



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 21, 2026

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

RE: CCN: 245213

Cycle Start Date: August 5, 2026

Dear Administrator:

On August 5, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J).

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 30, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 5, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

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

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, EBENEZER RIDGES GERIATRIC CARE CENTER is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 5, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245213		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER EBENEZER RIDGES GERIATRIC CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 13820 COMMUNITY DRIVE , BURNSVILLE, Minnesota, 55337			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 8/04/26 through 8/05/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was Reviewed H52133576C (245213) and a deficiency was issued at F689 at a IJ past non-compliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.			F0000			
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to collaborate care with hospice agency to ensure proper training and safety with mechanical lift transfers, when hospice aide (H)-A and facility registered nurse (RN)-A did not follow manufacturer instruction in properly securing the lift sling for 1 of 1 resident (R1). This resulted in an immediate			F0689	"Past Noncompliance - no plan of correction required"		

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

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

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F0689 SS = SQC-J	Continued from page 1 Jeopardy (IJ) when R1 fell from the lift and sustained a fracture. The IJ began on 7/30/26, at 7:30 am. when H-A hooked up the Hoyer sling to get R1 ready for shower and requested RN-A to assist with transfer to the shower chair. H-A did not cross the leg straps and during the transfer R1 slid out of the Hoyer sling and hit her leg on the bed while RN-A was attempting to lower R1 to the floor. An X-Ray was taken and R1 was found to have a Tibia/Fabia fracture. The director of nursing (DON) and administrator were notified of the IJ on 8/05/26 at 12:15 p.m. The facility implemented corrective action prior to the start of survey, and this is issued in past noncompliance. The administrator and the DON were informed of the IJ removal on 7/30/26, when the facility trained their staff on sling inspection and safety, EZ Way Smart Lift Competency and transfer audits. R1's significant change minimum data set (MDS) dated 4/30/26, indicated R1 was moderately cognitively impaired, had no mood or behavioral issues. R1's MDS further indicated R1 was dependent with transfers and had medically complex conditions which included dementia, hypertension, and depression. R1's Care Plan dated 4/20/26, indicated R1 needed total assist of two using mechanical Hoyer lift, using a medium sling due to right sided weakness. A Facility Reported Incident dated 7/30/26 at 11:15 a.m., indicated on 7/30/26 at 7:30 a.m. R1 was hooked up the Hoyer sling by H-A to get R1 ready for shower and requested RN-A to assist with transfer to the shower chair. H-A did not cross the leg straps and during the transfer R1 slid out of the Hoyer sling and hit her leg on the bed while RN-A was attempting to lower R1 to the floor. An X-Ray was taken and R1 was found to have a Tibia/Fabia fracture.R1's Fall Risk Assessment (FRA) dated 7/26/26, indicated R1 was high risk for falls due to intermittent confusion, chair bound, non-ambulatory and predisposing diseases. R1's FRA dated 7/30/26, indicated R1 was high risk for falls due to intermittent confusion, chair bound, non-ambulatory and predisposing diseases. R1's Radiology Results Report dated 7/30/26, indicated there is an acute mildly displaced fracture of the proximal tibia and fibula metaphysis (the main shinbone (tibia) and the smaller outer leg bone (fibula) are broken near the top (proximal end) in the flared area before the knee joint (metaphysis), and the broken pieces are out of place displaced) . Distal tibia and fibula are otherwise intact.			F0689			

