STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245213	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Ridges Geriatric Care Center	13820 Community Drive Burnsville, MN 55337

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review, the facility failed to accommodate bathing/shower preferences for 1 of 1 residents (R159) reviewed for choices. Findings include: R159's admissions Minimum Data Set (MDS) dated [DATE] identified admission to facility on 11/4/24, had impaired cognition, required substantial to maximal assistance for showering, toileting, lower body dressing, and personal hygiene. Review of transitional care unit (TCU) care sheet identified all residents by room number, name, primary diagnoses, and day of the week with AM or PM next to it. R159 identified Fri PM associated with it. R159's care plan dated 11/4/24 identified, Care Plan: I will have my preferences followed. During interview with R159 and family member (FM)-B on 11/18/24 at 3:14 p.m., R159 stated facility never offered or asked preferences on day and time of showers. R159 and FM-B stated he was informed that the showers and bath schedules were assigned per room number. R159 stated, I prefer to shower in the morning because I get too tired to participate in showering [in] the evenings after I work with physical therapy. FM-B stated, [R159] likes mornings better than evenings for showers. During interview with nursing assistant (NA)-A on 11/19/24 at 12:49 a.m., NA-A stated she worked full-time on the TCU where R159 resided. NA-A stated the expectation of nursing assistants at start of their shifts was to look at the resident's care plan in computer system and review the paper care sheets on each unit to see what shower days and times are assigned. NA-A pointed to the paper care sheet and stated, Showers are assigned per room. He[R159] is Friday PMs. NA-A stated, [nursing assistants] always go by the sheet here. During interview with NA-B on 11/19/24 at 1:06 p.m., NA-B stated he worked full-time on the TCU and I look at the care sheets which say what room and shower days [are assigned]. Shower days and times [are] with the room and not preference of the resident. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with registered nurse (RN)-A on 11/19/24 at 1:25 p.m., RN-A stated expectation of nursing assistants to look at the care sheet first to identify shower days and times. RN-A indicated shower day assignments are scheduled per room. During interview with director of nursing (DON) on 11/21/24 at 9:47 a.m., DON stated, the baths and showers are divided out by room number on the TCU. DON stated, [assigned shower days] are not reflective of [R159] preferences. It makes sense he would like a shower in the morning before therapy instead of later in the day after he is tired out from working with therapy. We should not be assigning shower days per room. Requested policy on choices and preferences and did not receive.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect upper body impairment for 1 of 2 residents (R162) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, identified the purpose of the RAI process was to help ensure holistic care was provided. According to the RAI/MDS, the definition of functional limitation in range of motion is, limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living or places the resident at risk of injury. Coding instructions for GG0115A Functional Limitation in Range of Motion question, the Upper Extremity (Shoulder, Elbow, Wrist, Hand) include: Code 0, no impairment: if resident has full functional range of motion on the right and left side of upper/lower extremities. Code 1, impairment on one side: if resident has an upper-and/or lower-extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury. Code 2, impairment on both sides: if resident has an upper-and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury. Examples of coding instructions include: 1. The resident can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. They are able to perform grooming activities (e.g., brush their teeth, comb their hair) with their right upper extremity and are also able to pivot to their wheelchair with the assistance of one person. They are, however, unable to voluntarily move their left side (limited arm, hand, and leg motions), as they have a flaccid left hemiparesis from a prior stroke. Coding: GG0115A would be coded 1, upper-extremity impairment on one side. R162's admissions Minimum Data Set (MDS) dated [DATE], identified R162 with admission to facility's transitional care unit (TCU) on 11/1/24, with moderately impaired cognition, and required partial to moderate assistance with upper body dressing and personal hygiene and required substantial to maximal assistance with showers or bathes and lower body dressing. The MDS section GG0115: Functional Limitation in Range of Motion identified R162 with, No impairment of upper and lower extremity. In addition, R162 with diagnoses of a stroke, cancer, and hypertension (high blood pressure). R162's initial visit notes from physician dated 11/4/24, [R162] originally presented with left upper extremity weakness. And not able to move her left arm. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 11/18/24 at 3:42 p.m., R162 was observed seated in a recliner watching television in her room. R162 was observed with her left arm in shoulder sling with left arm immobilized. R162 stated, I have this [pointing to sling] because I had a stroke. R162 stated it was important for the sling to be on so her left arm would not flop down as she had no control or feeling in it. R162 stated that she admitted to the facility with the sling and that staff at the facility were applying it and removing it daily. Review of R162 care plan, orders, and nursing assistant care sheet and Kardex failed to mention an assessment for use about the sling, including purpose for it, who was responsible for applying and removing it, and when it should be done. During interview with rehabilitation supervisor (RS) on 11/20/24 at 9:38 a.m., stated, R162 came in after stroke and diagnoses with metastatic [wide spread] brain and lung cancer. RS stated R162 had Left arm weakness was fully flaccid [paralyzed as a result of interrupted communication within the nervous system]. RS stated the assessment for use of a sling was a therapy department responsibility and was unable to determine if R162 was assessed for use of the sling. RS stated the process was for therapy to assess use and appropriateness of a sling and a nursing communication form would be filled out by therapy and given to nursing department who would upload the information in resident's care plan and Kardex. RS stated the expectation was staff would not apply or remove the sling without orders and recommendations from the therapy department. During interview with nursing assistant (NA)-B on 11/20/24 at 10:00 a.m., NA-B stated, Yes [R162] had a sling on her left arm. She could not use the arm at all. No nothing in care plan or our Kardex for us to do anything with the sling. And [R162] had therapy every day so I think they took care of it. During interview with TCU nurse manager registered nurse (RN)-A on 11/20/24 at 10:40 a.m., RN-A stated, [R162] had splint on her for support and arm [sic] she cannot control it. RN-B stated there were no instructions to use, apply or remove the sling. It is important for the staff to know what they need to look out for and why. In this instance it was not done. During interview with the director of Resident Assessment Instrument (RAI)/MDS (DR) on 11/20/24 at 11:13 a.m., DR reviewed R162's admission MDS information and stated, looks like no impairment was noted for the upper and lower extremities. DR stated, 'if patient has no use of arm and it is not their previous norm then this was coded incorrectly. During interview with RN-A on 11/20/24 at 11:32 a.m., RN-A looked at R162's admission MDS and stated, not correct because of left arm in sling. It should have been coded accurately. During interview with director of nursing (DON) on 11/21/24 at 9:58 a.m., DON stated, [R162] had impairment of arm. The MDS response was inaccurate and should not have been coded as, 'No impairment'. Facility policy titled MDS/CARE PLAN PROCESS/RESIDENT ASSESSMENT updated 11/11/24 identified Use the Minimum Data set forms and CAA's (Care Area Assessment) collect data and supplemental forms as needed to complete a comprehensive, review of the resident's status. And MDS coordinator does MDS coding and prioritizing.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on interview and document review, the facility failed to ensure care conferences were conducted upon admission for 1 of 2 residents (R103) reviewed for care conferences. Findings include: R103's admission Minimum Data Set (MDS) assessment, dated 11/4/24, indicated R103 had intact cognition with no hallucinations or delusions with an admitted [DATE]. Diagnoses included: displaced bicondylar fracture of left tibia (fracture in left lower leg), muscle weakness, other abnormalities of gait and mobility, left foot drop (dragging of front of foot when walking and/or inability to raise toes or the foot from the ankle), and infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts (an infection caused related to implanted devices from surgery). R103's care plan, printed 11/18/24, indicated R103 discharge planning: [R103] was living at home where she is planning to return home at discharge with an intervention of arrange for in home services as ordered, with an