Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 2, 2024

Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, MN 55337

RE: CCN: 245213
Cycle Start Date: May 13, 2024

Dear Administrator:

On June 14, 2024, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 23, 2024

Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, MN 55337

RE: CCN: 245213
Cycle Start Date: May 13, 2024

Dear Administrator:

On May 13, 2024, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 13, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by November 13, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 23, 2024

Administrator
Ebenezer Ridges Geriatric Care Center
13820 Community Drive
Burnsville, MN 55337

Re: Event ID: TCUR11

Dear Administrator:

The above facility survey was completed on May 13, 2024, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 _____	C 05/13/2024

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 On 5/13/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed, H52133670C/MN103190 with deficiencies issued at F550 & F692. In addition, a deficiency was issued at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		6/13/24

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

Electronically Signed | 05/28/2024

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 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to promote dignity and respect to 1 of 4 (R1) residents reviewed. R1 was not properly dressed when leaving her room for therapy services. R1 did not have an incontinent brief on and upon standing urinated on herself, her wheelchair, and the floor in the presence of other residents and staff.	F 550	F550 – Resident Rights/Exercise of Rights Corrective action as it applies to affected residents: R1 has discharged from the facility. Corrective Action as it applies to other potentially affected residents: All residents with incontinence of bowel or	

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F 550	Continued From page 2 Findings include: R1's admission Minimum Data Set (MDS) dated 4/30/24 indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required maximum assistance with toileting hygiene, showering and dressing. She required moderate assistance with rolling in bed, positioning from sitting to lying and she was dependent from sitting to standing with transfers. R1 was dependent in her manual wheelchair. R1 was frequently incontinent of urine and bowel. R1's pertinent diagnoses were cirrhosis of the liver, acute respirator failure with hypoxia, portal hypertension (increased pressure in the venous system), morbid obesity and type 2 diabetes mellitus with neuropathy (nerve damage from diabetes). R1's care plan dated 5/4/24 indicated R1 required the assistance of one staff member to dress and undress. R1 had actual impairment to her skin bilaterally on her buttocks. The intervention was to wear no incontinent brief while in bed and be gentle with peri-cares. The care plan did not indicate what R1 was to wear for incontinence protection when she was out of bed. In addition, the care plan did not indicate to use towels for incontinence concerns while R1 was in bed. Upon interview on 5/13/24 at 9:46 a.m. occupation therapy assistant (OTA)-A stated she would go to R1's room to get her out of bed for therapy. R1 would be dressed in a hospital gown per her choice. She stated when staff would stand her up towels that were placed between R1's legs would fall to the floor. She stated that	F 550	bladder have potential to be affected. The Dignity & Activities of Daily Living policies will be reviewed with all staff in all departments in mandatory in-service training sessions. Reoccurrence will be prevented by: Random audits of resident cares will be completed by the Director of Nursing or designee to assure dignity is maintained during patient cares. Therapy sessions will be audited by the Therapy Director or designee to assure treatment sessions preserve resident dignity and patient choice. The DON or designee will monitor for compliance periodically and report findings to the QAPI Committee for review and further recommendations to assure ongoing compliance. Persons responsible for compliance: Director of Nursing & Therapy Director Date of Completion: 6/13/24	

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F 550	Continued From page 3 the therapy staff did not put a brief on her stating that the responsibility of the nursing staff. OTA-A did recall an incident in therapy where her and another therapy staff member were assisting R1 to stand and upon standing R1 became incontinent of urine on herself, her wheelchair, and the floor in the therapy room. R1 was immediately sat down in her chair, as a fall prevention, then was wheeled back to her room. OTA-A left R1 in her room and notified the nursing staff to assist her to be cleaned up. Upon interview on 5/13/24 at 11:41 R1 stated she was usually taken to therapy without anything covering her peri-area. She stated she was o.k. with wearing a hospital gown if staff dressed her in two gowns, one to cover the front and one to cover the back of her body. She stated one day in therapy the staff assisted her to stand by the parallel bars and upon impact her bladder released, and she urinated on herself, her wheelchair, and the floor. She stated she was sat down in the urine saturated chair and taken back to her room for clean-up. She stated she humiliated as other residents witnessed the event and staff as well. In addition, R1 stated "some" staff would place towels between her legs since she urinated so much in bed requiring frequent bed changes. Upon interview on 5/13/24 at 11:50 a.m. R1's family member (FM)-A stated he visited R1 almost daily and was present the day she was incontinent of urine with no urinary protection in therapy. He stated he stayed with R1 all afternoon as R1 could not stop crying because she was so humiliated. Upon interview on 5/13/24 at 12:17 p.m.	F 550		

