DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2023

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

RE: CCN: 245587
Cycle Start Date: October 27, 2022

Dear Administrator:

On December 1, 2022, we notified you a remedy was imposed. On January 5, 2023 the Minnesota Department(s) of Health and Public Safety 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 29, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 27, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 16, 2022, 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 January 27, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 29, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed 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

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January 26, 2023

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

Re: Reinspection Results
Event ID: PIDR12

Dear Administrator:

On December 13, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 26, 2022. At this time these correction orders were found corrected.

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

Electronically delivered
November 16, 2022

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

Re: State Nursing Home Licensing Orders
Event ID: PIDR11

Dear Administrator:

The above facility survey was completed on October 27, 2022 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be acknowledged electronically and submitted to:

Pete Cole, RN Unit Supervisor
Metro Team C District 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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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.

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

Feel free to contact me with any questions related to this letter.

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

(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
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME 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 10/24/22 through 10/27/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure.The following licensing orders were issued at 0850 and 1320.	3 000		

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3 000	Continued From page 1 Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were found to be unsubstantiated: H55875229C (MN83917) H5587095C (MN76590). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota Rules, Chapter 4655 for Boarding Care Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic	3 000		

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3 000	Continued From page 2 State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3 000		
3 850	MN Rule 4655.4800 Subp. 1 Dental Care; Services Subpart 1. Services. Patients and residents shall be provided with dental services appropriate to their needs. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review the facility failed to provide dental services for 1 of 4 residents (R5) reviewed for dental services. Findings include: R's admission minimum data set (MDS) dated 11/29/21, and significant change MDS dated 1/21/22, indicated R5 was cognitively intact and had no natural teeth. R5's face sheet dated 10/27/22, did not indicate R5 was edentulous (had no teeth) in her	3 850	CORRECTED	12/9/22

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3 850	Continued From page 3 diagnoses list. Subsequent MDS assessments dated 4/14/22, 7/14/22, 8/21/22, 8/23/22, and the most recent a quarterly MDS dated 10/13/22, indicated R5 was cognitively intact, but the oral/dental section was not completed. R5's care plan dated 10/14/22, indicated R5 had full upper and lower dentures. R5's Oral/Dental assessment imbedded in the Nursing Assessment dated 11/23/21, indicated R5 had no natural teeth. R5's Oral/Dental assessment imbedded in the Nursing Assessment dated 8/23/22, indicated R5 had broken or loosely fitted full or partial dentures. R5's Nutritional Assessment dated 4/14/22, indicated R5, "Has dentures but does not have here." R5's Nutritional Assessment dated 7/14/22, indicated R5, "Has dentures but does not have here." R5's Nutritional Assessment dated 10/13/22, indicated R5, "Has dentures but does not have here." Ebenezer Oral Exam dated 4/8/22, indicated, "Resident preference is not to wear dentures and no more routine dental appointment." Ebenezer Oral Exam dated 7/12/22, indicated, "Resident states lower denture is causing her some discomfort and would like to see a dentist. Will forward her request for dental visit when available." There was no evidence in the medical record of follow-up for a dental appointment. R5's Appletree Dental Consent dated 11/26/21,	3 850		

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3 850	Continued From page 4 indicated, "Plans to refuse all dental services." There was no evidence the service was offered again. When interviewed on 10/24/22, at 3:39 p.m. R5 stated she had some pain when she wore her dentures, and they did not fit well and could not wear them but would like to. R5 stated she had told staff, but staff reported back to say she would have to wait as the dental service did not have a opening. During observation on 10/24/22, at 3:39 p.m. R5 was not wearing dentures. When interviewed on 10/26/22, at 10:21 a.m. licensed practical nurse (LPN)-A stated the process for a resident to obtain dentures was the nurses report the need to the in-house healthcare provider, and the provider would write an order to see the dentist. The LPN-A stated the health records team was in charge of scheduling the appointments. The LPN-A further stated each resident gets an oral exam by nursing annually to assess for changes. When interviewed on 10/26/22, at 10:53 a.. social worker (SW)-A stated the facility did not currently have dental services available, and the director of medical records (DMR) was trying to find a new provider, but residents could go to an outside provider. When interviewed on 10/26/22, at 11:03 a.m. the director of medical records (DMR) stated he had not been notified R5 needed a dental appointment and he had no consent for the service on file. The DMR stated he had to have a consent on file to schedule an appointment, and then the HUCs would schedule it. The DMR said	3 850		

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3 850	Continued From page 5 he could send R5 to an outside provider, but some providers were scheduled out to 2023. The DMR stated he would work on getting R5 on the list for a dental appointment. When interviewed on 10/26/22, at 10:48 a.m. the registered dietician (RD) stated she had assessed that R5 had no teeth but had not informed the SW or nursing staff R5 had no teeth and wound benefit from having teeth. The RD stated having dentures could prevent R5 from having chewing issues and that it was logical that she, rht RD, should have told someone. When interviewed on 10/27/22, at 08:56 a.m. SW-B stated the process to obtain dental services was for the clinical team to assess the need for dentures or a dental appointment. SW-B stated then, the nursing staff would ask the resident to sign a consent form, and then the appointment for dentistry could be scheduled. SW-B stated residents can change their minds, and if the resident initially declined in-house services, and then later wanted an in-house service, a consent would be obtained at the time of request or identified need. Additionally, SW-B stated If nursing assessed R5's dentures were broken, the nurse should have informed the provider on the clinical team, and then the provider could have written an order for the service. When interviewed on 10/27/22, at 10:10 a.m. RN-B stated if she assessed a need for dentures, she would inform the nurse manager, and e-mail the DMR to get the resident on the list for dental services, or may tell the DMR in person. RN-B stated she did not recall if she notified the DMR R5 needed hearing aids, and did not chart about it. RN-B stated she had not and would not	3 850		

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3 850	Continued From page 6 normally document the communication to the DMR, but that it was possible she had not communicated the need. When interviewed on 10/27/22, at 10:19 a.m. the director of nursing (DON) stated she expected nursing staff to assess for change, and to refer to the required services. The DON further stated if a nurse assessed a need that a resident previously declined, she expected staff to re-approach the resident who previously declined the service to ask again for the consent, and document the response. The Dental and Dentures Policy dated 10/2017, indicated upon admission, annually, and with significant change of condition and as needed Ebenezer Oral Exam would be completed by licensed staff on each resident, and any changes or issues would be addressed with the resident and/or resident representative. The policy further stated if dentures were broken, chipped, or ill-fitting the nurse will promptly refer the resident to dental services within three days. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review/revise policies/procedures to ensure each resident receives dental care as needed. An annual review and audit of each residen'ts dental needs could be performed by the DON or designee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	3 850		
31320	MN Rule 4655.8670 Subp. 4 Food Supplies; Storage of perishable foods	31320		12/9/22

