Electronically delivered
October 12, 2022

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

RE: CCN: 245213
Cycle Start Date: October 3, 2022

Dear Administrator:

On October 3, 2022, 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 immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

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).

REMOVAL OF IMMEDIATE JEOPARDY

On October 3, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

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 $11,292; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 3, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Ebenezer Ridges Geriatric Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 3, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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, Rapid Response Unit Supervisor

Metro 1, Golden Rule Office
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: 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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 10/03/2022

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 9/29/22, 9/30/22, 10/3/22, 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 SUBSTANTIATED at F689 for PAST NON-COMPLIANCE. H52134751C (MN86999) The following complaints were found to be UNSUBSTANTIATED: H52134796C (MN86999) & H52134873 (MN87106). Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of three residents (R2) was free from accidents and received adequate	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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 689	Continued From page 1 assistance when R2 was transferred by two staff in a mechanical lift with the wrong size and type of sling. R2 fell through the sling to the floor. As a result of the identified noncompliance, immediate Jeopardy (IJ) was called due to the risk of serious injury, serious harm, serious impairment that was likely to occur. The immediate jeopardy began on 9/23/22, when the facility failed to use the correct size and type of sling for a mechanical lift transfer and R2 fell to the floor. The administrator and the director of nursing (DON) were notified of the immediate jeopardy at 1:30 p.m. on 10/3/22 The immediate jeopardy was removed, and the deficient practice was corrected on 9/25/22, prior to the start of the survey, therefore was issued at Past Noncompliance. Findings include: R2's Pain Interview & Evaluation assessment form dated 9/7/22, noted R2 denied pain at the time of assessment but would occasionally say "ouch" if her legs are moved. R2's quarterly Minimum Data Set (MDS) dated 9/8/22, noted R2 required total dependence and two staff for transfers from surface to surface and her diagnoses included: late onset Alzheimer's disease and age-related physical debility. A progress note dated 9/23/22, indicated R2 had fallen through the Hoyer (Mechanical lift) sling onto the floor while being transferred from the bed to her wheelchair, the floor nurse and nurse practitioner assessed the resident for injury, vital signs, and felt it safe to lift the resident from the floor using the Hoyer. The note identified an	F 689		

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F 689	Continued From page 2 abrasion to the right rear shoulder, a mid/upper back abrasion, and identified the root cause of the fall to be improper fitting of the Hoyer sling before transfer. A Nursing Home Visit form dated 9/23/22, indicated the nurse practitioner provided a visit for assessment following the report of a fall and presumed head strike. The nurse practitioner noted R2 appeared comfortable and denying pain, no gross deformity noted upon exam, but noted R2 did say "ow" with passive left leg raise, there were no bruises but small superficial abrasions on the left shoulder and scattered midline along the spine. The nurse practitioner noted upon repeat exam with MD present, R2's left leg pain had resolved. An incident report dated 9/23/22, indicated R2 fell through the Hoyer sling to the floor, R2 was assessed for injury by nurse, nurse practitioner, and was lifted from the floor to the bed with assist of four staff. The form noted abrasions to the upper-mid back area as well to the left rear shoulder. A fall risk assessment form dated 9/23/22, noted R2 was not a high risk for falls. R2's care plan revised on 9/23/22, noted R2 required mechanical lift with two staff assistance for transfers. A Pain Interview & Evaluation assessment form dated 9/24/22, noted R2 denied pain at the time of assessment and did not have any complaints of pain with rolling or turning in bed. An undated written statement from NA-A	F 689		

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F 689	Continued From page 3 indicated she got the resident ready for the day and went to get assistance from another nursing assistant to transfer R2. The statement noted as they were getting R2 near her wheelchair, she slipped through the sling. The statement noted the nurse mentioned that the sling does not belong to R2 and that NA-A got the sling from R2's wheelchair. An undated written statement from a nursing assistant that provided assist with the transfer indicated she latched the sling to the machine and was guiding the resident towards he chair when R2 fell through the sling to the floor. During an interview on 9/30/22, at 8:42 a.m. nursing assistant (NA)-A stated she was originally assigned to a different group of residents and oriented to that group by a seasoned staff member but had to be reassigned due to someone calling in sick and was not oriented to the new group of residents. NA-A assisted R2 that morning to get ready for the day, she stated she could not find R2's Hoyer sling in the her room so she went into the hallway where resident wheelchairs are kept and found a sling on R2's wheelchair in the hall. NA-A stated it was common that residents had their own Hoyer slings but that the slings were not labeled. NA-A stated she had been assigned to work at the facility by her agency for about 3 months and had never cared for this group of residents before. NA-A stated she had primarily worked on the transitional care unit (TCU) and felt most comfortable on that unit, she had heard that the residents on R2's floor were more challenging and informed the scheduler at the facility she preferred the TCU but was assigned where the facility needed her. NA-A stated she positioned	F 689		

