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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZK18

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00756

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245213**
2.STATE VENDOR OR MEDICAID NO.
(L2) **834243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EBENEZER RIDGES GERIATRIC CARE CENTER**
(L4) **13820 COMMUNITY DRIVE**
(L5) **BURNSVILLE, MN** (L6) **55337**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **114** (L18)
13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 05/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/14/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245213

June 5, 2016

Ms. Jill Acosta, Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, Minnesota 55337

Dear Ms. Acosta:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 19, 2016 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 12, 2016

Ms. Jill Acosta, Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, Minnesota 55337

RE: Project Number S5213027, F5213025

Dear Ms. Acosta:

On March 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 10, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On April 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 19, 2016. Based on our visit, we have determined that your facility has obtained compliance with deficiencies issued pursuant to our standard survey, completed on March 10, 2016, effective April 19, 2016 and therefore remedies outlined in our letter to you on March 21, 2016, will not be imposed.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245213 (Y1)	A. Building B. Wing (Y2)	4/26/2016 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 04/19/2016	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 04/19/2016	ID Prefix F0411 Reg. # 483.55(a) LSC	Correction Completed 04/19/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	**REVIEWED BY (INITIALS)** GL/mm	**DATE** 05/12/2016	**SIGNATURE OF SURVEYOR** 15507	**DATE** 04/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 3/10/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245213	A. Building 01 - MAIN BUILDING 01 B. Wing	4/29/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 03/14/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 05/12/2016	**SIGNATURE OF SURVEYOR** 37010	**DATE** 04/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 3/10/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245213	A. Building 02 - EBENEZER RIDGES TRANSITIONAL CARE UNIT B. Wing	4/29/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 03/14/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TL/mm	DATE 05/12/2016	SIGNATURE OF SURVEYOR 37010	DATE 04/29/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/10/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZK18

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00756

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245213**

2.STATE VENDOR OR MEDICAID NO.
(L2) **834243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EBENEZER RIDGES GERIATRIC CARE CENTER**
(L4) **13820 COMMUNITY DRIVE**
(L5) **BURNSVILLE, MN** (L6) **55337**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/10/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **114** (L18)

13.Total Certified Beds **114** (L17)

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Lisa Hanson, HFE NE II — 04/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 04/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/14/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 21, 2016

Ms. Jill Acosta, Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, Minnesota 55337

RE: Project Number S5213027

Dear Ms. Acosta:

On March 10, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 19, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 10, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245213	A. BUILDING _____ B. WING _____	03/10/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		4/19/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/30/2016

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

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 2 of 3 residents (R15, R87) who were reviewed for range of motion (ROM). Findings include: R15's care plan dated 12/31/15, did not include the presence of any contractures, nor did the plan provide direction or instruction for staff to perform daily hand hygiene or routine skin checks to R15's contracted right hand. In addition, the NA care assignment sheet lacked instructions for the NAs to provide daily ROM and/or PROM for R15. R15 was observed and interviewed on 3/7/16, at 1:46 p.m. Her right hand was tightly contracted into a fist and was resting on the right wheelchair (w/c) arm rest. The resident was only able to move her thumb and index finger, and the other three fingers were fixed in place. R15's morning cares were observed on 3/9/16, at 9:57 a.m. performed by a nursing assistant (NA)-C. R15 was lying in bed with her right hand closed into a fist. NA-C washed R15's body starting with her face and working downward to her legs. At no time did NA-C wash, attempt to open, or observe the inside of R15's contracted hand, rather she wiped the washcloth over the outside of the resident's hand. When cares were completed, NA-C assisted R15 to the dayroom. NA-C was asked why she did not wash the palm of R15's right hand. NA-C responded, "Yes, I usually wash inside her hand, but today I did not.	F 279	TAG F279 Develop Comprehensive Care Plans 1.Corrective Action: Residents # 15 and 87 Care Plans were updated On 3/30/2016 to include the presence of Contractures, decrease in range of motion, Range of Motion and hand care to be provided. 2.Corrective Action as it applies to other residents: The Policy and Procedure for Individualized Care Plans was reviewed and remains current. All residents with contractures, decrease in range of motion will be reviewed to assure their Care Plans reflect the location(s) of the contractures, decrease range of motion and the planned treatment. Licensed staff will be in-serviced on the Policy and Procedure on Individualized Care Plan. Care plan development for contractures, range of motion and hand care needs. 3.Date of Completion 4/19/2016 4.Reoccurrence will be prevented by:	