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31320	Continued From page 7 Subp. 4. Storage of perishable food. All perishable food shall be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. Meat and dairy products shall be stored at 40 degrees Fahrenheit or below, and fruit and vegetables at 50 degrees Fahrenheit or below. When stored together, the lower temperature shall apply. Temperatures shall be monitored by an accurate thermometer. This MN Requirement is not met as evidenced by: During observation, interview, and document review the facility failed to have a system in place to monitor and record refrigerator temperatures in all 4 nursing stations in the facility. This had the potential to affect all 90 residents along with staff and visitors. Findings include: The facilities Food Refrigerator Temperature Logs located on each refrigerator in the nursing stations included the following information: -2nd floor North temperature log dated April 2022 had no recorded temperatures -2nd floor South temperature log dated July 2022, included one temperature. -3rd floor North temperature log dated October 2022, included eight temperatures. -3rd floor South temperature log dated August 2022, included one temperature. During an interview on 10/27/22, at 9:13 a.m. licensed practical nurse (LPN)-C stated the dietary department was responsible for recording	31320	CORRECTED	

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31320	Continued From page 8 the temperature of the food refrigerators in the nursing stations. During an interview on 10/27/22, at 9:21 a.m. nursing assistant (NA)-A stated the nurses are responsible for recording temperatures for the medication refrigerators and the regular refrigerators in the nursing station. During an interview on 10/27/22, 9:24 a.m. registered nurse (RN)-C stated the nurses are responsible for recording temperatures for both (food and medication) refrigerators. During an interview on 10/27/22, 9:28 a.m. RN-D stated the dietary department was responsible for recording temperatures for the refrigerators in the nursing stations. During an interview on 10/27/22, at 9:31 a.m. NA-C stated the nurses are responsible for recording temperatures for both refrigerators in the nursing stations. During an interview on 10/27/22, at 9:37 a.m. the dietary manager (DM)-A stated the dietary department was responsible for recording temperatures for the refrigerators in the nursing station and it hasn't been getting done because she lost her supplemental dietary staff who use to be responsible for it. DM-A further stated she has not been putting up or taking down the temperature logs and is unaware of who is doing it but verified the temperatures should be recorded on a daily basis. During an interview on 10/27/22, at 10:30 a.m the director of nursing (DON) stated the dietary department was responsible for recording the temperatures in the refrigerators on the unit.	31320		

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31320	Continued From page 9 A policy on recording refrigerator temperatures was requested but not received. SUGGESTED METHOD OF CORRECTION: The dietician or dietary manager, or designee, could review/revise policies/procedures to ensure each resident refrigerator and freezer is monitored for appropriate temperatures. A log could be kept on each refrigerator, and a monthly review and audit of each unit's refrigerator and freezer temperature log could be performed by the dietician or dietary manager or designee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	31320		
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	2 000		

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2 000	Continued From page 10 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 10/24/22 through 10/27/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. The following licensing orders were issued at 0890 and 0900. and The following complaints were found to be unsubstantiated: H55875229C (MN83917) H5587095C (MN76590). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is	2 000		

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2 000	Continued From page 11 listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program	2 890		12/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	C 10/27/2022

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2 890	Continued From page 12 that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain range of motion (ROM) for 1 of 1 residents (R50) reviewed for hand contractures and limited ROM. Findings include: R50's face sheet indicated a diagnosis of left hand contracture (a tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) and osteoarthritis (inflammation of the joints). R50's annual Minimum Data Set (MDS) assessment dated 8/23/22, indicated R50 was moderately cognitively impaired and required assist of one person for bed mobility, dressing, toileting, and personal hygiene. R50's care plan revised on 2/16/22 indicated: -"Splint/Brace Program Left palm protector on in	2 890	CORRECTED	

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2 890	Continued From page 13 Am off with PM cares to be done by nursing staff". R50's care conference note on 9/6/22 indicated a splint be applied for left hand contracture. R50's treatment administration record (TAR) for October 2022 for dated 10/1/22 to 10/25/22 indicated no documentation by nursing staff for applying and removing the splint. R50's occupational therapy evaluation and plan of treatment for 1/27/22, indicated the establishment of a range of motion (ROM) program to maintain and prevent further contracture with fitting of left hand splint to maintain skin integrity and caregiver training on splint use. On 10/24/22 at 4:19 p.m., R50 was observed to be sitting up in her wheelchair with left hand on lap. Splint was not present. R50 stated staff was aware of missing splint and did not help her find the splint. R50 stated the splint, "should be on all the time". Left hand noted with contractures with left small finger curled and pressing onto palm of hand which was reddened. R50 stated she was unable to use left hand. On 10/25/22 at 9:47 a.m., R50 observed to be laying in bed without the splint on. R50 stated staff were aware of missing splint and offered no other alternative to relieve pressure of left small finger pressing into palm of hand. On 10/26/22 at 11:13 a.m., R50 observed to be sitting in wheelchair with a rolled up washcloth on left hand. Wash cloth was not placed under little finger of left hand to relieve pressure of little finger onto palm of hand.	2 890		

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2 890	Continued From page 14 Nursing assistant care sheet posted in R50's bedroom printed 2/25/22 stated: Nursing Rehab/Restorative: "Splint/Brace Program Left palm protector on in AM off with PM cares. Hand was with soap and water and let air dry." Interview with nursing assistant (NA)-D on 10/26/22, at 7:53 a.m., (NA)-D stated the nursing assistant care sheets posted in resident rooms assist the nursing assistants with types of cares required by the resident such as ambulation, turning, feeding, dressing, preferences, and communication needs. NA-D stated the care sheets indicate if a splint or brace is needed and when it should be applied and removed. NA-D stated if the resident refuses to wear a splint or brace then staff should reapproach the resident and inform the nurse so the nurse can approach the resident about it. NA-D stated the nurse was responsible to chart refusals and attempts in the electronic medical record (EMR). Interview with NA-E on 10/26/22, at 2:18 p.m., NA-E stated the care sheets posted in resident rooms stated if resident is to have a splint or not. NA-E stated she recalled seeing the hand splint for R50, "last week" and that R50 has worn the splint for at least a year. NA-E stated she discovered the splint was missing earlier in the day and notified therapy to replace it. Interview with licensed practical nurse (LPN)-D on 10/26/22 at 11:20 a.m., (LPN)-D stated R50 required assistance with all her personal cares and, "uses a left hand brace" and is expected to wear it. LPN-D stated that nursing is responsible to chart in the EMR if R50 refuses to wear it or if it is missing. LPN-D confirmed R50's left hand brace was missing and believed it was missing	2 890		

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2 890	Continued From page 15 for one day. LPN-D stated the nursing assistance assigned for R50 on 10/26/22 discovered the splint was missing and notified therapy to replace it. LPN-D stated that R50's left hand could become, "more contracted or tight and more painful" without the splint. Interview with occupational therapist (OT)-A on 10/27/22, at 10:50 p.m., (OT)-A stated the purpose of a hand splint is to prevent fingers from curling further and contracting more. In addition, R50's hand splint was needed to prevent any skin breakdown to her palm. Interview with rehabilitation director (RD)-B on 10/26/22 at 11:39 a.m., (RD)-B stated nursing staff were responsible for donning and doffing the splint. RD-B stated the risk of not wearing a hand splint could be worsening of contracture. Interview with director of nursing (DON) on 10/26/22 at 1:34 p.m., DON stated therapy staff are expected to assess the resident for splint use and then demonstrate to nursing staff how to don and doff the device. DON stated expectation for nursing staff to document application of splint on R50's EMR treatment record. DON stated that there is nothing on R50's treatment record that addresses splint use including number of times staff attempted to apply it and if resident refuses or declines to have it on. Facility policy titled Applying a brace or splint, updated 10/21, stated the primary responsibility for applying the splint is nursing and to document the procedure in the resident's record. SUGGESTED METHOD OF CORRECTION:	2 890		