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F 550	Continued From page 4 registered nurse (RN)-A unit manager stated she was not aware of an incident where R1 became incontinent in therapy. She stated the therapy staff proceeded correctly after the incontinence episode by bringing R1 back to her room for nursing staff to clean her up. RN-A stated therapy staff can and should be dressing and making sure the residents leave their room in appropriate attire. She stated if they are uncertain of how to dress a person than they should ask the nursing staff. Upon interview on 5/13/24 at 12:29 p.m. RN-B stated she had worked with R1 and stated she was unaware that staff were placing towels between her legs and unaware or R1 was going to therapy without an incontinent brief on. She stated the facility uses blue pads that wick away moisture from incontinent patients to assist in avoiding bed changes. RN-B was unaware of the incontinence incident therapy, stating therapy staff should be putting an incontinence brief on a resident if they are not wearing one before taking them out of their room. Upon interview on 5/13/24 at 12:45 p.m. physical therapy assistant (PTA)-A stated RN would not wear an incontinent brief in bed and therapy would find her in bed with towels between her legs. She stated after the day R1 became incontinent during a therapy session she would make sure R1 had an incontinence brief on before taking her out of her room. Upon interview on 5/13/24 at 3:02 p.m. the director of nursing (DON) stated she was aware that R1 was to be left in bed without anything covering her peri-area for skin healing. She stated she would not expect staff to be placing	F 550		

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F 550	Continued From page 5 towels on R1, but rather be checking and changing her wicking pad. The DON stated that therapy has been trained and should be part of morning cares including insuring residents leave their room in proper attire. A facility policy titled Dignity with a revision date of 10/21 indicated the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This means staff must carry out activities which assists the resident to maintain and enhance his/her self-esteem and self-worth. Assisting residents to dress in their own clothes appropriate with time of day and individual preferences.	F 550		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		6/13/24

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F 692	Continued From page 6 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a systematic approach to assess and evaluate residents' fluid status to monitor the effectiveness of interventions for 2 of 2 residents (R1 and R3) assessed. R1 and R3 were on a daily fluid restriction, the facility was documenting the intake. The facility did not have a system in place to evaluate the total daily fluid intake to determine adequacy or if the provider required notification. Findings include: R1's nursing progress notes dated 4/24/24 - 5/7/24 did not include any documentation regarding R1's fluid restriction, except on 4/25/24 at 1:29 a.m. a note indicated "drank 300 cc." R1's physician orders dated 4/25/24 indicated P1 was on a fluid restriction of 1200 milliliters (ml) per day. 500 cubic centimeters (cc) day shift, 500 cc evening shift and 200 cc night shift. R1's care plan dated 4/26/24 indicated to monitor intake and record every meal. Staff was to provide and serve diet as ordered: Heart Healthy/regular textures and regular liquid. The care plan did not indicate R1 had a fluid restriction. R1's admission Minimum Data Set (MDS) dated 4/30/24 indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required maximum	F 692	F692 – Nutrition/Hydration Status Maintenance Corrective action as it applies to affected residents: R1 and R3 have discharged from the facility. Corrective action as it applies to other potentially affected residents: All residents on fluid restrictions are potentially affected. A new fluid restriction policy and procedure has been created and put into place. All staff will be educated on the fluid restriction policy at all staff in-services. If fluid intake patterns are outside of ordered parameters, nursing will contact the provider for further orders and treatment recommendations. All residents on fluid restriction will have their total intake between meals and med pass recorded on the treatment sheets daily. The night shift nurse assigned to the patient will be responsible for the totaling the daily volumes and alerting the provider of any concerns. Reoccurrence will be prevented by: Random audits of resident fluid intakes will be completed by the Dietary Manager or designee. Results of the findings will be forwarded to the QAPI Committee for review and further recommendations to assure ongoing compliance. Persons responsible for compliance: Director of Nursing & Dietary Department Date of completion: 6/13/24	