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F 279	Continued From page 2 Most of the time I cannot open her hand to clean or check her skin." R15's Minimum Data Set (MDS) assessment dated 1/7/16 indicated the resident's functional ROM of the upper extremities (shoulder, elbow, wrist, hand) was impaired on one side, as well as lower extremities (hip, knee, ankle, foot) on both sides. Physician orders dated 1/8/16, for R15 included physical therapy (PT) and occupational therapy (OT) for "ambulation/transfers/posture in wheelchair, also check fit of right boot/splint due to red area on top of ankle." On 2/24/16, physician orders directed staff to provide ROM once daily to R15's right lower and upper extremities, right knee, ankle, and toes. In addition, staff was to provide passive range of motion (PROM) to the right elbow, wrist and digits (fingers) and clarified, "[NAs] will do and nurse to assure completion." Physician orders dated 3/1/16, indicated R15 had diagnoses including dementia and hemiplegia (paralysis) affecting the right dominant side. The director of nursing (DON) reported on 3/7/16, at 3:00 p.m. R15 did not have any contractures. The DON said a nurse and NA checked each residents' skin at bath time. During an interview on 3/8/16, at 3:31 p.m. a licensed practical nurse (LPN)-B verified R15's hand was contracted, and reported the resident was receiving ROM by the NAs daily during morning cares. At 3:54 p.m. NA-D explained that R15 had been admitted with right hand contractures, and a NA	F 279	Random audit of two residents on various units, to include new admissions will have their Care Plans reviewed weekly for 90 days to assure any contractures are indicated along with treatment to be provided. The results of these audits will be shared with QAPI committee for input on system improvement opportunities and the need to increase, decrease, or discontinue the audits. 5.The correction will be monitored by: DON or Designee	

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F 279	Continued From page 3	F 279		

provided ROM each shift. NA-D said R15 did not utilize a splint and was not longer receiving PT or OT services. After ROM was provided for a resident, NA-D said it was documented in the facility's computer system. NA-D and the surveyor looked in the system for documentation showing R15 had received ROM services, however, such documentation could not be located.

NA-C reported in an interview on 3/9/16, at 7:19 a.m. she was routinely assigned to care for R15 and would be providing cares for the resident that day. NA-C explained that R15 had contractures on both her legs and right hand. NA-C stated, "I do not do ROM for [R15]. Two other [NAs] come up here to do it. We take turns." At 7:26 a.m. LPN-C clarified ROM was performed by the NAs, and R15 was not receiving restorative nursing services (as described by NA-C).

An initial occupational therapy note dated 1/11/16, indicated R15 presented with contractures and skilled therapy was needed to address the impairment. OT recommendations were for R15 to "wear a resting hand splint on right hand and right wrist for 4 hours on and 4 hours off in order to improve PROM for adequate hygiene and inhibit abnormal positions."

A follow-up interview on 3/9/16, at 2:06 p.m. the DON verified if a resident had a hand contracture it would have been considered standard of care to provide daily hand hygiene and the NAs should have been doing this for R15.

A physical therapy assistant (PTA)-A verified on 3/10/16, at 8:56 a.m. therapy staff had not performed any ROM services for R15 after 2/1/16. Instead, the therapy staff were waiting to

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F 279	Continued From page 4	F 279		

hear back from the vendor regarding a Dynamic hand splint. However PTA-A stated, "I would expect nursing to monitor daily skin integrity in contracted areas and when splint or braces are being worn."

A follow-up interview on 3/10/16, at 9:19 a.m. R15 reported therapy staff had been to her room to see her and observe her hand. R15 denied a nurse or NA were checking her palm, or were ROM or were attempting to open her fingers. R15 said, "No one has asked me to move my fingers or even wash the palm of my hand."