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2 890	Continued From page 16 The director of nursing (DON) or designee could work with the therapy department to identify and develop programming for residents in need of range of motion services or those at risk for decline. The DON or designee could educate staff. The DON or designee could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate, routine monitoring of a pressure injury was completed and recorded for 1 of 2 residents	2 900	CORRECTED	12/9/22

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2 900	Continued From page 17 (R45) reviewed for pressure ulcer care and services. Findings include: R45's quarterly Minimum Data Set (MDS) dated 8/30/22, indicated R45 was cognitively intact and had diagnoses of failure to thrive and stage IV pressure ulcer that was present upon admission. The MDS further identified R45 was independent with bed mobility and transfers. R45's skin Care Area Assessment (CAA) dated 9/20/21, indicated R45 had a stage IV pressure ulcer on the left ischial tuberosity (IT) (backside of hip) that measured 6 centimeters (cm) by 3.5 cm. Furthermore, R45 was at risk for further skin breakdown related to decreased mobility and malnutrition. R45's provider order dated 6/5/22, indicated R45's left IT wound required measurement of length, width, and depth on bath day every Sunday evening. Staff were to document measurements in R45's electronic medical record (EMR) under progress notes and skin alteration tab. R45's care plan dated 10/22/22, indicated R45 was at risk for skin breakdown and had a stage IV pressure area to the left IT. R45's care plan further indicated R45 required weekly wound treatment documentation that included measurement of width, length, and depth and any other notable changes. A review of R45's weekly bath and pain assessments indicated R45's wound was measured a total of 5 times during the 17-week review between 7/1/22- 10/23/22. These dates	2 900		

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2 900	Continued From page 18 included 7/10/22, 7/24/22, 8/21/22, 9/4/22, and 10/16/22. R45's EMR lacked indication R45's wound was measured for the other weeks 12 weeks during the time reviewed. During observation on 10/27/22, at 9:16 a.m. registered nurse (RN)- A was providing wound cares for R45's left IT wound. R45's wound measured 1.5cm x 1.5 cm and a depth of 5cm. RN-A stated he had measured R45's wound earlier in the week when nurse practitioner (NP)-A was in house and the measurement was the same. RN-A acknowledged the practitioner was told verbally and no documentation was completed in R45's record. When interviewed on 10/24/22, at 4:56 p.m. R45 stated she was not sure if wound cares were done appropriately as there was so many steps to it and felt the wound was getting worse. R45 further stated staff were doing dressing changes twice a day but was unsure how often the wound was being measured. When interviewed on 10/27/22, at 9:48 a.m. RN-A stated R45 received wound care twice a day and while the open area was getting smaller, the depth was not changing much. RN-A stated RN-B completed weekly wound rounds on every Tuesday and RN-B measured R45's wound at that time. R45 was no longer followed by the wound doctors as R45 declined services as the service was not covered by R45's insurance and was an out-of-pocket expense. RN-A confirmed R45's wound was managed by NP-A. RN-A reviewed R45's medical record and was not able to identify a wound measurement since the wound provider stopped seeing R45 in 6/2022.	2 900		

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2 900	Continued From page 19 RN-A further stated he was unaware of any other documentation of R45's wound measurements. When interviewed on 10/27/22, at 10:41 a.m. NP-A confirmed she was managing R45's wound. NP-A stated the course of treatment required a wound vac, but R45 was reluctant due to the out-of-pocket expense. NP-A verified the wound measurements were the same today as earlier in the week and was aware of how deep the wound was. NP-A further explained the wound is doing well but needs the wound vac to help fill in the depth. NP-A stated she was not involved in the weekly monitoring or measuring of R45's wound. NP-A further stated she expected the facility to measure R45's wound as ordered and update the provider team with any changes or concerns. When interviewed on 10/27/22, at 11:51 p.m. RN-B confirmed R45 was not on wound rounds as R45 requested not to have wound pictures taken. RN-B explained weekly measurements were completed by the floor nurses. When interviewed on 10/27/22, at 12:27 p.m. the director of nursing (DON) confirmed R45 was not followed in weekly skin rounds and wound assessment and measurements were completed on bath days. DON verified R54's wound monitoring was not documented consistently and was not able to verify if it was done. DON stated staff were expected to document measurements of R54's wound once a week. DON further stated wound measurements were important to obtain weekly to ensure the wound was not worsening. A facility policy titled Management of Skin Alterations revised 10/2021, directed residents with wounds will have at minimum weekly monitoring for appropriateness of treatment/care	2 900		

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2 900	Continued From page 20 plan, signs or symptoms of infection, pain or discomfort and signs of healing and will report to the provider as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review/revise policies/procedures for pressure ulcer monitoring and care, educate staff, and then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

Electronically delivered
November 16, 2022

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

RE: CCN: 245587
Cycle Start Date: October 27, 2022

Dear Administrator:

On October 27, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Pete Cole, RN Unit Supervisor
Metro Team C District 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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 January 27, 2023 (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 April 27, 2023 (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.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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

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	245587	A. BUILDING _____ B. WING _____	C 10/27/2022

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E 000	Initial Comments On 10/24/22, through 10/27/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1)	E 041		11/23/22

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

Electronically Signed | 11/23/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	C 10/27/2022

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EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records	E 041		

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E 041	Continued From page 2 Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test their emergency generator per NFPA 99 (2012 edition), Health Care Facilities	E 041	Submission of this Allegation of compliance is not a legal admission that a deficiency exists or that this Statement of	

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E 041	Continued From page 3 Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.2, 8.4.2.3, 8.4.9.5.1, 8.4.9, 8.4.9.1, and 8.4.9.2. This had the potential to affect all 90 residents who resided at the facility. Findings include: 1. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they have been running their generator at 30% of its load during the monthly inspections and the last annual load bank is out of date which was last done on 08/02/2021. 2. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility ' s Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	E 041	Deficiencies was correctly cited and is also not to be construed as an admission against Ebenezer Care Center, (the "Facility"), Administrator, of any Employees, Agents or other Individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or constructed as an agreement with allegations of noncompliance or admission by the facility. This plan of correction is not to be constructed as an admission by the facility or any of its agents that the survey agents□ findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for Medicare and Medicare programs.	