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F 689	Continued From page 4 the sling under R2, she hooked her up to the Hoyer lift and went to get help. NA-A stated she and another aide then used the machine to lift R2 from the bed and as they were moving the machine towards R2's wheelchair, R2 slid through the sling and fell onto the floor. NA-A stated the sling she used was different than other slings but that she thought it was appropriate for R2 because it had a shorter width and R2 is of smaller stature. NA-A stated following the incident the administrator and director of nursing (DON) asked her some questions and then asked her to leave, she had not been back to the facility since the incident. NA-A stated it was the wrong sling, it should not have been in the resident's chair and that she encouraged the administrator and DON to label the slings to each resident to prevent incidents in the future. NA-A stated "it was a miracle that she wasn't hurt, it wasn't a gentle fall." During an interview on 9/29/22, at 5:04 p.m. the nurse manager (NM)-A stated typically Hoyer slings are kept in resident rooms, they are not labeled, and are planning to go to a different system. NM-A stated slings are typically in resident rooms but they are not labeled. NM-A stated the sling used during the transfer for R2 was an "over the commode" sling, she had no idea where that sling could have come from and that there was only one resident that uses a commode sling for transfers, but her room was not nearby. NM-A stated in that instance she would have expected the nursing assistant to rely on critical thinking and that she should have noticed something didn't look right and the sling was too big. NM-A stated nursing assistants can refer to the care plan within the electronic medical record (EMR), the two staff involved were agency	F 689		

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F 689	Continued From page 5 staff, one had been on that floor once prior and the other had never been there before. NM-A stated when new agency staff were assigned she would verbally orientate them to the group they are assigned to in regards to transfer status and that they will go over the care sheet which includes where the resident eats and whether they require feeding assistance, she stated the facility will be implementing new group sheets but has not yet, the new group sheets will not identify the sling that should be used and that the nursing assistants should use the resident's weight in selecting sling size prior to any transfers. NM-A stated R2 was not injured during the transfer and that she "can't even fathom the fact" that R2 didn't have any injuries, R2 now has her Hoyer sling listed in her care plan because it is a specialty sling that includes a head rest. NM-A stated the facility has since placed laminated sheets on the mechanical lifts for staff to be able to identify the correct sling based on the resident weight. During an interview on 9/30/22, ay 9:22 a.m. NA-B stated she is an agency staff member and is assigned everywhere throughout the building and that the facility gives verbal report on the basics such as how a resident transfers and level of assistance but feels as though she gets "kind of thrown in". NA-B stated she thought that when she worked on the 3rd floor recently she noted there were new care sheets that identified transfer status but not sling size. NA-B stated when she was first assigned to the facility she did not have a login to the residents EMR system and that she was unsure how she would find the resident weight as she didn't think it was on a residents printed care plan in their rooms but would ask the nurse now that there had been	F 689		

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F 689	Continued From page 6 recent education on selecting sling size based on resident weight. During and interview on 9/30/22, at 9:36 a.m. the NM-B stated she had initiated new group sheets on her floor that include transfer status and level of assistance with transfers since the incident, the sheets used before did not have the transfer status listed on them . NM-B stated she had thought about adding the sling size to the care sheet but that staff can also look at the printed care plan in the resident room to see transfers status but noted it did not include sling size or weight. NM-B stated staff can ask the nurse or look in the EMR for resident weights in order to identify which sling size to use and that for new agency staff they are supposed to come in 30 minutes prior to the start of their shift to get assigned a login to the EMR system. NM-B stated she expected all staff to find out a resident weight prior to transfer with a mechanical lift and that the nurses should be coordinating with them and telling them. NM-B stated they have now implemented a daily 2:30 p.m. huddle where they go through resident care and weights. During an interview on 9/30/22, at 11:50 a.m. the director of nursing (DON) stated the wrong sling was used for transferring R2 resulting in a fall to the floor. The DON stated prior to her coming to the facility, they had nursing students that were there trying to help size slings and that they performed audits on how many slings per floor. The facility wanted to be sure they had one dedicated sling per resident and that was reviewed on a quarterly basis. The DON stated prior to the incident, staff would need to go by the manufacturer guidance and should have been weight based, and she was not sure what kind of	F 689		

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F 689	Continued From page 7 training was provided. A facility policy titled Mechanical Lift last revised on 3/18/20, noted staff should choose the appropriate sling for the resident's weight and to refer to the manufacturer's instructions for specific color sling for each weight requirement. The past noncompliance immediate jeopardy began on 9/23/22. The immediate jeopardy was removed and the deficient practice corrected by 9/25/22, after the facility implemented a systemic plan that included the following actions: R2's specific sling size and type is listed in banner of EMR and in care plan, laminated images of correct slings/sizing guides and tied them to the mechanical lifts, confirmed the two nursing assistants received training in mechanical lifts from their staffing agency, nursing staff education on selection of sling size and use of mechanical lifts, inspecting all mechanical lifts, and slings for proper sizing and function, resident care plans reviewed to ensure proper transfer status, onboarding training documents reviewed, audits on resident transfers and use of proper sling size.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 12, 2022

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

Re: Event ID: PNJS11

Dear Administrator:

The above facility survey was completed on October 3, 2022 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 10/03/2022

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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 9/29/22, 9/30/22, & 10/3/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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

Electronically Signed

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 10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER RIDGES GERIATRIC CARE CENTE	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) COMPLETE DATE
2 000	Continued From page 1 UNSUBSTANTIATED: H52134796C (MN86999) & H52134873C (MN87106). The following complaint was found to be SUBSTANTIATED: H52134751C (MN87076), however NO licensing orders were issued. 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		