R87's ROM care plan (revised 4/29/13) did not delineate when and what services were to be provided, but indicated "per therapy recommendations." Staff were directed to watch for redness related to R87's right leg brace.

R87 was observed on 3/8/16, at 1:50 p.m. while in bed. Her hand rested on top of the covers, and she was not wearing hand splints or finger separators. At the time of the observation, NA-A reported she was routinely assigned to care for R87. NA-A explained R87 required total assistance from staff for cares, including assistance from two staff to use a Hoyer full body lift, at times was able to answer yes or no questions. NA-A said R87 received ROM by the NAs during morning cares. When asked what instructions were provided for the NAs to care for a resident NA-A replied, "I know what to do because it's on my care sheet. I move her legs outward in the morning." However, when both NA-A and the surveyor reviewed the group 5 care assignment sheet, it did not include instruction for the NAs to perform ROM services for R87. NA-A stated, "I have been working here for a long time

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F 279	Continued From page 5	F 279		

and know what to do for [R87]. I take it upon myself to do [ROM]. I move both her legs outward to help get her pants on." NA-A denied any nurses had ever asked her whether she had performed ROM for R87.

Physician's orders for R87 dated 6/6/12, directed staff to perform AAROM to the resident's left upper extremities, left and right lower extremities, and left and right calf. "NA to do with nurse to assure compliance." R87's care plan dated 8/3/12, indicated R87 was to receive ROM due to unsteady balance with a hip fracture following a fall at home.

R87's OT discharge summary indicated the resident had been seen by therapy staff from 1/28/15 to 2/23/15. Discharge recommendations were for R87 to wear finger separator on left hand during all waking hours. In addition, a PROM and extended stretch program was to be competed by the NAs daily. An OT ROM Recommendations Worksheet dated 2/6/15, indicated R87 was to receive daily left upper extremities to the shoulder, elbow, wrist, all hand joints with 10 repetitions to each joint.

R87's MDS dated 1/7/16, noted the resident had severely impaired cognition and required extensive assistance with cares, and presented no behavioral issues including rejection of care. The MDS indicated under ROM, "no impairment" of both upper and lower extremities. No PT, OT, or restorative therapy was coded for the previous seven days.

During an interview on 3/8/16, at 2:03 p.m. LPN-A stated she "asked" the NAs if R87 had received ROM, and then marked it off in the treatment

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F 279	Continued From page 6 administration record (TAR). A short time later at 2:13 p.m. a registered nurse (RN)-B stated R87 was on a AAROM (active assisted ROM) program, but was unsure why it did not show up for the NAs to complete it in POC system. "It must of been put in wrong...This is not how it should be done. For some reason it was missed on this resident." At the same time, RN-A was attempting to locate documentation showing R87's ROM was being documented in the resident's electronic record. RN-A stated, "I do not see it being done." RN-A verified she was responsible for ensuring a resident's need for ROM was added to the POC system to ensure NAs were provided direction as to when and what specific services were to be performed. NA-B then reported at 2:31 p.m. she sometimes cared for R87 and just performed ROM to the resident's legs. NA-B then attempted to show the surveyor where ROM was indicated in the resident's POC, however, was unable to locate any NA documentation related to ROM for R87. NA-B explained that when a resident had ROM performed, the NAs "put it in" the POC that it had been completed, and then the nurses could look in the system to see whether it had been performed. NA-B denied any of the nurses had ever approached to her ask whether she had performed ROM for R87. R87 was not wearing splints or finger separators during subsequent observations on 3/9/16, at 7:40 a.m., 12:51 p.m., 1:27 p.m. or on 3/10/16, at 9:13 a.m. The POC Response History for the previous 14 days directed the NAs to perform the following for	F 279		