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E 041	Continued From page 4	E 041	1. On 11/07/22, the running of the emergency generator at 30% of its load during its monthly inspection was completed and documentation was created indicating this required testing had been achieved. In addition, the annual testing of the load bank was also completed on 11/07/22 and documentation was created indicating this required testing had been achieved. The ECC Director of Environmental Services will ensure future compliance with this required testing by monitoring compliance dates, oversee the testing and will maintain all relevant documentation. 2. The Emergency Power Supply Systems, (EPSS) was tested for four hours on 11/7/2022 and placed on ECC□s annual schedule for completion of the required testing and documentation was created indicating this required testing had been achieved. The ECC Director of Environmental Services will ensure future compliance with this testing and will maintain all relevant documentation.	
F 000	INITIAL COMMENTS On 10/24/22 through 10/27/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. and	F 000		

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F 000	Continued From page 5 The following complaints were found to be unsubstantiated: H55875229C (MN83917) H5587095C (MN76590) 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 substantial compliance with the regulations has been attained.	F 000		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document	F 685	Submission of this Allegation of	12/9/22

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F 685	Continued From page 6 review the facility failed to provide audiology services for 1 of 1 resident (R5) reviewed for communication devices. Findings include: R5's admission Minimum Data Set (MDS) dated 11/29/21, indicated R5 was cognitively intact. R5's quarterly MDS dated 10/13/22, indicated R5 was cognitively intact, and indicated adequate hearing with no need for hearing aids. R5's face sheet dated 10/27/22, did not indicate R5 was hard of hearing on her diagnoses list. R5's Sensory/ Communication assessment imbedded in the Nursing Assessment dated 11/23/21, indicated adequate hearing and no hearing aids. R5's Sensory/Communication assessment imbedded in the Nursing Assessment dated 8/23/22, indicated moderate difficulty with hearing, and no hearing aids, although the subsequent MDS assessment on 10/13/22, indicated R5 had adequate hearing. When interviewed on 10/24/22, at 3:39 p.m. R5 stated she had hearing aids, but they were missing. R5 stated she had informed staff and stated she needed her hearing aids. R5 had difficulty hearing at a normal level of conversation and surveyor had to speak loudly and repeat self so R5 could hear. During observation on 10/24/22, at 3:39 p.m. R5 was not wearing hearing aids. When interviewed on 10/26/22, at 10:21 a.m.	F 685	compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against Ebenezer Care Center, (the "Facility"), Administrator, of any Employees, Agents or other Individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or constructed as an agreement with allegations of noncompliance or admission by the Facility. This plan of correction is not to be constructed as an admission by the Facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for Medicare and	

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F 685	Continued From page 7 licensed practical nurse (LPN)-A stated the process for a resident to obtain hearing aids was for nurses to report the need to the in-house healthcare provider, and the provider would write an order to see the audiologist. The LPN-A stated the health records team was in charge of scheduling appointments. When interviewed on 10/26/22, at 10:28 a.m. registered nurse (RN)-A stated the supervisor for the health unit coordinators (HUCs) would schedule audiology appointments for residents as needed. When interviewed on 10/26/22, at 10:53 a.m. social worker (SW)-A stated nursing staff had not informed her R5 needed hearing aids or was missing them. The SW-A stated nursing staff could tell her, or the supervisor for the HUCs to schedule an appointment, but hearing tests could be scheduled as needed. When interviewed on 10/26/22, at 11:03 a.m. the director of medical records (DMR) stated he had not been notified R5 needed an audiology appointment and he had no consent for the service on file. The DMR stated he had to have a consent on file to schedule an appointment, and then the HUCs would schedule it. When interviewed on 10/27/22, at 08:56 a.m. SW-B stated the process to obtain hearing aids was for the clinical team to assess the need for hearing aids. Upon admission, residents were asked if they want any in-house services, like audiology services which would help with hearing aids. Then, if the resident required hearing aids, nursing staff would ask the resident to sign a consent form, and then the appointment for	F 685	Medicare programs. Individual Patient: R5- hearing aides were brought in by family unknown to staff. The policy on Hearing Aides was reviewed and revised. Consent was obtained for audiology services for R5. Identification of Other Residents: All current residents with hearing aids will be evaluated by LPN/RN to ensure the functioning of their hearing aids. All residents wearing hearing aids will be assessed on admission, quarterly. annually, significant change and as needed. Hearing aid services will be offered and set up as needed. Measures Systemic Changes: All staff involved in the coordination of hearing services were re-educated on the process of obtaining services. Date of Completion: December 9th, 2022 To Ensure Correction is Achieved and Sustained: Random chart audits will be conducted by the DON or designee to ensure auditory services are offered at care conferences. 3 random chart audits will be completed weekly for 4 weeks, then 2 random chart audits per month for 2 months. Audit results will be reviewed at the QAPI meeting to review and make recommendations for ongoing monitoring.	

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F 685	Continued From page 8 audiology could be scheduled. Further, SW-B stated R5's hearing aids were found in her room in a drawer on 10/27/22, with a broken wire, and R5 signed the consent for an audiology appointment. SW-B stated residents can change their minds, and if the resident initially declined in-house services, which R5 did upon admission, and then later wanted an in-house service, a consent would be obtained at the time of request or identified need. . Additionally, SW-B stated if nursing assessed a change in R5's hearing abilities, the nurse should have informed the provider on the clinical team, and then the provider could have written an order for the service. When interviewed on 10/27/22, at 10:10 a.m. RN-B stated if she assessed a need for hearing aids, she would inform the nurse manager, and e-mail the DMR to get the resident on the list for audiology services, or may tell the DMR in person. RN-B stated she assessed R5's hearing during a nursing assessment as documented on the 8/23/22, communication assessment, and documented a decline in hearing ability, but did not ask R5 if she wanted hearing aids nor did she ask if she wanted an audiology appointment. RN-B stated she did not recall if she notified the DMR that R5 needed hearing aids, and did not chart about it. RN-B stated she had not and would not normally document the communication to the DMR, but that it was possible she had not communicated the need at all. When interviewed on 10/27/22, at 10:19 a.m. the director of nursing (DON) stated she expected nursing staff to assess for change, and to refer to the required services. The DON further stated if a nurse assessed a need that a resident previously	F 685	Monitoring of Compliance: Medical Records Director/The Director of Nursing or Designee	

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F 685	Continued From page 9 declined, she expected staff to re-approach the resident who previously declined the service to ask again for the consent, and document the response. A policy about hearing and audiology services was requested but not provided.	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate, routine monitoring of a pressure injury was completed and recorded for 1 of 2 residents (R45) reviewed for pressure ulcer care and services. Findings include: R45's quarterly Minimum Data Set (MDS) dated 8/30/22, indicated R45 was cognitively intact and had diagnoses of failure to thrive and stage IV	F 686	Submission of this Allegation of compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against Ebenezer Care Center, (the "Facility"), Administrator, of any Employees, Agents or other Individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not	12/9/22