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F 692	Continued From page 7 assistance with toileting hygiene, showering and dressing. She required moderate assistance with rolling in bed, positioning from sitting to lying and she was dependent from sitting to standing with transfers. R1 was dependent in her manual wheelchair. R1 was frequently incontinent of urine and bowel. R1's pertinent diagnoses were cirrhosis of the liver, acute respiratory failure with hypoxia, portal hypertension (increased pressure in the venous system), morbid obesity and type 2 diabetes mellitus with neuropathy (nerve damage from diabetes). R1's Point of Care response history for the task of fluids consumed indicated: 4/24/24 240 cc at 8:03 p.m. 4/25/24 400 cc at 8:49 p.m. 4/26/24 150 cc at 10:13 a.m. and 250 cc at 2:26 p.m. 4/27/24 400 cc at 10:07 a.m. and 380 cc at 1:07 p.m. 4/28/24 400 cc at 11:31 a.m. and 370 cc at 2:44 p.m. and 360 cc at 8:31 p.m. 4/29/24 400 cc at 9:52 a.m. and 390 cc at 1:10 p.m. and 480 cc at 8:54 p.m. 4/30/24 380 cc at 10:04 a.m. 5/1/24 360 cc at 2:23 p.m. and 560 cc at 2:23 p.m. [sic] 5/2/24 360 cc at 10:01 a.m. and 240 cc at 1:53 p.m. and 200 cc at 8:55 p.m. 5/3/24 480 cc at 9:18 a.m. and 240 cc at 1:53 p.m. 5/4/24 360 cc at 10:01 a.m. and 240 cc at 1:53 p.m. and 200 cc at 8:55 p.m. 5/5/24 360 cc at 2:42 p.m. and 420 cc at 2:42 p.m. 5/6/24 240 cc at 9:21 a.m. and 220 cc at 1:42 p.m. and 240 cc at 10:37 p.m. 5/7/24 400 cc at 9:33 a.m.	F 692		

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F 692	Continued From page 8 R1's electronic treatment record (eTAR) dated 4/25/24 - 5/7/24 indicated R1's fluid intake was: 4/25/24 200 cc on the p.m. shift and 200 cc on the night shift 4/26/24 500 cc on the a.m. shift and 500 cc on the p.m. shift and 150 on the night shift 4/27/24 500 cc on the a.m. shift and 240 cc on the p.m. shift and 150 cc on the night shift 4/28/24 240 cc on the a.m. shift and 240 cc on the p.m. shift and 200 cc on the night shift 4/29/24 280 cc on the a.m. shift and 480 cc on the p.m. shift and 200 cc on the night shift 4/30/24 400 cc on the a.m. shift and 480 cc on the p.m. shift and 120 cc on the night shift 5/1/24 500 cc on the a.m. shift and 80 cc on the p.m. shift and 120 on the night shift 5/2/24 500 cc on the a.m. shift and 80 cc on the p.m. shift and 120 cc on the night shift 5/3/24 240 cc on the a.m. shift and 110 cc on the p.m. shift and 200 cc on the night shift 5/4/24 500 cc on the a.m. shift and 200 cc on the p.m. shift and 200 cc on the night shift 5/5/24 480 cc on the a.m. shift and 400 cc the p.m. shift and 200 on the night shift 5/6/24 480 cc on the a.m. shift and 400 cc on the p.m. shift and 100 cc on the night shift R1's Hospital emergency department (ED) note dated 5/7/24 at 11:11 a.m. indicated R1's chief complaint was abdominal pain. R1 had a history of pleural effusion (build-up of fluid between the lungs), and liver cirrhosis with ascites (fluid build-up in the abdomen) who presented to the ED for abdominal pain and bloating. On 5/7/24 at 12:00 p.m. R1 was diagnosed with severe sepsis (a life-threatening infection). R1's other admission to the hospital diagnoses were portal vein thrombosis, acute urinary tract infection, liver	F 692		

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F 692	Continued From page 9 cirrhosis and pleural effusion. Clinically significant risk factors were hyperkalemia (high potassium in the blood), hypercalcemia (high calcium in the blood), hypoalbuminemia (a condition when the body doesn't produce enough albumin protein that's responsible for keeping fluid in your blood vessels). Upon interview on 5/13/24 at 11:46 a.m. R1 stated she was still in the hospital stating she had been admitted with portal vein hypertension, a urinary tract infection and a "bunch of my labs were off." R1 stated she did not understand how the facility was managing her fluid restrictions. She stated no one talked to her about it, other than one unidentified nursing assistant (NA) told her that the fluids on her meals were planned out. R3's eTAR dated 4/14/24 - 5/13/24 indicated R3 had an order for a 1200 cc fluid restriction. The nursing staff did not documentation how much fluid R3 consumed during the shift. The nursing staff only checked the boxes indicating the fluid restriction was administered. R3's nursing progress notes reviewed from 4/4/24 - 5/13/24 did not have any documentation of a fluid restriction or intake measures. R3's care plan dated 4/8/24 indicated R3 was at risk for nutritional altercation related to dialysis. R3 had a renal-dialysis diet. Staff was to monitor food and fluid intake at meals and monitor for signs of dehydration. R3's care plan did not indicate any fluid restrictions. R3's Point of Care Response History for the tasks of fluid consumed dated 4/14/24 - 5/13/24 indicated:	F 692		