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F 279	Continued From page 7 R87: "AAROM program, do hand joint and finger separator on left hand during am cares. Left upper extremities shoulder flex and elbow extension 5 times each joint. Right and left lower extremities 10 times to each join and calf right and left 30 seconds times 3 reps [repetitions]." However, documentation was lacking to show AAROM was performed for R87, as the form read, "No Data Found." The facility's 12/13 Range of Motion policy read, "Each resident/patient is assisted in reaching his/her highest level of independence and functional ability. The purpose is to: 1. Move the resident's joints through as full a rang of motion as possible. 2. Improve or maintain joint mobility and muscle strength. 3. Prevent contractures. 4. Reduce pain. 5. Prevent complications of mobility."	F 279		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide range of motion (ROM) to minimize the potential for decline for 2 of 3 residents (R15, R87) reviewed for ROM.	F 318	TAG F318 Increase/Prevent Decrease in Range of Motion 1.Corrective Action:	4/19/16

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F 318	Continued From page 8 Findings include: R15 was observed and interviewed on 3/7/16, at 1:46 p.m. Her right hand was tightly contracted into a fist and was resting on the right wheelchair (w/c) arm rest. The resident was only able to move her thumb and index finger, and the other three fingers were fixed in place. R15 explained her hand had been that way since a stroke in 2000 (sixteen years prior). In a follow-up interview on 3/8/16, at 3:31 p.m. R15 stated, "My right hand is hard to open. I had it since 2000 and it has gotten a little worse." R15 explained that she had not received therapy services "in a long time" but someone had told her a splint had been ordered for her to wear. R15's morning cares were observed on 3/9/16, at 9:57 a.m. performed by a nursing assistant (NA)-C. R15 was lying in bed with her right hand closed into a fist. NA-C washed R15's body starting with her face and working downward to her legs. At no time did NA-C wash, attempt to open, or observe the inside of R15's contracted hand, rather she wiped the washcloth over the outside of the resident's hand. When cares were completed, NA-C assisted R15 to the dayroom. NA-C was asked why she did not wash the palm of R15's right hand. NA-C responded, "Yes, I usually wash inside her hand, but today I did not. Most of the time I cannot open her hand to clean or check her skin." The care plan for R15 dated 12/31/15, did not include the presence of any contractures, nor did the plan provide direction or instruction for staff to perform daily hand hygiene or routine skin checks	F 318	Residents #15 is being treated by OT and PT and resident #87 is currently being treated by OT. 2.Corrective Action as it applies to other residents: The Policy and Procedure for Range of Motion was reviewed and remains current. A facility wide audit will be conducted by licensed staff for all residents at risk of a decline in Range of Motion to assure they have an appropriate treatment program in place. Residents will be referred to therapy for Evaluation and treatment as needed. In-services for nursing staff will be held to review the Policy and Procedure for Range of Motion. Range of Motion needs and subsequent treatment programs needed to maintain or prevent decline in joint mobility. 3.Date of Completion: 4/19/2016 4.Reoccurrence will be prevented by: Random audits of two residents on various units, to include new admissions at risk of a decline in ROM will be audited weekly for 90 days to assure they are receiving the recommended ROM program.	

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F 318	Continued From page 9 to R15's contracted right hand. R15's Minimum Data Set (MDS) assessment dated 1/7/16 indicated the resident had moderate cognitive impairment, but was able to make self understood and had clear comprehension. R15 was dependent on staff for bathing and grooming. She presented no behavioral issues, including rejection of care. Functional ROM of the resident's upper extremities (shoulder, elbow, wrist, hand) was impaired on one side, as well as lower extremities (hip, knee, ankle, foot) on both sides. The MDS did not reflect the resident was receiving physical or occupational therapy, or a restorative program, active or passive ROM, or splint assistance during the previous seven days. Physician orders dated 1/8/16, for R15 included physical therapy (PT) and occupational therapy (OT) for "ambulation/transfers/posture in wheelchair, also check fit of right boot/splint due to red area on top of ankle." On 2/24/16, physician orders directed staff to provide ROM once daily to R15's right lower and upper extremities, right knee, ankle, and toes. In addition, staff was to provide passive range of motion (PROM) to the right elbow, wrist and digits (fingers) and clarified, "[NAs] will do and nurse to assure completion." Physician orders dated 3/1/16, indicated R15 had diagnoses including dementia and hemiplegia (paralysis) affecting the right dominant side. R15's POC [Point of Care] Response History dated 2/24/16 to 3/8/16, directed the NA to perform the following for R15: PROM to right lower extremities, knees, toes, ROM to right upper extremities elbow, wrist and digits. Documentation indicated the task had been	F 318	The results of these audits will be shared with QAPI committee for input on system improvement opportunities and the need to increase, decrease, or discontinue the audits. 5.The Correction will be monitored by: Director of Nursing or Designee	