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F 686	Continued From page 10 pressure ulcer that was present upon admission. The MDS further identified R45 was independent with bed mobility and transfers. R45's skin Care Area Assessment (CAA) dated 9/20/21, indicated R45 had a stage IV pressure ulcer on the left ischial tuberosity (IT) (backside of hip) that measured 6 centimeters (cm) by 3.5 cm. Furthermore, R45 was at risk for further skin breakdown related to decreased mobility and malnutrition. R45's provider order dated 6/5/22, indicated R45's left IT wound required measurement of length, width, and depth on bath day every Sunday evening. Staff were to document measurements in R45's electronic medical record (EMR) under progress notes and skin alteration tab. R45's care plan dated 10/22/22, indicated R45 was at risk for skin breakdown and had a stage IV pressure area to the left IT. R45's care plan further indicated R45 required weekly wound treatment documentation that included measurement of width, length, and depth and any other notable changes. A review of R45's weekly bath and pain assessments indicated R45's wound was measured a total of 5 times during the 17-week review between 7/1/22- 10/23/22. These dates included 7/10/22, 7/24/22, 8/21/22, 9/4/22, and 10/16/22. R45's EMR lacked indication R45's wound was measured for the other weeks 12 weeks during the time reviewed.	F 686	constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or constructed as an agreement with allegations of noncompliance or admission by the Facility. This plan of correction is not to be constructed as an admission by the Facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for Medicare and Medicare programs. Individual Patient: R45s pressure ulcer was assessed on October 27th, 2022. Policies/procedures for pressure ulcer monitoring and care were reviewed and remain current. Identification of Other Residents: All residents with current pressure ulcers	

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F 686	Continued From page 11 During observation on 10/27/22, at 9:16 a.m. registered nurse (RN)- A was providing wound cares for R45's left IT wound. R45's wound measured 1.5cm x 1.5 cm and a depth of 5cm. RN-A stated he had measured R45's wound earlier in the week when nurse practitioner (NP)-A was in house and the measurement was the same. RN-A acknowledged the practitioner was told verbally and no documentation was completed in R45's record. When interviewed on 10/24/22, at 4:56 p.m. R45 stated she was not sure if wound cares were done appropriately as there was so many steps to it and felt the wound was getting worse. R45 further stated staff were doing dressing changes twice a day but was unsure how often the wound was being measured. When interviewed on 10/27/22, at 9:48 a.m. RN-A stated R45 received wound care twice a day and while the open area was getting smaller, the depth was not changing much. RN-A stated RN-B completed weekly wound rounds on every Tuesday and RN-B measured R45's wound at that time. R45 was no longer followed by the wound doctors as R45 declined services as the service was not covered by R45's insurance and was an out-of-pocket expense. RN-A confirmed R45's wound was managed by NP-A. RN-A reviewed R45's medical record and was not able to identify a wound measurement since the wound provider stopped seeing R45 in 6/2022. RN-A further stated he was unaware of any other documentation of R45's wound measurements. When interviewed on 10/27/22, at 10:41 a.m. NP-A confirmed she was managing R45's wound. NP-A stated the course of treatment required a	F 686	were reviewed to ensure routine weekly assessment of the wound(s) is completed and documented. Measures Systemic Changes: All licensed nurses were re-educated on the policy for management of skin alterations. Date of Completion: December 9th, 2022 To Ensure Correction is Achieved and Sustained Random chart audits for weekly wound assessments will be conducted by the DON or designee. 3 random chart audits will be completed weekly for 4 weeks, then 2 random chart audits per week for 1 month. Audit results will be reviewed at the QAPI meeting to review and make recommendations for ongoing monitoring. Monitoring of Compliance: The Director of Nursing or Designee.	

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	245587	A. BUILDING _____ B. WING _____	C 10/27/2022

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F 686	Continued From page 12 wound vac, but R45 was reluctant due to the out-of-pocket expense. NP-A verified the wound measurements were the same today as earlier in the week and was aware of how deep the wound was. NP-A further explained the wound is doing well but needs the wound vac to help fill in the depth. NP-A stated she was not involved in the weekly monitoring or measuring of R45's wound. NP-A further stated she expected the facility to measure R45's wound as ordered and update the provider team with any changes or concerns. When interviewed on 10/27/22, at 11:51 p.m. RN-B confirmed R45 was not on wound rounds as R45 requested not to have wound pictures taken. RN-B explained weekly measurements were completed by the floor nurses. When interviewed on 10/27/22, at 12:27 p.m. the director of nursing (DON) confirmed R45 was not followed in weekly skin rounds and wound assessment and measurements were completed on bath days. DON verified R54's wound monitoring was not documented consistently and was not able to verify if it was done. DON stated staff were expected to document measurements of R54's wound once a week. DON further stated wound measurements were important to obtain weekly to ensure the wound was not worsening. A facility policy titled Management of Skin Alterations revised 10/2021, directed residents with wounds will have at minimum weekly monitoring for appropriateness of treatment/care plan, signs or symptoms of infection, pain or discomfort and signs of healing and will report to the provider as needed.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility	F 688		12/9/22

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F 688	Continued From page 13 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain range of motion (ROM) for 1 of 1 residents (R50) reviewed for hand contractures and limited ROM. Findings include: R50's face sheet indicated a diagnosis of left hand contracture (a tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) and osteoarthritis (inflammation of the joints). R50's annual Minimum Data Set (MDS) assessment dated 8/23/22, indicated R50 was moderately cognitively impaired and required	F 688	Submission of this Allegation of compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against Ebenezer Care Center, (the "Facility"), Administrator, of any Employees, Agents or other Individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency.	

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F 688	Continued From page 14 assist of one person for bed mobility, dressing, toileting, and personal hygiene. R50's care plan revised on 2/16/22 indicated: -"Splint/Brace Program Left palm protector on in Am off with PM cares to be done by nursing staff". R50's care conference note on 9/6/22 indicated a splint be applied for left hand contracture. R50's treatment administration record (TAR) for October 2022 for dated 10/1/22 to 10/25/22 indicated no documentation by nursing staff for applying and removing the splint. R50's occupational therapy evaluation and plan of treatment for 1/27/22, indicated the establishment of a range of motion (ROM) program to maintain and prevent further contracture with fitting of left hand splint to maintain skin integrity and caregiver training on splint use. On 10/24/22 at 4:19 p.m., R50 was observed to be sitting up in her wheelchair with left hand on lap. Splint was not present. R50 stated staff was aware of missing splint and did not help her find the splint. R50 stated the splint, "should be on all the time". Left hand noted with contractures with left small finger curled and pressing onto palm of hand which was reddened. R50 stated she was unable to use left hand. On 10/25/22 at 9:47 a.m., R50 observed to be laying in bed without the splint on. R50 stated staff were aware of missing splint and offered no other alternative to relieve pressure of left small finger pressing into palm of hand.	F 688	Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or constructed as an agreement with allegations of noncompliance or admission by the Facility. This plan of correction is not to be constructed as an admission by the Facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for Medicare and Medicare programs. Individual Patient: R50s missing splint was replaced and applied to resident. Staff caring for R50 were re-educated on her plan of care as it relates to use of splint. Policy and Procedure for Braces or Splints was reviewed and is current. Identification of Other Residents: Residents identified for utilizing splints or braces will be reviewed for continued appropriateness.	