initiation date of 11/18/24. R103's progress notes, dated 10/29/24 to 11/21/24, were reviewed. Progress notes lacked evidence of R103 having a care conference since admission on 10/29/24. Furthermore, lacked documentation of a planning of a care conference. On 11/18/24 at 3:12 p.m., R103 indicated she has not had a care conference since admission. R103 indicated there has been no meeting of any kind to talk about discharge or the plan around this. R103 stated she asked the nurse practitioner at the facility last week about having a care conference as they are thinking she might discharge in a couple of weeks but has not heard anything about any sort of meeting or care conference. R103's provider note, dated 11/18/24, was reviewed. The provider note did not mention a care conference and potential discharge plan or date. On 11/20/24 at 10:19 a.m., nurse manager on third floor registered nurse (RN)-D verified R103 has not had a care conference since admission to the facility on [DATE] [22 days ago]. R103 indicated that social worker sets up the care conferences for residents. RN-D indicated they talked about R103 in rounds yesterday and will going to do a care conference soon as R103 has a home assessment set up on 11/22/24. RN-D stated they think the social worker wanted to wait until closer to dischage for a care conference. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 9:33 a.m., social worker (SW)-A verified that she is the social worker for R103. SW-A verified that when a resident is admitted to the facility, specifically transitional care unit (TCU), they try to do a care conference within the first week or two of admission. SW-A stated it is expected that a care conference is done no later than 21 days after admission. SW-A verified R103's care conference is probably beyond 21 days and verified R103 has not had a care conference since arriving at the facility. SW-A verified R103's admission was 10/29/24 which was more than 21 days ago. SW-A stated R103's care conference was missed. On 11/21/24 at 10:18 a.m., director of nursing (DON) stated the expectation is that a care conference is held no later than 21 days after admission. A facility policy titled Care Conference Process, revised 10/18, indicated a care conference is held for every resident receiving care within our facilities upon admission, quarterly, with significant change and as needed. Furthermore indicating care conference for an individual resident is held within 21 days of an admission.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., showers) was completed for 4 of 5 residents (R89, R103, R159, R162) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R89 R89's admissions Minimum Data Set (MDS) dated [DATE], identified R89 with admission to facility's transitional care unit (TCU) on 10/26/24, had severe cognitive impairment, required substantial to maximal assistance with showers, upper and lower body dressing, and personal hygiene. In addition, R89 was documented with an indwelling catheter (drain urine from the bladder) and had diagnoses of left arm fracture, non-Alzheimer's dementia, depression, and urinary retention. Furthermore, the MDS stated R89 and family participated in the assessment and goal setting process. During initial screening on 11/18/24 at 12:15 a.m., surveyor provided with undated TCU nursing assistant care sheet. During interview with nursing assistant (NA)-A on 11/19/24 at 12:49 a.m., NA-A stated she had worked full-time on the TCU since, January [2024]. NA-A stated the expectation of nursing assistants at start of their shifts was to look at the resident's care plan in the computer system and review the paper care sheets on each unit to see what shower days and times are assigned. NA-A pointed to the paper care sheet and stated, Showers are assigned per room. NA-A stated, [nursing assistants] always go by the sheet here. NA-A stated nursing assistants document in the Task[s] section of the electronic medical record (EMR) for assigned tasks. Review R89's of undated nursing assistant care sheet indicated R89's assigned bathing day and time was Saturday evenings. Per bathing task in the electronic medical record (EMR) indicating a shower was missed or not documented on 11/9/24. R89's progress note dated 10/26/24 to 11/20/24, failed to identify R89 refused a shower on 11/9/24. During interview with R89 on 11/21/24 at 8:21 a.m., R89 stated, my daughter [FM-A] is helping with the arrangements [for discharge]. I get confused. I like to get washed up. It makes me feel normal and less gross. It is important to me to have my hair washed. I cannot remember the last time I had it washed. It does feel like its ben a least a week since it was washed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with family member (FM)-A