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F 318	Continued From page 10	F 318		

completed 10 of the 13 days at various times, generally between 9:00 and 11:00 a.m.

The director of nursing (DON) reported on 3/7/16, at 3:00 p.m. R15 did not have any contractures. The DON also verified a nurse and NA checked each residents' skin at bath time.

During an interview on 3/8/16, at 3:31 p.m. a licensed practical nurse (LPN)-B stated R15 was capable of communicating her needs, using a call light, and self-propelling a w/c using her legs. LPN-B verified R15's hand was contracted, and reported the resident was receiving ROM by the NAs daily during morning cares.

At 3:54 p.m. NA-D explained that R15 had been admitted with right hand contractures, and a NA provided ROM each shift. NA-D said R15 did not utilize a splint and was not longer receiving PT or OT services. After ROM was provided for a resident, NA-D said it was documented in the facility's computer system. NA-D and the surveyor looked in the system for documentation showing R15 had received ROM services, however, such documentation could not be located. In addition, the NA care assignment sheet lacked instructions for the NAs to provide daily ROM and/or PROM for R15.

NA-C reported in an interview on 3/9/16, at 7:19 a.m. she was routinely assigned to care for R15 and would be providing cares for the resident that day. NA-C explained that R15 had contractures on both her legs and right hand. NA-C stated, "I do not do ROM for [R15]. Two other [NAs] come up here to do it. We take turns." At 7:26 a.m. LPN-C clarified ROM was performed by the NAs, and R15 was not receiving restorative nursing

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	245213	A. BUILDING _____ B. WING _____	03/10/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 11 services (as described by NA-C). An initial occupational therapy note dated 1/11/16, indicated R15 presented with contractures and skilled therapy was needed to address the impairment. OT recommendations were for R15 to "wear a resting hand splint on right hand and right wrist for 4 hours on and 4 hours off in order to improve PROM for adequate hygiene and inhibit abnormal positions." R15 was seen by occupational therapy staff on 1/13, 1/14, 1/15, 1/18, 1/20, 1/27, and 2/1. On 1/18/16, the staff recommended a Dynamic Progressive Splint to support optimal positioning while promoting increased ROM at the wrist and digits. However, on 2/5/16, Medicare part A denied coverage of the specialized splint for R15. An OT discharge note was not found in the documentation, and there were no further notes until 3/8/16 when the resident was seen by an occupational therapist/registered (OT/R)-A. The note read, "Patient reported pain in 4th and 5th digit of hand due to severe contracture at rest, noted decreased right hand skin integrity with sloughing of skin and mild odor to palm of hand. Provide proper hand hygiene and NA present for education on daily hand hygiene to increase skin integrity and to prep for potential splinting for management of tone and muscular relaxation." OT/R-A was interviewed on 3/9/16, at 8:50 a.m. and explained that a previous therapy note indicated R15 was supposed to have received 12 therapy visits between 1/11/16 and 4/9/16. However, "yesterday" (3/8/16) was the first time this OT/R had seen R15. A follow-up interview on 3/9/16, at 2:06 p.m. the	F 318		

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DON verified if a resident had a hand contracture it would have been considered standard of care to provide daily hand hygiene and the NAs should have been doing this for R15.

A physical therapy assistant (PTA)-A verified on 3/10/16, at 8:56 a.m. therapy staff had not performed any ROM services for R15 after 2/1/16. Instead, the therapy staff were waiting to hear back from the vendor regarding the Dynamic hand splint. However PTA-A stated, "I would expect nursing to monitor daily skin integrity in contracted areas and when splint or braces are being worn."