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F 688	Continued From page 15 On 10/26/22 at 11:13 a.m., R50 observed to be sitting in wheelchair with a rolled up washcloth on left hand. Wash cloth was not placed under little finger of left hand to relieve pressure of little finger onto palm of hand. Nursing assistant care sheet posted in R50's bedroom printed 2/25/22 stated: Nursing Rehab/Restorative: "Splint/Brace Program Left palm protector on in AM off with PM cares. Hand was with soap and water and let air dry." Interview with nursing assistant (NA)-D on 10/26/22, at 7:53 a.m., (NA)-D stated the nursing assistant care sheets posted in resident rooms assist the nursing assistants with types of cares required by the resident such as ambulation, turning, feeding, dressing, preferences, and communication needs. NA-D stated the care sheets indicate if a splint or brace is needed and when it should be applied and removed. NA-D stated if the resident refuses to wear a splint or brace then staff should reapproach the resident and inform the nurse so the nurse can approach the resident about it. NA-D stated the nurse was responsible to chart refusals and attempts in the electronic medical record (EMR). Interview with NA-E on 10/26/22, at 2:18 p.m., NA-E stated the care sheets posted in resident rooms stated if resident is to have a splint or not. NA-E stated she recalled seeing the hand splint for R50, "last week" and that R50 has worn the splint for at least a year. NA-E stated she discovered the splint was missing earlier in the day and notified therapy to replace it. Interview with licensed practical nurse (LPN)-D	F 688	Residents splint/brace use will be assessed on admission, quarterly, annually, significant change and as needed. OT evaluation and treatment as needed. Measures Systemic Changes: All nursing staff were re-educated on the policy for applying splints/braces. All nursing staff were re-educated on documentation required with splints/braces and how to document when splints/braces are refused. Date of Completion: December 9th,2022 To Ensure Correction is Achieved and Sustained Random observational audits will be completed by the DON/designee to ensure programs for splints/braces are implemented. 3 random observational audits will be completed weekly for 4 weeks, then 2 random observational audits per weekly for 1 month. Audit results will be reviewed at the QAPI meeting to review and make recommendations for ongoing monitoring. Monitoring of Compliance: The Correction will be monitored by: The Director of Nursing or Designee.	

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F 688	Continued From page 16 on 10/26/22 at 11:20 a.m., (LPN)-D stated R50 required assistance with all her personal cares and, "uses a left hand brace" and is expected to wear it. LPN-D stated that nursing is responsible to chart in the EMR if R50 refuses to wear it or if it is missing. LPN-D confirmed R50's left hand brace was missing and believed it was missing for one day. LPN-D stated the nursing assistance assigned for R50 on 10/26/22 discovered the splint was missing and notified therapy to replace it. LPN-D stated that R50's left hand could become, "more contracted or tight and more painful" without the splint. Interview with occupational therapist (OT)-A on 10/27/22, at 10:50 p.m., (OT)-A stated the purpose of a hand splint is to prevent fingers from curling further and contracting more. In addition, R50's hand splint was needed to prevent any skin breakdown to her palm. Interview with rehabilitation director (RD)-B on 10/26/22 at 11:39 a.m., (RD)-B stated nursing staff were responsible for donning and doffing the splint. RD-B stated the risk of not wearing a hand splint could be worsening of contracture. Interview with director of nursing (DON) on 10/26/22 at 1:34 p.m., DON stated therapy staff are expected to assess the resident for splint use and then demonstrate to nursing staff how to don and doff the device. DON stated expectation for nursing staff to document application of splint on R50's EMR treatment record. DON stated that there is nothing on R50's treatment record that addresses splint use including number of times staff attempted to apply it and if resident refuses or declines to have it on.	F 688		

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F 688	Continued From page 17 Facility policy titled Applying a brace or splint, updated 10/21, stated the primary responsibility for applying the splint is nursing and to document the procedure in the resident's record.	F 688		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those	F 791		12/9/22

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F 791	Continued From page 18 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to provide dental services for 1 of 4 residents (R5) reviewed for dental services. Findings include: R's admission minimum data set (MDS) dated 11/29/21, and significant change MDS dated 1/21/22, indicated R5 was cognitively intact and had no natural teeth. R5's face sheet dated 10/27/22, did not indicate R5 was edentulous (had no teeth) in her diagnoses list. Subsequent MDS assessments dated 4/14/22, 7/14/22, 8/21/22, 8/23/22, and the most recent a quarterly MDS dated 10/13/22, indicated R5 was cognitively intact, but the oral/dental section was not completed. R5's care plan dated 10/14/22, indicated R5 had full upper and lower dentures. R5's Oral/Dental assessment imbedded in the Nursing Assessment dated 11/23/21, indicated	F 791	Submission of this Allegation of compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against Ebenezer Care Center, (the "Facility"), Administrator, of any Employees, Agents or other Individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this	

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F 791	Continued From page 19 R5 had no natural teeth. R5's Oral/Dental assessment imbedded in the Nursing Assessment dated 8/23/22, indicated R5 had broken or loosely fitted full or partial dentures. R5's Nutritional Assessment dated 4/14/22, indicated R5, "Has dentures but does not have here." R5's Nutritional Assessment dated 7/14/22, indicated R5, "Has dentures but does not have here." R5's Nutritional Assessment dated 10/13/22, indicated R5, "Has dentures but does not have here." Ebenezer Oral Exam dated 4/8/22, indicated, "Resident preference is not to wear dentures and no more routine dental appointment." Ebenezer Oral Exam dated 7/12/22, indicated, "Resident states lower denture is causing her some discomfort and would like to see a dentist. Will forward her request for dental visit when available." There was no evidence in the medical record of follow-up for a dental appointment. R5's Appletree Dental Consent dated 11/26/21, indicated, "Plans to refuse all dental services." There was no evidence the service was offered again. When interviewed on 10/24/22, at 3:39 p.m. R5 stated she had some pain when she wore her dentures, and they did not fit well and could not wear them but would like to. R5 stated she had told staff, but staff reported back to say she would have to wait as the dental service did not have a opening.	F 791	Allegation of Compliance within this time frame should in no way be considered or constructed as an agreement with allegations of noncompliance or admission by the Facility. This plan of correction is not to be constructed as an admission by the Facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for Medicare and Medicare programs. Individual Patient: R5 face sheet was revised to reflect resident is edentulous. A dental appointment was scheduled for 12/1/22 The Dental policy was reviewed and revised. Identification of Other Residents: Corrective Action as it applies to other residents: On admission, annually and with significant change of condition an Ebenezer Oral Exam will be completed by licensed staff on each resident. Any changes or issues will be addressed with the Resident/family/representative. Staff will assist with setting up appointments and transportation as needed. Measures Systemic Changes: All staff involved in the coordination of dental services were re-educated on the process of obtaining services.	