on 11/21/24 at 8:38 a.m., FM-A stated she recalled being present for R89's admissions assessment. FM-A stated, Mom [R89] likes showers in the morning but I am quite sure she was never asked if she preferred a specific day or time of the day for the shower. I think [R89] missed a shower while she was there. They [staff] said they were going to do it but I believe they forgot. [R89] is a lot of work to get in and out of the shower so I am sure it was forgotten, or they did not have enough staff to do it. She had one last week, I think. And, Yes, she likes her hair washed. Makes her feel good, like it does for all of us. A wet washcloth is not the same as a shower. I feel disgusting if I don't have a shower and I am quite sure she would not like missing a good shower or bath. She used to shower every day. During interview with registered nurse (RN)-A on 11/19/24 at 1:25 p.m., RN-A stated the expectation of nursing assistants was to look at the care sheet first to identify shower days and times. RN-A indicated shower day assignments are scheduled per room. R159 R159's admissions MDS dated [DATE], identified R159 with admission to facility's TCU on 11/4/24, R159 had impaired cognition, and required substantial to maximum assistance with showers or baths, toileting, lower body dressing, and personal hygiene. Also, R159 was documented with diagnoses of fracture to right hip, and arthritis. In addition, section F0400 of the MDS titled Interview for Daily Preferences. C. How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Answer coded was, 1. Very important. During interview with NA-B on 11/19/24 at 1:06 p.m., NA-B stated he worked at facility on TCU for sixteen years and noted that R159 was to receive showers on Fridays in the evening per the nursing aide care sheet. NA-B stated the expectation of staff was to document showers including refusals in the EMR under Tasks. NA-B verified R159's EMR lacked documentation of showers or refusals from R159. During interview with NA-A on 11/19/24 at 12:49 a.m., NA-A stated she had worked full-time on the TCU since, January [2024]. NA-A stated the expectation of nursing assistants is to look in resident's care plan, Kardex and (undated) care sheet to determine what assistance is required for each resident. NA-A stated the expectation of nursing assistants was to document in the Task[s] section of the electronic medical record EMR for assigned tasks, subsequently, NA-A reviewed R159's care sheet and noted shower day is Fridays in the evening and stated the EMR lacked documentation of showers or refusals from R159. During interview with TCU nursing manager, registered nurse (RN)-A on 11/19/24 at 1:06 p.m., RN-A stated the expectation of nursing assistants was to look at the resident's care plan, Kardex and (undated) paper care sheet to determine the assistance needed and shower days and times. RN-A looked at R159's EMR and verified no documentation of showers or refusals since he was admitted [DATE]. RN-A stated, It was not being documented of being offered, refused, ecetera and it should be. RN-A stated, I expect documentation in a progress note if he refuses a shower. It horrifies me that he hasn't had shower since he was admitted . It is important that our residents get a shower and cleaned up. R162 (continued on next page)

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	245213	A. Building B. Wing	11/21/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R162's admission MDS dated [DATE], identified R162 with admission to facility's TCU on 11/1/24, with moderately impaired cognition, and required partial to moderate assistance with upper body dressing and personal hygiene and required substantial to maximal assistance with showers or bathes and lower body dressing. In addition, R162 was documented with diagnoses of a stroke, cancer, and hypertension (high blood pressure). During interview with R162 on 11/18/24 at 3:42 p.m., R162 stated, I prefer a shower if they [staff] could do it. I don't recall if I was asked. R162's undated care sheet identified R162's showers were assigned for Friday mornings. R162's Tasks tab in EMR identified documentation of having a shower on 11/15/24, missing 11/1/24 and 11/8/24. R159 progress notes dating from 11/4/24 to 11/19/24, failed to document a shower was offered or declined on 11/1/24 and 11/8/24. During interview with RN-A on 11/20/24 at 10:40 a.m., RN-A stated, She [R162] should have been given a shower. Additionally stating we [facility] have noticed that some [residents] have missed the showers and we are not documenting it. During interview with director of nursing (DON) on 11/21/24 at 9:52 a.m., DON verified showers are not being charted. Showers were missed. Showers are important to everyone, and they should not have been missed. Facility policy titled BATH, SHOWER updated 2/24 identify, 23. Document bath/shower in the EHR (electronic health record). 