A follow-up interview on 3/10/16, at 9:19 a.m. R15 reported therapy staff had been to her room to see her and observe her hand. R15 denied a nurse or NA were checking her palm, or were ROM or were attempting to open her fingers. R15 said, "No one has asked me to move my fingers or even wash the palm of my hand."

Nursing progress notes were reviewed and did not reflect documentation of skin checks to R15's palm. Only one note 2/24/16, indicated "ROM will continue with nursing staff and writer will follow up with therapy to note splint arrival and reassess at that time." In addition, follow up documentation was lacking regarding the status of R15's hand splint.

R87 was observed on 3/8/16, at 1:50 p.m. while in bed. Her hand rested on top of the covers, and she was not wearing hand splints or finger separators. At the time of the observation, NA-A reported she was routinely assigned to care for R87. NA-A explained R87 required total assistance from staff for cares, including

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F 318	Continued From page 13	F 318		

assistance from two staff to use a Hoyer full body lift, at times was able to answer yes or no questions. NA-A said R87 received ROM by the NAs during morning cares. When asked what instructions were provided for the NAs to care for a resident NA-A replied, "I know what to do because it's on my care sheet. I move her legs outward in the morning." However, when both NA-A and the surveyor reviewed the group 5 care assignment sheet, it did not include instruction for the NAs to perform ROM services for R87. NA-A stated, "I have been working here for a long time and know what to do for [R87]. I take it upon myself to do [ROM]. I move both her legs outward to help get her pants on." NA-A denied any nurses had ever asked her whether she had performed ROM for R87.

Physician's orders for R87 dated 6/6/12, directed staff to perform AAROM to the resident's left upper extremities, left and right lower extremities, and left and right calf. "NA to do with nurse to assure compliance." R87's care plan dated 8/3/12, indicated R87 was to receive ROM due to unsteady balance with a hip fracture following a fall at home.

R87's care plan ---- did not delineate when and what ROM services were to be provided, but indicated "per therapy recommendations." Staff were directed to watch for reddness related to R87's right leg brace.

R87's OT discharge summary indicated the resident had been seen by therapy staff from 1/28/15 to 2/23/15. Discharge recommendations were for R87 to wear finger separator on left hand during all waking hours. In addition, a PROM and extended stretch program was to be competed by

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the NAs daily. An OT ROM Recommendations Worksheet dated 2/6/15, indicated R87 was to receive daily left upper extremities to the shoulder, elbow, wrist, all hand joints with 10 repetitions to each joint.

R87's MDS dated 1/7/16, noted the resident had severely imparired cognition and required extensive assistance with cares, and presented no behavioral issues including rejection of care. The MDS indicated under ROM, "no impairment" of both upper and lower extremeties. No PT, OT, or restorative therapy was coded for the previous seven days.

During an interview on 3/8/16, at 2:03 p.m. LPN-A stated she "asked" the NAs if R87 had received ROM, and then marked it off in the treatment administration record (TAR).

A short time later at 2:13 p.m. a registered nurse (RN)-B stated R87 was on a AAROM (active assisted ROM) program, but was unsure why it did not show up for the NAs to complete it in POC system. "It must of been put in wrong...This is not how it should be done. For some reason it was missed on this resident." At the same time, RN-A was attempting to locate documentation showing R87's ROM was being documented in the resident's electronic record. RN-A stated, "I do not see it being done." RN-A verified she was responsible for ensuring a resident's need for ROM was added to the POC system to ensure NAs were provided direction as to when and what specific services were to be performed.