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F 791	Continued From page 20 During observation on 10/24/22, at 3:39 p.m. R5 was not wearing dentures. When interviewed on 10/26/22, at 10:21 a.m. licensed practical nurse (LPN)-A stated the process for a resident to obtain dentures was the nurses report the need to the in-house healthcare provider, and the provider would write an order to see the dentist. The LPN-A stated the health records team was in charge of scheduling the appointments. The LPN-A further stated each resident gets an oral exam by nursing annually to assess for changes. When interviewed on 10/26/22, at 10:53 a.. social worker (SW)-A stated the facility did not currently have dental services available, and the director of medical records (DMR) was trying to find a new provider, but residents could go to an outside provider. When interviewed on 10/26/22, at 11:03 a.m. the director of medical records (DMR) stated he had not been notified R5 needed a dental appointment and he had no consent for the service on file. The DMR stated he had to have a consent on file to schedule an appointment, and then the HUCs would schedule it. The DMR said he could send R5 to an outside provider, but some providers were scheduled out to 2023. The DMR stated he would work on getting R5 on the list for a dental appointment. When interviewed on 10/26/22, at 10:48 a.m. the registered dietician (RD) stated she had assessed that R5 had no teeth but had not informed the SW or nursing staff R5 had no teeth and wound benefit from having teeth. The RD stated having dentures could prevent R5 from	F 791	Date of Completion: December 9th,2022 To ensure correction is achieved and sustained Random chart audits will be conducted by the DON or designee to ensure vision and hearing services are offered at care conferences. 3 random chart audits will be completed weekly for 4 weeks, then 1 random chart audit weekly for 2 months. Audit results will be reviewed at the QAPI meeting to review and make recommendations for ongoing monitoring. Monitoring of Compliance: The Correction will be monitored by: Medical Record Director / Director of Nursing or Designee.	

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F 791	Continued From page 21 having chewing issues and that it was logical that she, rht RD, should have told someone. When interviewed on 10/27/22, at 08:56 a.m. SW-B stated the process to obtain dental services was for the clinical team to assess the need for dentures or a dental appointment. SW-B stated then, the nursing staff would ask the resident to sign a consent form, and then the appointment for dentistry could be scheduled. SW-B stated residents can change their minds, and if the resident initially declined in-house services, and then later wanted an in-house service, a consent would be obtained at the time of request or identified need. Additionally, SW-B stated If nursing assessed R5's dentures were broken, the nurse should have informed the provider on the clinical team, and then the provider could have written an order for the service. When interviewed on 10/27/22, at 10:10 a.m. RN-B stated if she assessed a need for dentures, she would inform the nurse manager, and e-mail the DMR to get the resident on the list for dental services, or may tell the DMR in person. RN-B stated she did not recall if she notified the DMR R5 needed hearing aids, and did not chart about it. RN-B stated she had not and would not normally document the communication to the DMR, but that it was possible she had not communicated the need. When interviewed on 10/27/22, at 10:19 a.m. the director of nursing (DON) stated she expected nursing staff to assess for change, and to refer to the required services. The DON further stated if a nurse assessed a need that a resident previously declined, she expected staff to re-approach the	F 791		

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F 791	Continued From page 22 resident who previously declined the service to ask again for the consent, and document the response. The Dental and Dentures Policy dated 10/2017, indicated upon admission, annually, and with significant change of condition and as needed Ebenezer Oral Exam would be completed by licensed staff on each resident, and any changes or issues would be addressed with the resident and/or resident representative. The policy further stated if dentures were broken, chipped, or ill-fitting the nurse will promptly refer the resident to dental services within three days.	F 791		
F 812 SS=C	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		12/9/22

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	245587	A. BUILDING _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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F 812	Continued From page 23 During observation, interview, and document review the facility failed to have a system in place to monitor and record refrigerator temperatures in all 4 nursing stations in the facility. This had the potential to affect all 90 residents along with staff and visitors. Findings include: The facilities Food Refrigerator Temperature Logs located on each refrigerator in the nursing stations included the following information: -2nd floor North temperature log dated April 2022 had no recorded temperatures -2nd floor South temperature log dated July 2022, included one temperature. -3rd floor North temperature log dated October 2022, included eight temperatures. -3rd floor South temperature log dated August 2022, included one temperature. During an interview on 10/27/22, at 9:13 a.m. licensed practical nurse (LPN)-C stated the dietary department was responsible for recording the temperature of the food refrigerators in the nursing stations. During an interview on 10/27/22, at 9:21 a.m. nursing assistant (NA)-A stated the nurses are responsible for recording temperatures for the medication refrigerators and the regular refrigerators in the nursing station. During an interview on 10/27/22, 9:24 a.m. registered nurse (RN)-C stated the nurses are responsible for recording temperatures for both (food and medication) refrigerators. During an interview on 10/27/22, 9:28 a.m. RN-D	F 812	Submission of this Allegation of compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against Ebenezer Care Center, (the "Facility"), Administrator, of any Employees, Agents or other Individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or constructed as an agreement with allegations of noncompliance or admission by the Facility. This plan of correction is not to be constructed as an admission by the Facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the	

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F 812	Continued From page 24 stated the dietary department was responsible for recording temperatures for the refrigerators in the nursing stations. During an interview on 10/27/22, at 9:31 a.m. NA-C stated the nurses are responsible for recording temperatures for both refrigerators in the nursing stations. During an interview on 10/27/22, at 9:37 a.m. the dietary manager (DM)-A stated the dietary department was responsible for recording temperatures for the refrigerators in the nursing station and it hasn't been getting done because she lost her supplemental dietary staff who use to be responsible for it. DM-A further stated she has not been putting up or taking down the temperature logs and is unaware of who is doing it but verified the temperatures should be recorded on a daily basis. During an interview on 10/27/22, at 10:30 a.m the director of nursing (DON) stated the dietary department was responsible for recording the temperatures in the refrigerators on the unit. A policy on recording refrigerator temperatures was requested but not received.	F 812	rules of participation for Medicare and Medicare programs. Measures Systemic Changes: The policy on recording refrigerator temperatures was reviewed and remain current. Refrigerator temps will be obtained and recorded daily. All dietary staff were re-educated on the policy and procedure for taking and recording refrigerator temps daily. To Ensure Correction is Achieved and Sustained Random observational audits will be completed by the Dietary Manager/Designee. 3 random observational audits will be completed weekly for 4 weeks, then 2 random observational audits per weekly for 1 month. Audit results will be reviewed at the QAPI meeting to review and make recommendations for ongoing monitoring. Monitoring of Compliance: The Dietary Manager or Designee will monitor compliance. Date of Completion: December 9th, 2022	

Electronically delivered
November 16, 2022

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

Re: State Nursing Home Licensing Orders
Event ID: PIDR11

Dear Administrator:

The above facility was surveyed on October 24, 2022 through October 27, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Pete Cole, RN Unit Supervisor
Metro Team C District 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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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.