49339 R103 R103's admission Minimum Data Set (MDS) assessment, dated 11/4/24, indicated R103 had intact cognition with no hallucinations or delusions with an admitted [DATE]. Diagnoses included: displaced bicondylar fracture of left tibia (fracture in left lower leg), muscle weakness, other abnormalities of gait and mobility, left foot drop (dragging of front of foot when walking and/or inability to raise toes or the foot from the ankle), and infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts (an infection caused related to implanted devices from surgery). In addition, R103 was dependent on staff for showers/bathing and transfers, and required maximal assistance from staff for dressing, personal hygiene and mobility. R103's care plan, printed 11/18/24, indicated R103 has an ADL [activity of daily living] self-care performance deficit with the following intervention: -BATHING/SHOWERING: Assistance by (2) staff with bathing/showering. Staff to provide nail care as needed. If diabetic, nail care to be done by nurse. Report need of nail care to nurse. -PERSONAL HYGIENE: assist of 2 staffs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R103's Kardex, printed 11/20/24, indicated R103's bathing was Saturday PM (evening). Further, indicated assistance by (2) staff with bathing/showering prefers to have a bath. R103's task log, printed 11/20/24, indicated R103's bathing was completed with total dependence with one person physical assist. The document lacked evidence for an entry on 11/16/24, which would be the next scheduled bathing/showering day per schedule. R103's progress notes, dated 10/29/24 to 11/21/24, were reviewed. Progress notes lacked evidence of R103 refusing showers or staff assistance with ADLs. Furthermore, lacked documentation of staff offering an additional showers/bed bath/partial bath since last documented bath/shower on 11/9/24. R103's November Administration Record, printed 11/18/24, indicated an order for: -Complete weekly/bath and pain sheet assessment in PCC [electronic health record - EHR]. If any new alterations in skin integrity, follow the skin alterations and wounds checklist. Bath declined, skin audit must still be completed. Every evening shift every Saturday. It was documented the assessment was completed for 11/2/24, 11/9/24, and 11/16/24. During an interview on 11/18/24 at 3:12 p.m., R103 stated that her shower/bath day was scheduled to be on Saturdays. She stated that she not offered and did not get a bath or shower this past Saturday (11/16/24) and the last shower/bath she had was on 11/9/24. R103 was displeased that she was not offered a shower in 9 days. R103 indicated her preference was to have a shower/bath daily, understood that this was likely not possible but going 9 days without a shower was not acceptable. R103 stated she had told staff that she would like more than one shower/bath a week. R103 indicated she was told that they offer one shower/bath a week. On 11/20/24 at 9:20 a.m., registered nurse (RN)-C stated that upon admission, residents are assessed to determine if they want one or two showers a week, in the morning or evening, and that is added to the care plan. RN-C stated that if a shower or bath is missed, for any reason, the nursing assistant is expected to notify the nurse and the shower is to be attempted again another day. RN-C indicated the skin assessment, which is documented on the administration record, is completed by the nurse on the scheduled shower day, whether the shower is completed or not. RN-C indicated that a progress note is entered when a resident refuses a shower and when a shower is attempted or offered again. On 11/20/24 at 10:07 a.m., nurse manager on the 3rd floor RN-D verified that residents are expected to be showered at least once a week and can get an additional shower if requested. RN-D verified the nurse should document in the progress notes when a shower is refused or not given. RN-D reviewed R103's EHR, verified the weekly skin assessment was completed on 11/16/24 and verified R103 did not receive a shower on 11/16/24. RN-D verified R103's last shower was 11/9/24 which was 11 days ago, at time of interview. RN-D verified R103 needed assistance with showering/bathing and would not be able to complete this task independently. RN-D stated the expectation is that residents are showered or bathed at least weekly. RN-D indicated they would follow up with R103 regarding her showers. A facility policy titled Bath Shower, revised 2/24, indicated the purpose of the policy was that a resident feels cleansed and refreshed per resident's wishes after bathing, and indicated baths/showers to be documented in EHR.

