip from the office has been removed and the fridge and microwave which were plugged into the power strip are now plugged directly into the wall socket. Recurrence will be prevented by: Staff have been educated about the requirements surrounding power cords and extension cord use in nursing homes. Individual staff with power cords in their offices have been educated about the items which can/cannot be plugged into them. Date of Completion: March 27, 2025 The correction will be monitored by: The Administrator or their designee		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		3/27/25	

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K 923	Continued From page 7 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to maintain proper storage of oxygen cylinder NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. This deficient finding could have a widespread impact on the residents within			K 923	K923 – Gas Equipment – Cylinder and Container Storage Correction: The cylinder which was stored outside of a rack or secured to wall was returned to the vendor from which it originated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NEW LOCATION B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025	
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K 923	Continued From page 8 the facility. Findings include: On 02/25/2025, between 9:00 AM and 11:30 AM, it was revealed by observation that a oxygen cylinder was stored in a upright manner in the Oxygen Storage Room without being placed in an approved storage rack or chained to the wall in an upright manner. An interview with the Facility Director verified this deficient finding at the time of discovery.			K 923	Recurrence will be prevented by: Nursing staff have been educated about proper oxygen storage and the requirements of keeping oxygen in an approved storage rack or chained to the wall. Date of Completion: March 27, 2025 The correction will be monitored by: The Administrator or their designee		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 16, 2025

Administrator
Ebenezer Integrated Care & Rehab
45 West 10th Street
Saint Paul, MN 55102

RE: CCN: 245587
Cycle Start Date: February 27, 2025

Dear Administrator:

On March 14, 2025, we notified you a remedy was imposed. On April 8, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 27, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 29, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 14, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 29, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 27, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 16, 2025

Administrator
Ebenezer Integrated Care & Rehab
45 West 10th Street
Saint Paul, MN 55102

Re: Reinspection Results
Event ID: S35P12

Dear Administrator:

On April 8, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us