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F 692	Continued From page 10 4/14/24 480 cc at 10:11 a.m. and 480 cc at 1:59 p.m. and 550 cc at 10:19 p.m. 4/15/24 R3 not available in the a.m. and 200 cc at 1:04 p.m. 4/16/24 300 cc at 9:38 a.m. and 300 cc at 1:10 p.m. 4/17/24 R3 not available in the a.m. and 500 cc at 10:28 p.m. 4/18/24 360 cc at 11:00 a.m. and 360 cc at 2:12 p.m. and 300 cc at 10:13 p.m. 4/17/24 R3 not available in the a.m. and 500 cc at 10:28 p.m. 4/18/24 360 cc at 11:00 a.m. and 360 cc at 2:12 p.m. and 300 cc at 10:13 p.m. 4/19/24 R3 not available in the a.m. and 120 cc at 2:24 p.m. 4/20/24 480 cc at 11:04 a.m. and 240 cc at 2:21 p.m. and 120 cc at 7:08 p.m. 4/21/24 480 cc at 9:14 a.m. and 480 cc at 2:24 p.m. and 120 cc at 7:18 p.m. 4/22/24 R3 not available in the a.m. and 300 cc at 12:53 p.m. and 120 cc at 7:08 p.m. 4/23/24 300 cc at 9:17 a.m. and 300 cc at 1:03 p.m. and 120 cc at 7:39 p.m. 4/24/24 R3 not available in the a.m. and 200 cc at 1:18 p.m. and 500 cc at 10:05 p.m. 4/25/24 380 cc at 10:07 a.m. and 280 cc at 1:48 p.m. and 120 cc at 7:09 p.m. 4/26/24 R3 not available in the a.m. and 360 cc at 1:55 p.m. and 120 cc at 7:26 p.m. 4/27/24 240 cc at 1:17 p.m. and 180 cc at 1:18 p.m. and 120 cc at 6:32 p.m. 4/28/24 300 cc at 9:11 a.m. and 300 cc at 2:10 p.m. and 500 cc at 10:57 p.m. 4/29/24 R3 not available in the a.m. and 240 cc at 2:05 p.m. 4/30/24 300 cc at 9:10 a.m. and 300 cc at 2:10 p.m. and 550 cc at 10:57 p.m. 5/1/24 R3 not available in the a.m. and 300 cc at	F 692		

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F 692	Continued From page 11 2:22 p.m. and 120 cc at 6:46 p.m. 5/2/24 R3 not available in the a.m. and 240 cc at 1:12 p.m. and 120 at 8:02 p.m. 5/3/24 R3 not available in the a.m. and 250 cc at 2:11 p.m. 5/4/24 480 cc at 11:21 p.m. and 240 cc at 2:13 p.m. and 120 cc at 7:17 p.m. 5/5/24 390 cc at 9:08 a.m. and 400 cc at 2:14 p.m. 5/6/25 R3 not available in the a.m. and 300 cc at 1:07 p.m. 5/7/24 300 cc at 9:04 a.m. and 300 cc at 1:32 p.m. and 120 cc at 8:09 p.m. 5/8/24 R3 not available in the a.m. and 300 cc at 2:23 p.m. and 500 cc at 6:00 p.m. 5/9/24 360 cc at 10:48 a.m. and 200 cc at 2:01 p.m. and 120 cc at 7:46 p.m. 5/10/24 R3 not available in the a.m. and 120 cc at 7:11 p.m. 5/11/24 240 cc at 12:55 p.m. and 120 cc at 12:55 p.m. and 550 cc at 10:00 p.m. 5/12/24 300 cc at 8:59 a.m. and 300 cc at 1:02 p.m. and 550 cc at 6:12 p.m. 5/13/24 R3 not available in the a.m. R3's quarterly MDS dated 4/9/24 indicated R3 had a BIMs score of 15 indicating she was cognitively intact. R3 required extensive assistance with bed mobility and total dependence for transferring. R3's pertinent diagnoses were Asthma, respiratory failure, end stage renal disease and congestive heart failure. R3's clinical physician order dated 4/30/24 indicated R3 had a fluid restriction of 120 ml at nighttime, 180 ml in the a.m. and p.m. and 240 ml with meals. Upon interview on 5/13/24 at 1:23 R3 stated she	F 692		