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
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2022**

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EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/26/2022. At the time of this survey, Ebenezer Care Center Bldg. 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/23/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Ebenezer Care Center Building 01 is a 3-story building with a full basement. The building was constructed at 4 different times. The original building was constructed in 1919 and was determined to be of Type III(200) construction. In 1924, an addition was constructed to the Northside of the building that was determined to be of Type III(200) construction. In 1928, another addition was constructed to the Southside of the building that was determined to be of Type III(200) construction.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 119 beds and had a census of 86 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered	K 161		1/26/23

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K 161	Continued From page 3 Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to construct the building with the correct construction type per NFPA 101 (2012 edition), Life Safety Code, section 19.1.6.1.This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by observation that Building 01 is a 3-story building of Type III(200) construction. This type of construction is not allowed for a building of this height. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 161	Ebenezer Care Center had an approved FSES on record prior to July 5, 2016 as a NF/SNF and will use the mandatory values in NFPA 101A, 2001 edition, to meet the fire safety requirements for recertification. This form will be completed and submitted as part of this Plan of Correction on or before January 26, 2023.	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to	K 211		1/26/23

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K 211	Continued From page 4 full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.1.10.1, and 7.2.1.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by observation that the exit corridor in the basement had clothes racks, boxes, plastic bins, and a wooden shelf stored in it. 2. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by observation that the doors on all floors for both south stairwells swing against the direction of egress travel. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 211	1. On 11/23/2022, the Ebenezer Care Center, (ECC) Environmental Services Department staff removed all clothes racks, boxes, plastic bins, and wooden shelf stored in it from the exit corridor in the basement. Reeducation provided to all Ebenezer Care Center staff that clothes, clothes racks, boxes, plastic bins and wooden shelving cannot be stored out in the facility corridors. The ECC Director of the Environmental Services will ensure monthly inspection is done and documents the corridor is clear for Egress. 2. Ebenezer Care Center had an approved FSES on record prior to July 5, 2016 as a NF/SNF and will use the mandatory values in NFPA 101A, 2001 edition, to meet the fire safety requirements for recertification. This form will be completed and submitted as part of this Plan of Correction on or before January 26, 2023.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		11/23/22

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K 353	Continued From page 5 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2 and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the five-year sprinkler internal pipe inspection was out of date the last five-year internal pipe inspection was dated 03/22/2017. 2. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by observation that the gauge on the sprinkler system was out of date the date on the gauge was 03/22/2017.	K 353	1. On 11/18/22, the five-year sprinkler internal pipe inspection was completed at Ebenezer Care Center and dated correctly on the documentation generated for the inspection. The ECC Director of Environmental Services will ensure future compliance with this required inspection by monitoring compliance dates, oversee the inspection and will maintain all relevant documentation. 2. The gauge on the sprinkler system was replaced on 11/18/22 and correctly dated. The ECC Director of Environmental Services will ensure future compliance with this required inspection by monitoring compliance dates, oversee the inspection and will maintain all relevant documentation.	

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K 353	Continued From page 6 An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 353		
K 541 SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain laundry chutes per NFPA 101 (2012 edition), Life Safety Code, section 19.5.4.1. This deficient finding could have an isolated impact on the residents within the facility.	K 541	On 11/15/2022, a new 3rd floor laundry chute door latch mechanism was installed and is now working correctly. Beginning 11/15/22, Ebenezer Care Center housekeepers now observe the laundry chutes daily to validate that the doors are	11/23/22

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K 541	Continued From page 7 Findings include: On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by observation that the laundry chute door on the third floor near the bathroom was missing the handle and the latch was taped over so the door would not positively latch. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 541	operating correctly. The ECC Director of Environmental Services will ensure future compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the	K 761	On 11/11/2022, all the inspection of all Ebenezer Care Center fire doors was completed. The Environmental Services Department will maintain a log as to when each inspection is to occur as well as when it was completed. The ECC Director of Environmental Services will ensure	11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 8 residents within the facility. Findings include: On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide me with an annual fire door inspection report. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 761	future compliance with this required inspection by monitoring compliance dates, oversee the inspection and will maintain all relevant documentation.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 9 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.2, 8.4.2.3, 8.4.9.5.1, 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they have been running their generator at 30% of its load during the monthly inspections and the last annual load bank is out of date which was last done on 08/02/2021. 2. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility's	K 918	1. On 11/07/22, the running of the emergency generator at 30% of its load during its monthly inspection was completed and documentation was created indicating this required testing had been achieved. In addition, the annual testing of the load bank was also completed on 11/07/22 and documentation was created indicating this required testing had been achieved. The ECC Director of Environmental Services will ensure future compliance with this required testing by monitoring compliance dates, oversee the testing and will maintain all relevant documentation. 2. The Emergency Power Supply Systems, (EPSS) was tested for four hours on 11/7/2022 and placed on ECC's annual schedule for completion of the required testing and documentation was created indicating this required testing had been achieved. The ECC Director of Environmental Services will ensure future compliance with this testing and will maintain all relevant documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2022**

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EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

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K 918	Continued From page 10 Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **02 - BLDG TWO** B. WING _____	**10/26/2022**

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EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/26/2022. At the time of this survey, Ebenezer Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/23/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **02 - BLDG TWO** B. WING _____	**10/26/2022**

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

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

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

In 1952 building 02, a 3-story addition of Type 1(332) construction was added. The 1952 addition was surveyed as a separate building. This facility is fully protected throughout by an automatic fire sprinkler system throughout. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.

The facility has a capacity of 119 beds and had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **02 - BLDG TWO** B. WING _____	**10/26/2022**

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EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

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K 000	Continued From page 2 census of 86 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2 and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility.	K 353	1. On 11/18/22, the five-year sprinkler internal pipe inspection was completed at Ebenezer Care Center and dated correctly on the documentation generated for the inspection. The ECC Director of Environmental Services will ensure future compliance with this required inspection by monitoring compliance dates, oversee the inspection and will maintain all relevant documentation.	11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **02 - BLDG TWO** B. WING _____	**10/26/2022**

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EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

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K 353	Continued From page 3 Findings include: 1. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the five-year sprinkler internal pipe inspection was out of date the last five-year internal pipe inspection was dated 03/22/2017. 2. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by observation that the gauge on the sprinkler system was out of date the date on the gauge was 03/22/2017. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 353	2. The gauge on the sprinkler system was replaced on 11/18/22 and correctly dated. The ECC Director of Environmental Services will ensure future compliance with this required inspection by monitoring compliance dates, oversee the inspection and will maintain all relevant documentation.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 761	On 11/11/2022, all the inspection of all	11/23/22

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	245587	A. BUILDING **02 - BLDG TWO** B. WING _____	**10/26/2022**

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EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

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K 761	Continued From page 4 and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide me with an annual fire door inspection report. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 761	Ebenezer Care Center fire doors was completed. The Environmental Services Department will maintain a log as to when each inspection is to occur as well as when it was completed. The ECC Director of Environmental Services will ensure future compliance with this required inspection by monitoring compliance dates, oversee the inspection and will maintain all relevant documentation.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 5 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.2, 8.4.2.3, 8.4.9.5.1, 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they have been running their generator at 30% of its load during the monthly inspections and the last annual load bank is out of date which was last done on	K 918	1. On 11/07/22, the running of the emergency generator at 30% of its load during its monthly inspection was completed and documentation was created indicating this required testing had been achieved. In addition, the annual testing of the load bank was also completed on 11/07/22 and documentation was created indicating this required testing had been achieved. The ECC Director of Environmental Services will ensure future compliance with this required testing by monitoring compliance dates, oversee the testing and will maintain all relevant documentation. 2. The Emergency Power Supply Systems, (EPSS) was tested for four hours on 11/7/2022 and placed on ECC's annual schedule for completion of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 6 08/02/2021. 2. On 10/26/2022 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility ' s Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 918	required testing and documentation was created indicating this required testing had been achieved. The ECC Director of Environmental Services will ensure future compliance with this testing and will maintain all relevant documentation.	