Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 4, 2025

Administrator
Ebenezer Ridges Geriatric Care Center

13820 COMMUNITY DRIVE
BURNSVILLE, MN 55337

RE: CCN: 245213
Cycle Start Date: July 29, 2025

Dear Administrator:

On July 29, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 constituted actual harm that was not immediate jeopardy (Level G).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

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 listed below to the CMS location.

• Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

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.

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

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 an "E" tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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.

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

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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245213**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Ridges Geriatric Care Center	**13820 COMMUNITY DRIVE , BURNSVILLE, Minnesota, 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
F0000	INITIAL COMMENTS On 7/29/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was Reviewed H52131067C / MN2570542 and a deficiency was issued at F760 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F0000		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that 1 of 3 residents (R1) reviewed was free from a significant medication error. R1 was given another residents insulin causing her to be sent to the hospital for treatment. Findings include: R1's clinical physician orders dated 7/15/25 – 7/29/25 did not indicate R1 was ordered insulin. R1's admission Minimum Data Set (MDS) dated 7/21/25 indicated R1's Brief Inventory of Mental Status (BIMS) was a 15 indicating she was cognitively intact. R1 did	F0760	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245213**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/29/2025**

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F0760 SS = G	Continued from page 1 not receive any injections including insulin. R1's diagnosis's were urinary tract infection, overactive bladder, hypothyroidism (the thyroid gland does not produce enough thyroid hormone), gastro-esophageal reflux disease, muscle weakness, encephalopathy (a condition where the brains function is impaired) and ischemic cardiomyopathy (damage of a heart muscle making it difficult for the heart to pump blood). R1's diagnoses did not include diabetes. R1's nursing progress note dated 7/23/25 at 7:57 p.m. indicated misadministration of Novolog insulin 31 units to R1 and R1 was a non-diabetic resident. LPN-A was distracted by nursing assistant (NA)-A while ready to enter the residents room to administer insulin. NA-A asked LPN-A to speak to the resident in the next room regarding a concern he had, and it was urgent. LPN-A was already with the insulin in her hand. LPN-A entered the resident's room who had a concern. On the way-out LPN-A noticed two more call lights going off including the one who was administered the insulin. LPN-A accidentally entered the wrong room that had all light on thinking it was the room of the resident who needed the insulin. LPN-A apologized to the resident for being late with the insulin. R1 did not say anything at first but after administering the dose LPN-A realized she administered the insulin to the wrong resident. R1 was also surprised stating she was not diabetic. LPN-A apologized and called the charge nurse right away. LPN-A also called 911 but was unable to talk. The charge nurse arrived, and LPN-A handed over the phone. LPN-A checked R1's blood sugar after 15 minutes following the insulin administration and her blood glucose level was 142. A glass of orange juice was administered. The ambulance arrived and R1 was taken to the emergency department. R1's emergency department document dated 7/23/25 at 8:13 p.m. indicated the clinical impression was a diagnosis of hypoglycemia (blood glucose levels are too low). R1's hospital history and physical dated 7/23/25 indicated R1 was evaluated after inadvertently administered insulin at her transitional care unit. R1 was noted to have a glucose level of 52 (normal range 70-99) upon arrival to the emergency room. R1 had no history of diabetes and not on insulin therapy. R1 was given D50 (a concentrated sterile glucose 50% in 50% water) in the emergency room and started on dextrose infusion. R1's blood sugar dropped to 48 and was	F0760		