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F 692	Continued From page 12 wasn't certain how the facility monitored her fluid intake. She stated she has never had a discussion from the nursing or dietary department. R3 was a former health care professional and stated she watches her intake on her own. Upon interview on 5/13/24 at 1:45 p.m. LPN-A stated the nursing staff enforce fluid restriction by educating the residents and the nursing assistants. She was uncertain who is responsible for auditing the total daily intake and reporting to the provider if there are concerns. Upon interview on 5/13/24 at 1:54 p.m. RN-A the unit manager stated she was uncertain who manages the fluid restrictions. She stated, "I think dietary does." Upon interview on 5/13/24 at 2:02 p.m. the assistant dietary manager stated the facility does not have a dietician currently, so the corporate dietician provides direction to the facility. She stated the Point of Care forms are where the NA's document after resident eats. The kitchen supplies fluid restriction residents with the order provided on their trays. She stated the eTAR where the nursing staff document the resident fluid intake with their medication administration. The manager was uncertain who monitored the fluid restrictions daily. Upon interview on 5/13/24 at 3:02 p.m. the director of nursing (DON) stated the dieticians are responsible for watching for an increase in fluid concerns with the residents. She stated the dialysis department watches the fluid levels for R3. The DON stated if the nursing staff were to notice any symptoms of a fluid concerns for a	F 692		

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F 692	Continued From page 13	F 692		

resident, they would report the concern to the dietician and/or the provider. The DON was unable to provide daily fluid totals for R1 or R3.

Upon interview on 5/13/24 at 3:46 p.m. the corporate registered dietician (RD)-A stated she was new to her role and was not completely familiar with the process of fluid restriction. She stated she is aware the kitchen follows the restriction orders when placing beverages on the meal trays. She was not certain who was to be watching fluid restrictions "at the end of the day." She stated she looks closely at the resident assessment and completes her own assessment quarterly for the MDS. The RD attempted to run a report on the Point Click Care (the facilities software system) to find daily intake totals and stated, "I can't find this, it would be helpful, this is a concern."

A facility policy titled Intake and Output Monitoring revision date of 12/13 indicated.
-Enter Resident name and/or identification on the daily intake and output record.
-Measure and record all liquids ingested.
-Estimate and record ice and foods that becomes liquid at room temperature (i.e., ice cream, Jello).
-Instruct Resident to urinate in bedpan, urinal, or collection graduate in toilet.
-Measure urine and record amount on individual record.
-If any bleeding, emesis, diarrhea, or drainage occurs, measure and record as output.
-When enteral nutritional therapy, or intravenous fluid is administered record amount on individual record.
-The intake and output are to be totaled and recorded in medical record every shift.
-Intake and output are totaled every twenty-four

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F 692	Continued From page 14 hours. -The total I & O is placed in the Resident's medical record. -The nurse is responsible to evaluate the total I & O per shift. If the intake and output is not adequate, notify the MD/NP. -Take action per physician orders. -Licensed nurses will evaluate the resident's I & O on a 24-hour bases and weekly basis to determine adequacy.	F 692		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		6/13/24

