



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 29, 2026

Administrator
Ebenezer Integrated Care & Rehab
45 WEST 10TH STREET
SAINT PAUL, MN 55102

RE: CCN: 245587

Cycle Start Date: December 5, 2025

Dear Administrator:

On December 16, 2025, we notified you a remedy was imposed. On January 13, 2026 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 17, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 5, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 16, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 5, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 17, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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December 16, 2025

Administrator
Ebenezer Integrated Care & Rehab
45 WEST 10TH STREET
SAINT PAUL, MN 55102

RE: CCN: 245587
Cycle Start Date: December 5, 2025

Dear Administrator:

On December 5, 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).

This survey also found other 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), whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 5, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 5, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 5, 2026.

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

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

- 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 \$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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 5, 2026. 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.

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:

**Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728**

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 5, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

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,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

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



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December 16, 2025

Administrator
Ebenezer Integrated Care & Rehab
45 WEST 10TH STREET
SAINT PAUL, MN 55102

Re: Event ID: 1DD3BB-H1

Dear Administrator:

The above facility survey was completed on December 5, 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,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Ebenezer Integrated Care & Rehab			STREET ADDRESS, CITY, STATE, ZIP CODE 45 WEST 10TH STREET , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>On 12/4/25-12/5/25, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H55877662C (2666638) with deficiencies cited at F880 and F689 at Past Non-Compliance</p> <p>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.</p> <p>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.</p>	F0000		12/17/2025
F0689 SS = G	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to follow care plan interventions required to provide safe transfers for 1 of 3 residents (R1) who</p>	F0689	"Past Noncompliance - no plan of correction required"	12/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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
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F0689 SS = G	<p>Continued from page 1 required the use of a walker, gait belt, wheelchair and assist of one staff for transfer assistance. This resulted in actual harm when R1 was ambulated without contact guard assist and a wheelchair behind her, fell, and sustained a fracture of the shoulder. The facility implemented corrective action prior to the start of the survey, so therefore, the deficiency was issued at Past Noncompliance.</p> <p>Findings include:</p> <p>R1's face sheet dated 12/4/25, indicated R1 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) following unspecified cerebrovascular disease affecting right dominant side, acute on chronic diastolic heart failure, chronic obstructive pulmonary disease, type II diabetes, and atrial fibrillation.</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 10/7/25, indicated R1 was cognitively intact and was dependent on staff for assistance with activities of daily living (ADL) including transfers and toileting.</p> <p>R1's ADL care plan focus last revised on 10/9/25 identified R1 had a self-care performance deficit due to weakness, deconditioned and stroke with left side hemiparesis. R1's transfer care plan dated 8/26/25 directed staff to transfer R1 with an assist of one with a transfer belt and two wheeled walker.</p> <p>R1's therapy to nursing communication, dated 10/7/25 directed R1 required the assist of 1 with the gait belt and the wheelchair to follow. Comments included contact guard assist and bilateral knee braces. Walk 1 time day to dining room and back with one seated rest break, contact guard assist and bilateral knee braces on.</p> <p>R1's progress note dated 11/10/25 at 2:05 p.m., indicated that a nursing assistant reported to a nurse that while assisting R1 with toileting, the resident lost balance and fell while being assisted to sit in the wheelchair using a gait belt and a walker. The new intervention identified staff "is now using the current care plan." The nurse practitioner was notified and an order for an x-ray of the left shoulder was placed.</p> <p>R1's imaging results, dated 11/10/25 identified R1 had acute comminuted fracture (severe fracture with several breaks) of the proximal humerus (upper arm bone) which involves the surgical neck and greater tuberosity prominent bony landmark of the humerus), with mild displacement. There is normal joint alignment. Mild glenohumeral (shoulder joint) and severe</p>	F0689		