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F0760 SS = G	Continued from page 2 started on D10 (a concentrated sterile solution of 10% glucose and 90% water) at 150 milliliters per hour. R1's hospital summary of visit dated 7/23/25 indicated R1 was admitted to the hospital for concerns of hypoglycemia after inadvertently receiving insulin at the transitional care unit. R1's blood sugar had maintained with dexterous fluid and then subsequently eating adequately oral intake. A facility Medication/Treatment Error Report dated 7/23/25 indicated the medication involved with Insulin Aspart (rapid acting insulin) used for managing blood glucose levels in diabetics. R1 was not ordered Aspart Insulin, R2 was ordered the insulin needed and was due for 31 units. R1 did not have any immediate symptoms insulin at the facility. Emergency Medical Services arrived and started IV Dextrose (glucose given intravenously). R2's MDS dated 7/17/25 was not completed as R2 admitted on 7/17/25 and discharged on 7/27/25. R2's care plan dated 7/28/25 indicated R2 had Diabetes Mellitus R2 was to have blood glucose checks per providers orders and as needed. In addition, R2 was be administered diabetes medications as ordered by her provider. R2's Clinical Physician Orders dated 7/22/25 indicated R2 was to have Insulin Aspart FlexPen subcutaneous 100 unit/milliliter inject 28 units twice daily. Upon interview on 7/29/25 at 9:22 a.m. R1 stated in the evening on 7/23/25 a nurse entered her room and stated she had her medication. The nurse lifted her shirt and gave her an injection. R1 asked licensed practical nurse (LPN)-A what she had given her. LPN-A replied that she had given her the insulin she had requested. R1 told LPN-A she is not on insulin, and she was not diabetic. The next thing R1 recalled was getting orange juice and then the ambulance showed up. R1 was taken to the hospital where an IV was started and she spent the night in the hospital where staff was monitoring her all night. R1 stated she was told in the hospital that she received "a lot" of insulin.	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245213	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Ridges Geriatric Care Center	**13820 COMMUNITY DRIVE , BURNSVILLE, Minnesota, 55337**

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F0760 SS = G	Continued from page 3 Upon interview on 7/29/25 at 12:17 p.m. the director of nursing (DON) stated she was notified immediately of the medication error and the facility acted immediately with administering orange juice to R1 and calling for emergency medical services. The DON stated LPN-A had been suspended during the facility investigation, a pharmacy review had been completed, and nursing staff were re-educated before working with residents. In addition, R2 had a specialized order on her chart to have two nurses verify the five rights before the administration of her insulin since it was a high dose of short acting insulin, however R2 had been discharged from the facility on 7/27/25. Upon interview on 7/29/25 at 2:07 p.m. R1's family member (FM)-A stated she received a call from the facility that R1 was taken by ambulance to the emergency department because she had been given another residents insulin. Later that evening FM-A spoke with R1 and R1 told her she would be spending the night in the hospital. R1 told FM-A she did not give LPN-A consent to give the insulin it just happened so fast. FM-A stated the amount of short acting insulin could have killed R1 if R1 would not have cognitive enough to tell LPN-A she was not diabetic. FM-A also stated concerns after speaking with hospital staff that R1 had been tested for blood borne pathogens (infectious microorganisms such as bacterial or viruses that live in the blood) from the needle stick. FM-A was worried what those findings may result in. Upon interview on 7/29/25 at 3:53 p.m. LPN-A stated she was distracted when she administered insulin to the wrong resident. She was told by NA-A that another resident needed her, and it was urgent. LPN-A had already drawn-up R2's insulin when she checked on the unidentified resident. LPN-A then left the unidentified resident's room and answered a call light for R1 mistaking her for R2. LPN-A stated she apologized to R1 about being late with her medication and injected the insulin. LPN-A denied verifying R1's name. After she administered the insulin R1 asked what she have given her. LPN-A told her it was her insulin. R1 told LPN-A she was not on insulin and not diabetic. LPN-A immediately called the charge nurse and emergency medical services were notified. LPN-A stated she was suspended immediately following the medication error. A facility policy titled Medication Administration-General Guidelines with a revision date	F0760		

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NAME OF PROVIDER OR SUPPLIER **Ebenezer Ridges Geriatric Care Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **13820 COMMUNITY DRIVE , BURNSVILLE, Minnesota, 55337**	

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F0760 SS = G	Continued from page 4 of 6/13/25 indicated Residents are identified before medication is administered using two methods of identification, methods of identification include: -Checking residents name band -Asking a reliable resident for their first and last name -By referring to the photo attached to the electronic medical record (EMAR) -If necessary, verifying resident identification with other facility personnel.	F0760		

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Electronically delivered

August 4, 2025

Administrator

Ebenezer Ridge Geriatric Care Center
13820 COMMUNITY DRIVE
BURNSVILLE, MN 55337

Re: Event ID: 1D254D-H1

Dear Administrator:

The above facility survey was completed on July 29, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00756	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

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20000	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 7/29/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey. H52131067C / MN2570542	20000		

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00756	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		