NA-B then reported at 2:31 p.m. she sometimes cared for R87 and just performed ROM to the resident's legs. NA-B then attempted to show the

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F 318	Continued From page 15 surveyor where ROM was indicated in the resident's POC, however, was unable to locate any NA documentation related to ROM for R87. NA-B explained that when a resident had ROM performed, the NAs "put it in" the POC that it had been completed, and then the nurses could look in the system to see whether it had been performed. NA-B denied any of the nurses had ever approached to her ask whether she had performed ROM for R87. R87 was not wearing splints or finger separators during subsequent observations on 3/9/16, at 7:40 a.m., 12:51 p.m., 1:27 p.m. or on 3/10/16, at 9:13 a.m. The POC Response History for the previous 14 days directed the NAs to perform the following for R87: "AAROM program, do hand joint and finger separator on left hand during am cares. Left upper extremities shoulder flex and elbow extension 5 times each joint. Right and left lower extremities 10 times to each join and calf right and left 30 seconds times 3 reps [repetitions]." However, documentation was lacking to show AAROM was performed for R87, as the form read, "No Data Found." The facility's 12/13 Range of Motion policy read, "Each resident/patient is assisted in reaching his/her highest level of independence and functional ability. The purpose is to: 1. Move the resident's joints through as full a rang of motion as possible. 2. Improve or maintain joint mobility and muscle strength. 3. Prevent contractures. 4. Reduce pain. 5. Prevent complications of mobility."	F 318		
F 411	483.55(a) ROUTINE/EMERGENCY DENTAL	F 411		4/19/16

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F 411 SS=D	Continued From page 16 SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 3 residents (R15) reviewed for dental services. Findings include: R15 was interviewed on 3/7/16, at 1:48 p.m. at which time it was observed she was missing two top teeth. In a follow up interview on 3/9/16, at 9:58 a.m. R15 stated she had no difficulty eating, "even though I am missing the majority of my upper teeth." The resident also stated, "I thought I was going to get some teeth." An Admission Care Plan dated 12/31/15, indicated R15 had her own teeth, and required oral care in the morning and evening with staffs' assistance.	F 411	TAG F411 Routine/Emergency Dental Services in SNFS 1.Corrective Action: Resident #15 family was contacted regarding dental needs and consent was sent to the family and returned signed to the facility on 3/24/2016. 2.Corrective Action as it applies to other residents: The Policy and Procedure for Dental Services was reviewed and revised.	

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F 411	Continued From page 17 The Ebenezer Oral Exam form dated 1/5/16, indicated under condition of natural teeth, R15 had "no decayed or broken teeth/roots/loose or carinous [sic] conditions." However, the section noting whether a routine dental visit was needed was left blank. R15's MDS (Minimum Data Set) dated 1/7/16, for Oral/Dental Status indicated R15 had none of the following: broken or loosely fitting denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious or likely cavity or broken natural teeth, inflamed or bleeding gums or loose natural teeth, mouth or facial pain, discomfort or difficulty with chewing. An Apple Tree Dental MDS 3.0 Oral/Dental Assessment Form dated 1/20/16, noted R15 had broken root tips and missing teeth. The Dental Care Referral Recommendations included "routine dental referral, non-urgent dental care needs," but was noted R15 would benefit from dental treatment. R15's physician's orders dated 3/1/16, indicated the resident "may be seen per facility policy" for dental care. During an interview on 3/10/16, at 9:27 a.m. the health unit coordinator (HUC)-A explained Apple Tree Dental came to the facility monthly to see residents who were listed on the dental list. HUC-A stated she had never been informed R15's name was to have been added to the dental list. HUC-A explained if R15 requested to see the dentist, she would have started the process of ensuring she was seen.	F 411	A facility wide audit will be conducted by Medical Records for all residents to ensure Dental services are in place. In-services for licensed staff, medical records and social service will be held to review the Policy and Procedure for Dental Services. 3.Date of Completion: 4/19/2016 4.Reoccurrence will be prevented by: Random audits of two residents on various units, to include new Admissions, Dental Services will be audited weekly for 90 days to assure they are receiving the recommended dental services. The results of these audits will be shared with the QAPI committee for input on system improvement opportunities and the need to increase, decrease, or discontinue the audits. 5.The Correction will be monitored by: Director of Nursing or Designee	