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F 880	Continued From page 15 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow recommended precaution process for disinfecting medical equipment between resident use for 1 of 1 resident (R4) when observed. Licensed staff failed to disinfect the vital signs machine following the use on R4 who was on contact precautions and then used on another resident. In addition, the facility had placed R4 on incorrect isolation precautions. R4 was found to be on precautions due to suspicion of Covid requiring droplet precautions and he was on contact precautions. Findings include: Upon observation on 5/13/24 at 8:19 a.m. licensed practical nurse (LPN)-A was taking vital signs in R4's room. R4 had a cart with gowns, gloves, hand sanitizer and masks out of side of his room. The sign on the wall indicated R4 was on contact precautions that required staff to cleanse hands before entering and exiting room, don gloves and a gown when in room and discard before exiting the room. In addition, the staff were to use dedicated or disposable equipment or clean and disinfect reusable equipment before use on another person. LPN-A wheeled the vital sign machine out P4's room and placed the machine by the medication cart without sanitizing it. Upon observation and interview on 5/13/24 at 8:28 a.m. LPN-A wheeled the same vital sign machine into an unidentified resident's room and proceeded to take her vitals signs. LPN-A stated she usually wipes down the machine between each resident but was having a busy morning and	F 880	F880 – Infection Control Corrective action as if applies to affected residents: R4 has discharged from the facility. Corrective action as it applies to other potentially affected residents: All residents are potentially affected. Infection control policies and procedures related to types of precautions including airborne, transmission-based, contact/droplet and enhanced barrier precautions and sanitizing of reusable equipment will be reviewed at all staff in-services with all departments. Reoccurrence will be prevented by: The policy for Vital Tower/Blood Pressure Cuff Disinfection was reviewed and revised. Random audits of equipment sanitation and precaution signage will be completed by the Infection Preventionist or designee. If infection control breaches are noted during these observations, staff will receive immediate feedback and re-education. Persons responsible for Compliance: Infection Preventionist and Director of Nursing Date of Completion: 6/13/24	

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F 880	Continued From page 17 realized she should have disinfected it. LPN-A was not certain why R4 was on contact precautions. She stated, "I think because he is a new admit." LPN-A stated the facility "constantly" had Covid-19 outbreaks. Upon observation on 5/13/24 at 8:37 a.m. LPN-B used a vital sign machine on an unidentified resident room. The resident was on contact precautions. LPN-B did not sanitize the machine prior to taking the vitals signs. LPN-B placed the vital signs machine by her medication cart without disinfecting it after use. There is not an observation of LPN-B, or another staff member using the unsanitized machine on another resident. R4's nursing progress notes dated 5/10/24 - 5/13/24 did not indicate reason R4 was on contact isolation precautions. R4's care plan dated 5/13/24 indicated R4 had a localized infection that does not require precautions. R4's admission minimum data set (MDS) dated 5/16/24 was in progress, no isolation data identified. Upon interview on 5/13/24 at 7:52 a.m. the Administrator stated the facility is in Covid-19 outbreak and the facility had 11 cases between two units. Upon interview on 5/13/24 at 3:02 p.m. the director or nursing (DON) stated she was uncertain why R4 was on contact precautions. She stated the expectation of the staff is to disinfect equipment after use on each patient.	F 880		

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F 880	Continued From page 18 She stated ideally equipment would be disinfected before and after each use. Upon interview on 5/13/24 at 3:58 p.m. the infection preventionist (IP) stated R4 admitted with suspicions of Covid-19 since he was a new admission from a hospital setting. The IP was uncertain which precautions R4 was on. She stated R4's Covid test came back on 5/13/24 as negative so he could be taken off any precautions for Covid-19, however, would be assessed for enhanced barrier precautions due to a new pacemaker and surgical wound. A facility policy titled Transmission/Isolation precautions dated 11/1/23 indicated: DROPLET: Examples; Influenza, Mumps, Respiratory Disease, COVID-19, Mpox Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 mm in size) containing microorganisms generated from a person who has a clinical disease or is a carrier of the disease. Droplets are generated from the source person primarily during coughing, sneezing, talking, Transmission of large-particle droplets requires close contact between source and recipient persons. Private room and when a private room are not available, cohort with patient(s) who has active infection with the same microorganism but with no other infection. Perform hand hygiene. Mask, face shield/goggles, gown and gloves required prior to entering room. Isolation gowns must be impermeable to fluids. N95 mask to be worn when providing care for COVID-19 positive or suspected COVID-19 positive residents or unvaccinated residents during COVID-19	F 880		

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F 880	Continued From page 19 outbreak and with Mpox positive or suspected Mpox residents. -Remove PPE before leaving the patient's room. -Perform hand hygiene. -Eye protection should only be removed and reprocessed if it becomes visibly soiled or difficult to see through. -Use disposable equipment or patient dedicated equipment to stay in patient room if possible, disinfect between patient use, follow product wet times. -Limit the movement/transport of patients from room to essential purposes only. Place a universal mask on patient if possible, during transportation. -Maintain at least 6 feet from other patients and visitors when possible.	F 880		

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/13/24, 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. H52133670C/MN103190	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00756	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	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.	2 000		