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	245213	A. Building B. Wing	11/21/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to ensure as-needed (PRN) antipsychotic medications were limited to 14 days of use or re-evaluated by the medical provider to ensure necessity and reduce the risk of complication for 1 of 5 residents (R6) reviewed for unnecessary medication use. Findings include: R6's significant change Minimum Data Set (MDS) dated [DATE], indicated R6 had moderately impaired cognition and was receiving hospice services. R6 was dependent on staff for toileting, personal hygiene, and bed mobility. The MDS indicated R6 was diagnosed with dementia, anxiety, and depression. R6's Verbal Orders report dated 10/23/24, indicated a hospice provider (MD)-A had ordered two milligrams (mg) haloperidol (an antipsychotic medication) three times a day as needed (PRN) starting on 10/23/24. The report had a column titled Date Discontinued that was left blank and the order did not include an end date. R6's order summary report dated 10/23/24, indicated R6 had an order for two milligrams (mg) haloperidol three times a day as needed (PRN) starting on 10/23/24 for agitation or nausea ordered by nurse practitioner (NP)-A. The report included a section titled End Date that did not include a date for this order. R6's Medication Administration Record (MAR) dated 10/23/24 through 11/19/24, indicated R6 had received the PRN haloperidol with the order date 10/23/24 over ten times during the period. During an interview on 11/20/24 at 10:47 a.m., registered nurse (RN)-E, the unit nurse manager, stated she had reviewed R6's medical record and confirmed R6's PRN haloperidol order had been active for longer than fourteen days and a provider had not re-evaluated her during that time and renewed the order if needed. During an interview on 11/20/24 at 11:23 a.m., NP-A stated she was R6's primary care provider but R6 also received hospice care and the Haldol was managed by them. NP-A stated she would have expected the hospice provider to order PRN haloperidol for a maximum of 14 days and then reevaluate R6 for the appropriateness of continued haloperidol use prior to reordering it. NP-A stated she had not reassessed R6 for the appropriateness of this medication as it was ordered by hospice. During an interview on 11/20/24 at 11:35 a.m., RN-F, R6's hospice nurse, confirmed the hospice provider had not re-evaluated R6 after 14 days of PRN haloperidol use and had not ordered an end date for the medication. RN-F stated she had reviewed R6's hospice medical record and confirmed the order had not been renewed after 14 days of use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 8:30 a.m., the director of nursing (DON) stated R6's medical record had been reviewed and facility staff did not find that R6's PRN haloperidol had an ordered stop date or had been renewed by a provider after 14 days. The facility Psychopharmacologic Drug Use policy dated 7/8/24, indicated PRN psychotropic medications should be limited to 14 days unless the prescribing practitioner believes it was appropriate to extend past 14 days and documented the rationale in the medical record and indicated the duration. The policy did not include additional instruction for PRN antipsychotic medication use

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented or followed for 2 of 2 residents (R46 and R21) reviewed for EBP. Findings include: The CDC article titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24, indicated MDRO transmission in skilled nursing facilities was common and contributed to substantial resident morbidity. EBP is an infection control intervention to reduce transmission of MDROs by using gowns and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing that lead to indirect transfer of MDROs from resident to resident. The article indicated high-contact activities include changing linens, bathing, dressing, transferring, changing briefs, feeding tube care, etc. The article indicated EBP should be implemented (when contact precautions did not apply) for residents with wounds or indwelling medical devices (central lines, urinary catheter, feeding tube) regardless of MDRO colonization status. R46's quarterly Minimum Data Set (MDS) dated [DATE], indicated R46 had severely impaired cognition, was diagnosed with a stroke, and required total assistance with all care activities. The MDS indicated R46 received his nutrition through a feeding tube. R46's order summary report dated 11/4/24, indicated R46 had an enteral feeding tube. R46's progress note dated 11/19/24 at 12:21 p.m., indicated the staff development director/ registered nurse (SDD) had instructed podiatry per the nurse manager that R46 would like podiatry services in his room in bed but the SDD advised podiatry staff that they would not need to utilize EBP. The SDD explained to podiatry staff that working