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F 411	Continued From page 18 During an interview on 3/10/16, at 9:26 a.m. the director of nursing (DON) verified The Apple Tree Dental MDS 3.0 Oral/Dental Assessment Form dated 1/20/16, noted R15 had broken root tips and missing teeth and would have benefited from dental treatment. The DON stated he thought the facility had 90 days to provide dental service for newly admitted residents. The DON was unable to provide information dental services had been offered until after the surveyor brought the information to his attention on 3/8/16. At this time, the DON had contacted R15's family regarding her dental needs. The facility's 11/13, Dental Policy indicated the "facility will assist the resident in maintaining/achieving dental health...to ensure residents maintain and achieve the best possible dental health...Non-urgent issues: call family to identify need and dentist of their choice...assist family in getting an appointment with a local dentist. "	F 411		

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EBENEZER RIDGES GERIATRIC CARE CENTER	**13820 COMMUNITY DRIVE** **BURNSVILLE, MN 55337**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Ebenezer Ridges Geriatric Care Center and Transitional Care Unit was found NOT in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

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

Electronically Signed | 03/30/2016

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ebenezer Ridges Geriatric Care Center is a 3-story building with a partial basement. The building was built at 3 different times. The original building was built in 1976 and was determined to be of Type II(222) construction. The 1994 Chapel addition, is a 1-story and was determined to be of Type II(222) construction. The 2015 Transitional Care Unit addition, is a 1 story building with an underground parking garage. In 2015, an addition was constructed to the east side of the building that was determined to be of Type II(222) construction. Because the original building and the 1994 addition meet the construction type allowed for existing buildings, the 2 buildings will be surveyed as one building. The 2015 TCU building will be surveyed as a separate building. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor	K 000		

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K 000	Continued From page 2 smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms. The facility has a licensed capacity of 114 beds and had a census of 112 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 1100 and 1500 on 03/10/2016, based on review of available documentation it was revealed that there was no documentation for: a. The minimum 5 minute cool down period when testing the generator. This deficient practice was verified by the Director	K 144	Correction: The facility has added a column to the monthly emergency generator test log, to assure documentation of the five minute cool down period. The Director of Plant Operation or Designee will be responsible for monitoring to prevent reoccurrence.	3/14/16

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K 144	Continued From page 3 of Physical Plant Operations (BE).	K 144		

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	245213	A. BUILDING **02 - EBENEZER RIDGES TRANSITIONAL CARE UNIT** B. WING _____	**03/10/2016**

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EBENEZER RIDGES GERIATRIC CARE CENTER	**13820 COMMUNITY DRIVE** **BURNSVILLE, MN 55337**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Ebenezer Ridges Geriatric Care Center and Transitional Care Unit was found NOT in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

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

Electronically Signed | 03/30/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245213	A. BUILDING **02 - EBENEZER RIDGES TRANSITIONAL CARE UNIT** B. WING _____	**03/10/2016**

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K 000	Continued From page 1	K 000		

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

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

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

2. The actual, or proposed, completion date.

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

Ebenezer Ridges Geriatric Care Center is a 3-story building with a partial basement. The building was built at 3 different times. The original building was built in 1976 and was determined to be of Type II(222) construction. The 1994 Chapel addition, is a 1-story and was determined to be of Type II(222) construction. The 2015 Transitional Care Unit addition, is a 1 story building with an underground parking garage. In 2015, an addition was constructed to the east side of the building that was determined to be of Type II(222) construction. Because the original building and the 1994 addition meet the construction type allowed for existing buildings, the 2 buildings will be surveyed as one building. The 2015 TCU building will be surveyed as a separate building.

The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor

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K 000	Continued From page 2 smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms. The facility has a licensed capacity of 114 beds and had a census of 112 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 1100 and 1500 on 03/10/2016, based on review of available documentation it was revealed that there was no documentation for: a. The minimum 5 minute cool down period when testing the generator. This deficient practice was verified by the Director	K 144	Correction: The facility has added a column to the monthly emergency generator test log, to assure documentation of the five minute cool down period. The Director of Plant Operation or Designee will be responsible for monitoring to prevent reoccurrence.	3/14/16

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K 144	Continued From page 3 of Physical Plant Operations (BE).	K 144		