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F0689 SS = G	<p>Continued from page 2 acromioclavicular joint degeneration (where the shoulder meets the clavicle) changes. Osteopenia aortic atherosclerosis.</p> <p>R1's progress note dated 11/10/25 at 11:35 p.m., indicated the x-ray results were received and included the results as identified per the imaging result.</p> <p>R1 progress note dated 11/11/25 at 9:52 a.m., indicated the interdisciplinary team met to discuss R1's fall. The note indicated the care plan was not followed. The resident was transferring from toilet to her wheelchair by ambulation when care plan designates the resident is "pivot stand transfer" (sic-inconsistent with the care plan). The wheelchair was not positioned next to the resident during the attempted transfer. Resident's legs became weak when attempting to ambulate to her wheelchair outside the bathroom door and resident fell. Fall resulted in shoulder fracture. The new intervention included educating staff about current care plan, R1's walking program was discontinued. Requested and received orders for physical therapy to evaluate transfers, fall and pain management.</p> <p>R1's transfer intervention last revised 11/11/25 directed staff R1 required assist of two with a mechanical lift, medium sling size. The care plan had a focus section about R1's limited physical mobility due to weakness, deconditioned, poor balance, unsteady gait and a history of stroke with left side hemiparesis. Interventions included:</p> <ul style="list-style-type: none"> -Ambulation: resident does not walk. Not dated. -Escort in wheelchair to destinations. Not dated. -Non-weight bearing left shoulder, at least x 6 weeks. Not dated. -Non weight bearing left arm. Dated 11/10/25. -Shoulder Immobilizer to left arm at all times, remove daily for hygiene. Dated 11/26/25. <p>During an interview on 12/5/25 at 8:31 a.m., nursing assistant (NA)-C stated she was taking R1 to the bathroom Around 2:00 p.m., NA-C said she was new, and it was her first solo day on the unit. NA-C explained on 11/10/25 R1 was in bed and needed to use the bathroom. NA-C put the gait belt around R1's waist, R1 stood up, pivoted and transferred to the wheelchair, was brought to the toilet, R1 stood, pivoted and transferred onto the toilet. R1 was provided privacy,</p>	F0689		

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F0689 SS = G	<p>Continued from page 3 five minutes later NA-C returned. NA-C couldn't get the wheelchair to fit in the bathroom with the walker. NA-C held her gait belt, R1 stood up and NA-C pulled the walker closer. R1 had to take a few steps while NA-C pulled the wheelchair closer. While NA-C was pulling the wheelchair closer R1 became unsteady. NA-C helped lower her to the ground and went to get help. NA-C was re-educated to follow the care plan and to ask for help if needed. NA-C stated she was re-educated that the wheelchair would fit in the bathroom when the foot pedals were removed. NA-C stated she felt really bad and apologized to R1 and R1's family member.</p> <p>During an interview on 12/5/25 at 9:03 a.m., the nurse manager (NM)-A stated she did the staff re-education following R1's fall and was in the interdisciplinary team meeting. The education that was provided to the nursing assistant and other staff was about following the care plan and completing safe transfers. There were ongoing audits to observe staff completing transfers beginning 12/5/25 and were ongoing at the time of the survey.</p> <p>During an interview on 12/5/25 at 10:00 a.m., the administrator stated R1 was transferring from the toilet to the wheelchair and there was not an option based on where the wheelchair was positioned for her to complete the stand pivot transfer which is what was in her care plan. R1 took a few steps, lost her strength when trying to get to the wheelchair and fell. The nursing assistant helped lower her to the floor with the gait belt. Nurses were alerted and staff got her up from the floor with a full body mechanical lift. The nursing assistant was pulled from the schedule following the incident, was interviewed and re-educated one where to find the care plan and to make sure she understands what she was doing before she does it. Further education was provided to a wider group of staff. Audits were implemented for transfer statuses.</p> <p>The facility policy Vulnerable Adult Abuse Prohibition last revised 10/24, directs that Ebenezer skilled nursing facilities have zero tolerance for resident or patient abuse, neglect or exploitation or mistreatment. The goal is to provide residents with a safe and secure environment free from maltreatment.</p> <p>The facility policy Transfer Techniques Patient Assist last revised 4/2025, directs that staff should follow the care plan or the Kardex when transferring patients.</p> <p>The Past Noncompliance began on 11/10/25. The deficient practice was corrected by 11/11/25, after the facility</p>	F0689		