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F0689 SS = SQC-J	Continued from page 2 During interview on 8/04/26 at 9:45 a.m., director of nursing (DON) stated H-A had training from the hospice agency on 7/14/26 and started coming to the facility the following day, and it was assumed the agency had trained the H-A on lifts but found out after the incident he was not trained on the lifts and slings, they use. The DON stated the RN-A that assisted H-A had been working at the facility several years and RN-A did not see the leg slings were not crossed correctly. The DON stated the RN-A realized during the transfer R1 was sliding through the lower part of the sling, while H-A froze and RN-A guided R1 to the floor and R1 was contracted and frail and hit the side of the bed on her right side which caused the fracture. The DON stated after review of the incident it was decided to no longer allow any hospice agencies to assist with any mechanical lift transfers and signs were placed in all hospice patient's rooms and emailed all hospice companies. During interview on 8/04/26 at 1:36 p.m. nursing assistant (NA)-A stated he had completed a transfer with H-A with R1, and he had to remind him to criss cross the lower leg straps under her legs prior to hooking up the Hoyer lift. During interview on 8/04/26 at 2:54 p.m., RN-A stated during the incident on 7/30/26 she was asked by H-A to assist with the transfer with R1, and she was called into the room to quick help and she stated she asked him if he knew the resident and if he had transferred her before and he told me he had. RN-A stated R1 was hooked up to the lift and while in mid-air she noticed R1 was sliding out of the sling and H-A froze and she guided R1 to the floor and she had hit her right side on the bed frame. RN-A stated she had transferred R1 approximately 20 times before with no issues but was never the lead using the lift machine. RN-A stated usually the hospice staff knew how to transfer the residents. During interview on 8/04/26 at 7:08 p.m., NA-B stated he has completed transfers with H-A and he has had to remind him to cross the leg straps before on another resident on a different floor. NA-B stated after he found out about the fall of R1 he stated, "Oh looking back I wished he received better training on the Hoyer lifts". NA-B stated they have had several hospice aides there with no issues and sometimes they take the lead with the Hoyer lift with no issues, this was just an unfortunate incident. NA-B stated I should have said something for him to be retrained.			F0689			

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F0689 SS = SQC-J	Continued from page 3 During interview on 8/05/26 at 11:13 a.m., the DON stated she was surprised the hospice agency did not train their staff on the slings they used and finding out they only trained on a hammock sling which does not require a lower leg cris-cross. In addition, the administrator stated in their contract with the hospice agency they signed the durable medical equipment (DME) they would properly train their staff which would include Hoyer lifts and slings. Hospice Agreement dated 2/21/17, indicated the facility shall provide room and board services including, but not limited to supervising and assisting in the use of the facilities DME. inovihealthcare Universal sling is commonly used for seated transfers to and from wheelchair, commode, chair, recliner & bed. They can also be used to assist with bed pan and chux pad placement post bed transfer and during floor rescues. They've even been used to help support the pannus prior to providing cares. I before any sling is selected to ensure safety for both patient and caregiver. Steps when placing the sling on individual: 1) With label and handles facing away from the individual, place U shape webbing at tailbone/coccyx. 2) Keeping webbing flat bring leg straps along outside both thighs keeping equal length ensuring sling is centered. 3) Two options for placement of leg straps under legs: A) Safely bring each leg strap under and up between the legs and crisscross legs straps by threading one leg strap through the other strap. This locks the straps in place, so they don't migrate up into the groin. B) Safely bring each leg strap under both legs to create a hammock. (Place pillow between legs to avoid pinching before lifting) 4) Bring hanger bar down to individuals' chest: 5) Connect shorter (White) loops on shoulder to keep individual sitting up. 6) Connect longer (Yellow) loops on legs to keep individuals' legs lower.			F0689			

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F0689 SS = SQC-J	Continued from page 4 7) When initiating lift, raise patient 1” to 2” inches, then stop and perform a safety check to ensure all straps are securely attached to spreader bar. 8) Complete transfer The IJ that began on 7/30/26, at 7:30 a.m. was removed on 7/30/26, when the facility completed the following prior to the start of survey re-education and competency testing completed with all staff regarding the use of mechanical lists and lift slings, education completed with facility staff regarding hospice staff not able to assist with mechanical list transfers, education completed with facility staff regarding alerting management when noted further training needed, hospice agencies contracted with the facility were made aware their stare staff are not able to assist with mechanical lift transfers, signs placed in hospice resident rooms with directions for hospice staff not to assist with mechanical lift transfers, hospice staff and lift policy updated to indicate hospice staff are not able to assist with mechanical lift transfers, facility management staff completing mechanical lift transfer audits.			F0689			



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August 21, 2026

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

Re: Event ID: 2F52E2H1

Dear Administrator:

The above facility survey was completed on August 5, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00756		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER EBENEZER RIDGES GERIATRIC CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 13820 COMMUNITY DRIVE , BURNSVILLE, Minnesota, 55337			
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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 08/04/26 through 08/05/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H52133576C (245213) Minnesota Department of Health (MDH) is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in			20000			

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00756		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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20000	Continued from page 1 ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			