on his feet would not prevent a splash risk so they would not need to don or doff PPE for this encounter. During an observation on 11/19/24 at 11:42 a.m., licensed practical nurse (LPN)-B was observed in R46's room with gloves on but no gown. LPN-B was observed to lean into R46's bed, pull back his covers, and reposition R46's legs. LPN-B was then observed to continue leaning against R46's bed to adjust the pillows between R46's legs before removing his gloves and leaving the room. During an interview on 11/21/24 at 8:04 a.m., the SDD stated she completed EBP education for nursing staff. The SDD stated staff should utilize EBP when there was a splash risk but if an activity did have a splash risk such as transferring a resident or completing foot care EBP would not be needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 9:34 a.m. with the director of nursing (DON) and the infection preventionist (IP), the IP stated the SDD completed all staff infection prevention education. The IP stated it was important for staff to read the CDC infection control signs that outline when PPE was needed for residents on EBP. The IP stated she would expect nursing staff to utilize EBP when they were transferring a resident per the CDC sign. The DON stated when care was being given to a resident in bed and involved staff-to-resident contact, she would expect nursing staff to utilize PPE, given the possible burden of MDROs in the resident ' s room. The facility's EBP policy dated 11/8/24, indicated EBP was needed for residents with chronic wounds and indwelling medical devices such as feeding tubes. The policy indicated that glove and gown use should be utilized for dressing, bathing, transferring, providing hygiene, changing linens, assisting with toileting, etc. 48065 R21's quarterly Minimum Data Set (MDS) dated [DATE], indicated R21 had moderate cognitive impairment, was diagnosed with severe vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), left side hemiplegia (paralysis of the left side of the body), and a pressure area (pressure areas are injuries to the skin and the tissue below the skin that are due to extended pressure on the skin). The MDS also indicated R21 required substantial assistance with mobility, and total assistance with toileting and hygiene. R21's Clinical Diagnosis report printed 11/21/24, documented R21 was on enhanced barrier precautions related to a wound. R21's Order Summary report dated 11/21/24, indicated orders for wound care to right posterior thigh. The order directed nurses to 1. Clean right posterior thigh with unscented soap [Cetaphil/dove]. 2. Apply small amount of VASHE [a wound cleanser solution] on gauze, lay into wound bed, let it sit for 10 minutes, remove gauze, do not rinse. 3. Gently pack with VASHE moistened plain packing strip to fill depth of wound, ensure to leave a tail for easy removal. Do not overpack. 4. Cover with Mepilex dressing [Mepilex Ag is a soft and conformable dressing that absorbs exudate and inactivates wound pathogens]. Change every- day shift and as needed if soiled/saturated/dislodged. During observation on 11/20/24 at 10:22 a.m., nursing assistant (NA)-C was observed providing personal cares to R21 without wearing a gown. R21 was in bed, turned on her right side facing the wall and NA-C was adjusting R21's brief. NAR's legs were touching the bed linen and NA-C was wearing gloves. NA-C finished adjusting R21's pants and left the room to find another NA to help him transfer R21 with a mechanical lift. NA-C came back to the room followed by NA-D who was pushing the mechanical lift. Before entering R21's room, NA-C and NA-D put on gloves, but did not wear gowns and transferred R21 from her bed to her wheelchair. During interview on 11/20/24 at 10:27 a.m., NA-D confirmed she didn't use a gown when she assisted R21 during transfer. When asked regarding the EBP sign posted to the right side of R21's room, NA-D started reading it aloud. After she finished reading the sign NA-D said, I was supposed to clean my hands before I entered the room, wear gloves and a gown. NA-D stated she didn't know what EBP meant, but she could find out by asking the nurse. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/20/24 at 10:41 a.m., NA-C stated he didn't wear a gown while changing R21's brief and added I wore gloves. When directed to the EBP sign next to R21's door, NA-C asked, do I have to use a gown all the time? NA-C proceeded to read the sign and stated, we [staff] need to follow precautions to prevent further disease and infections to go around. During interview on 11/20/24 at 10:47 a.m., LPN-A, who was caring for R21 stated, it is concerning when staff don't follow EBP precautions due to the potential of spreading pathogens and diseases. LPN-A added the expectation was for all staff to follow the infection precautions as indicated by the signs posted adjacent to the resident's rooms.