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F0689 SS = G	Continued from page 4 implemented a systemic plan that included the following actions: immediate education on safe transfers and following the care plan. Audits completed by nursing leadership for review of safe transfers. Interviews with staff on 12/4/25 confirmed knowledge of facility policies. Observation of transfers on 12/4/25 demonstrated compliance with following the care plan for transfers.	F0689		
F0880 SS = D	<p>Infection Prevention & Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control</p> <p>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.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p>	F0880	<p>F880 Infection Control</p> <p>Corrective Action: Staff caring for R 2 and R3 were re-educated on the Hand Hygiene and Enhanced Barrier Precautions policies.</p> <p>Corrective Action as it applies to other residents: Nursing staff were re-educated on the policies for Hand Hygiene and Enhance Barrier Precautions. The policies for Hand Hygiene and Enhanced Barrier Precautions were reviewed and remain current.</p> <p>Reoccurrence will be prevented by: Random observational audits for Hand Hygiene and PPE use in regards to Enhance Barrier Precautions will be completed by the Director of Nursing or designee. The facility will conduct weekly audits for four (4) weeks. Beginning on the fifth (5) week the facility will conduct monthly audits for three (3) months.</p> <p>Results of the audits will be brought to the QAPI committee meeting for review and further recommendations.</p> <p>Date of completion: January 9, 2026</p> <p>The correction will be monitored by: The Director of Nursing or Designee</p>	12/17/2025

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NAME OF PROVIDER OR SUPPLIER Ebenezer Integrated Care & Rehab			STREET ADDRESS, CITY, STATE, ZIP CODE 45 WEST 10TH STREET , SAINT PAUL, Minnesota, 55102	
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F0880 SS = D	<p>Continued from page 5</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on document review, interview and observation, the facility failed to implement proper infection control when three staff were observed not following enhanced barrier precautions or hand hygiene during direct care for 2 of 4 (R3, R4, R5) residents reviewed for infection prevention.</p> <p>Findings include:</p> <p>Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents know to be infected with multi-drug-resistant organisms as well as those at increased risk of multi-drug resistant organism acquisition (residents with wounds or indwelling medical devices)</p>	F0880		

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F0880 SS = D	<p>Continued from page 6</p> <p>R2's face sheet dated 12/4/25, indicated R2 had diagnoses of cellulitis of unspecified part of limb, lymphedema (swelling), need for assistance with personal care, type II diabetes and rhabdomyolysis (breakdown of skeletal muscle tissue).</p> <p>R2's admission Minimum Data Set (MDS) assessment dated 11/27/25, indicated R2 was moderately cognitively impaired and dependent on staff for activities of daily living, including transfers.</p> <p>R2's care plan dated 12/4/25, had a focus section, "Enhanced barrier precautions indefinitely due to wounds." The interventions listed included gloves and gown prior to the high-contact care activity. High-contact resident care activities such as but not limited to: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use for central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care. R2's order set lacked orders for enhanced barrier precautions.</p> <p>During an observation on 12/4/25 at 8:54 a.m., R2 was in bed and was waiting for assistance with a transfer to his wheelchair. R2 had an EBP sign on his door that indicated when staff should practice EBP, and which PPE should be worn. Three staff, nursing assistant (NA)-A, NA-B and physical therapist (PT)-A were already in the room. They all had gloves on, but no gowns. R2's brief had leaked, and urine had soaked the bed linens. NA-A assisted R2 to change into a clean gown, the clean gown became soaked with urine immediately. NA-A left to get R2 a beverage, returned to the room and put on new gloves. NA-B and PT-A were working on obtaining a functioning mechanical lift, NA-B had left the room. At 9:03 a.m., NA-A removed R2's gown and placed a new one on without changing gloves or completing hand hygiene. NA-A adjusted the foot pedals on R2's wheelchair, changed her gloves and then adjusted the call light button. PT-A assists R2 in sitting up at the side of the bed. NA-A applied the mechanical lift sling. PT-A put on another gown to cover R2's back side. PT-A and NA-A both adjusted the sling and were questioning the size of the sling for the resident. R2 says he doesn't think the sling is the right size. At 9:10 a.m., PT-A left the room to obtain a different sling. R2 requested his morning supplement drink, NA-A shook the drink and opened it for R2. NA-A removed R2's gown on his back and put a larger size on to cover his back side. At 9:17 a.m., NA-B returned with a new sling, NA-B was not wearing gloves or a gown. NA-B operated the mechanical list and NA-A removed the soiled linens. NA-B transfers</p>	F0880		

