

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Ebenezer Integrated Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 45 West 10th Street Saint Paul, MN 55102	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598</p> <p>Based on interview and document review, the facility failed to determine causal factors and develop new interventions to prevent falls for 1 of 1 residents (R1) reviewed for falls who had a history of falls and slid out of wheelchair while transporting to appointment.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had dementia, schizophrenia and moderate cognitive impairment. R1's MDS further indicated she used a wheelchair for mobility and could not ambulate.</p> <p>R1's care plan dated 7/18/24, indicated R1 was at risk for falls related to deconditioning, balance problems, incontinence, psychoactive drug use and history of falls. R1's care plan directed staff to anticipate needs, give resident verbal reminders not to transfer without assistance and offer to lie down when observed restless in wheelchair.</p> <p>R1's Fall assessment dated [DATE], indicated R1 had intermittent confusion, chair bound, required assistive device and scored a fall risk of 13 (moderate risk for falls).</p> <p>A fall Interdisciplinary Note (IDT) note dated 5/28/24, indicated resident found lying on the floor, right side wheelchair nearby, shoes on. Resident stated she was trying to get back into bed. No injuries observed, impaired memory, confused, impaired safety judgement and misjudgment ability was noted.</p> <p>An Interdisciplinary Note (IDT) dated 8/28/24, indicated Driver called for res' called nursing station to say that res {R1} fell out of her wheelchair and that he could not get her to stay in the wheelchair. Writer told driver to call 911 to get assistance from EMT (emergency medical technician) but he refused to do that. The driver brought res back to facility as she sat on the floor of the van. When res arrived at facility, staff assessed her and returned her to her wheelchair. Resident {R1} unable to give description. The IDT note indicated using a gait belt and three staff members, res {R1} was returned to her wheelchair and then wheeled out of the van. Writer took her to dining room and sat with her while she ate dinner. When she was returned to her bed, nurse assessed her skin for any bruising and did a set of vitals. The IDT note indicated no injuries were observed, and she was wearing shoes, was confused and incontinent.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 8/29/24 at 10:06 a.m., indicated reviewed R1's fall reported by transportation company on 8/28/24. Resident slid from her wheelchair while being transported back to facility following appointment. No injuries appears to be an isolated occurrence. Not reportable, abuse/neglect is not suspected. Care plan reviewed.</p> <p>Review of R1's electronic health record lacked documentation a post-fall assessment had been completed which identified the cause of the fall and updated interventions put in place to prevent additional falls from occurring while transporting R1 to appointments.</p> <p>During an interview on 9/26/24 at 9:04 a.m., family member (FM)-A stated R1 had her appointment on 8/28/24, she had surgery that day and the appointment was supposed to be canceled however there was a mix up. FM-A stated she was informed on R1's way back from her appointment she fell out of her wheelchair, the driver called for help, and refused to follow the facility's request to send R1 to the hospital. The facility informed FM-A they would follow up with the transportation company on what exactly happened and a week later FM-A stated she had called and the transportation company had no knowledge of the incident with R1.</p> <p>During an interview on 9/30/24 at 2:08 p.m., the health unit coordinator (HUC)-A for memory care/long term care stated on 8/28/24, when R1 returned from her appointment she remembered the driver informing her R1 slid out of her wheelchair and had raised her seat belt. The HUC-A further stated R1 had been refusing her medications, was confused as she was talking about Jesus, drinking margaritas and being pregnant by Jesus when she returned from her appointment.</p> <p>During an interview on 9/30/24 at 2:30 p.m., the facility administrator stated she was aware of the incident with R1 sliding to the floor of the transportation van. The administrator stated the transporting company called the facility stating R1 slid out of her wheelchair on her way back from her appointment and asked what was wrong with our resident because she kept wanting to sit on the floor. The driver said she was sitting on the floor for 10 minutes before arriving back to the facility after her appointment. The administrator did state after the incident, she had attempted to reach the transportation company with no return calls.</p> <p>During an interview on 10/01/24 at 9:45 a.m., nursing assistant (NA)-A stated R1 was at risk for falls and when she was in her wheelchair she always attempted to slide out of her chair. In addition, NA-A stated it never felt safe to have her in a wheelchair for transportation for appointments.</p> <p>During an interview on 10/01/24 at 10:00 a.m., NA-B stated whenever R1 was placed in her wheelchair, she attempted to get out and wanted to slide out. NA-B stated the nursing staff had been informed of it and the only way R1 would have been safe to be transported to appointments was in a reclining wheelchair, not a regular wheelchair.</p> <p>During an interview on 10/01/24 at 10:05 a.m., transportation company owner stated the incident occurred around on 8/28/24, at 4:20 p.m., during traffic time after the driver picked R1 up from her appointment. At first R1 was sliding a little and asked the driver to slid her back into her chair, and once the driver started to drive he had to stop and slid her back into her chair, and then she ended up on the floor shortly after he started to drive again. The owner stated she did not understand how they could have sent R1 alone in the van with just the driver since she would not sit in a wheelchair alone. The owner stated R1 would not be allowed to use their company again unless a staff member was with or in a stretcher.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/01/24, at 12:00 p.m., the facility director of nursing (DON) stated she was not informed R1 was at risk of sliding out of her wheelchair. The DON further stated the staff should have informed her prior to R1's fall.</p> <p>Ebenezer Policy Fall Risk, Post Fall investigation, Follow Up, and Care, revision 12/23 indicated, the purpose is to define nursing role in the management of patients at risk for falls and post fall investigation, follow up and care.</p>