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F0880 SS = D	<p>Continued from page 7</p> <p>R2 to the wheelchair, adjusted his oxygen tubing and removed the sling. NA-A started opening cabinets, adjusted the bedside table and set up R2's breakfast on the bedside table. NA-A removed the soiled linen from the room, removed her gloves and used hand sanitizer. PT-A and NA-B left the room.</p> <p>R3's face sheet dated 12/4/25, indicated R3 has diagnoses of type II diabetes, traumatic subdural hemorrhage with loss of consciousness, need for assistance with personal care, chronic pancreatitis and repeated falls.</p> <p>R3's Medicare 5-day MDS assessment dated 12/2/25, indicated R3 was cognitively intact and required partial moderate assistance with some activities of daily living.</p> <p>R3's care plan dated 12/4/25, had a focus section, "Enhanced barrier precautions indefinitely due to wounds." The interventions listed included gloves and gown prior to the high-contact care activity. High-contact resident care activities such as but not limited to dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use for central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care. R3's order set lacked orders for enhanced barrier precautions.</p> <p>During an observation on 12/4/25 at 11:35 a.m., R3 was in her room sitting in a recliner. R3 had an EBP sign on her door that indicated when staff should practice EBP, and which PPE should be worn. NA-B was in the room tidying up for R3. NA-B was not wearing gloves or a gown. NA-B removed the dirty linen from R3's bed and placed it in a trash bag. NA-B then touched R3's walker, emptied the trash and put a new trash bag in. NA-B took the trash, soiled linen bag, nursing assistant tablet and exited the room. NA-B disposed of the trash and then washed her hands.</p> <p>During an interview on 12/4/25 at 1:01 p.m., NA-B stated hand hygiene should be completed when entering or leaving a resident room. Gloves should be changed anytime contact with a resident is stopped. EBP means that anytime personal cares or transfers are done, a gown and gloves should be worn. Staff know which residents require EBP because there are signs on the doors and in the Kardex. When asked why she did not wear a gown during R2's transfer, she stated she was called in while doing other things and it was her mistake.</p>	F0880		

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F0880 SS = D	<p>Continued from page 8</p> <p>During an interview on 12/4/25 at 1:10 p.m., NA-A stated hand hygiene should be completed if there is body fluid involved. Gloves should be changed after changes briefs or before touching something else. EBP means staff should wear a full gown when changing or transferring a resident to avoid infection. Signs on the door indicate if a resident requires EBP or not. NA-A stated she didn't know why she wasn't wearing a gown during R2's transfer.</p> <p>During an interview on 12/4/25 at 1:19 p.m., PT-A stated hand hygiene should be done before and after entering a room. Gloves should be changed during an exit or if they get wet or soiled. EBP means staff should be wearing gown and gloves and it is indicated on the resident's door. PT-A stated she wasn't doing direct cares, so she didn't need to wear a gown during R2's transfer.</p> <p>During an interview on 12/4/25 at 4:04 p.m., registered nurse (RN)-A who was also the infection preventionist, stated staff are educated about EBP upon orientation and there are annual in-services. EBP means staff must wear gowns and gloves during high contact care activities. High contact care activities would include patient transfers and changing bed linens. Gloves should be changed anytime perineal cares are done or when going from dirty to clean.</p> <p>During an interview on 12/5/25 at 9:03 a.m., nurse manager (NM)-A stated EBP means a patient has a preliminary disease or diagnosis that could be transmitted. The resident may have an indwelling catheter, device, wound or intravenous line. Gowns and gloves should be worn. A linen change would require a gown and gloves. Hand hygiene should be done all the time, when entering a room, when doing something dirty and going to clean. Gloves should be changed when going from clean to dirty.</p> <p>During an interview at 12/5/25 at 10:00 a.m., the administrator stated EBP means staff should wear a gown and gloves and maybe a face shield when providing close contact cares to prevent spread of infection. Hand hygiene should be completed when entering a room, and going from any clean to dirty task.</p> <p>The facility policy, Enhanced Barrier Precautions last revised 1/22/25 directs EBP to be practiced when completing the following high-contact resident care activities: dressing, bathing, transferring, providing hygiene, changing linens, assisting with toileting, device care or use and wound care.</p>	F0880		

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On 12/4/25-12/5/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with MN State Licensure.</p> <p>The following complaint was reviewed: H55877662C (2666638) no licensing orders with issued</p>	20000		12/17/2025

Office of Primary Care and Health Systems Management

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