

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 12/05/2025
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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to follow care plan interventions required to provide safe transfers for 1 of 3 residents (R1) who required the use of a walker, gait belt, wheelchair and assist of one staff for transfer assistance. This resulted in actual harm when R1 was ambulated without contact guard assist and a wheelchair behind her, fell, and sustained a fracture of the shoulder. The facility implemented corrective action prior to the start of the survey, so therefore, the deficiency was issued at Past Noncompliance. Findings include: R1's face sheet dated 12/4/25, indicated R1 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) following unspecified cerebrovascular disease affecting right dominant side, acute on chronic diastolic heart failure, chronic obstructive pulmonary disease, type II diabetes, and atrial fibrillation. R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R1 was cognitively intact and was dependent on staff for assistance with activities of daily living (ADL) including transfers and toileting. R1's ADL care plan focus last revised on 10/9/25 identified R1 had a self-care performance deficit due to weakness, deconditioned and stroke with left side hemiparesis. R1's transfer care plan dated 8/26/25 directed staff to transfer R1 with an assist of one with a transfer belt and two wheeled walker. R1's therapy to nursing communication, dated 10/7/25 directed R1 required the assist of 1 with the gait belt and the wheelchair to follow. Comments included contact guard assist and bilateral knee braces. Walk 1 time day to dining room and back with one seated rest break, contact guard assist and bilateral knee braces on. R1's progress note dated 11/10/25 at 2:05 p.m., indicated that a nursing assistant reported to a nurse that while assisting R1 with toileting, the resident lost balance and fell while being assisted to sit in the wheelchair using a gait belt and a walker. The new intervention identified staff is now using the current care plan. The nurse practitioner was notified and an order for an x-ray of the left shoulder was placed. R1's imaging results, dated 11/10/25 identified R1 had acute comminuted fracture (severe fracture with several breaks) of the proximal humerus (upper arm bone) which involves the surgical neck and greater tuberosity prominent bony landmark of the humerus), with mild displacement. There is normal joint alignment. Mild glenohumeral (shoulder joint) and severe acromioclavicular joint degeneration (where the shoulder meets the clavicle) changes. Osteopenia aortic atherosclerosis. R1's progress note dated 11/10/25 at 11:35 p.m., indicated the x-ray results were received and included the results as identified per the imaging result. R1 progress note dated 11/11/25 at 9:52 a.m., indicated the interdisciplinary team met to discuss R1's fall. The note indicated the care plan was not followed. The resident was transferring from toilet to her wheelchair by ambulation when care plan designates the resident is pivot stand transfer (sic-inconsistent with the care plan). The wheelchair was not positioned next to the resident during the attempted transfer. Resident's legs became weak when attempting to ambulate to her wheelchair outside the bathroom door and resident fell. Fall resulted in shoulder fracture. The new intervention included educating staff about current care plan, R1's walking program was discontinued. Requested and received orders for physical therapy to evaluate transfers, fall and pain management. R1's transfer intervention last revised 11/11/25 directed staff R1 required assist of two with a mechanical lift, medium sling size. The care plan had a focus section about R1's limited physical mobility due to weakness, deconditioned, poor balance, unsteady gait and a history of stroke with left side hemiparesis. Interventions included:-Ambulation: resident does not walk. Not dated.-Escort in wheelchair to destinations. Not dated.-Non-weight bearing left shoulder, at least x 6 weeks. Not dated.-Non weight bearing left arm. Dated 11/10/25.-Shoulder Immobilizer to left arm at all times, remove daily for hygiene. Dated 11/26/25. During an interview on 12/5/25 at 8:31 a.m., nursing assistant (NA)-C stated she was taking R1 to the bathroom Around 2:00 p.m., NA-C said she was new, and it was her first solo day on the unit. NA-C explained on 11/10/25 R1 was in bed and needed to use the bathroom. NA-C put the gait belt around R1's waist, R1 stood up, pivoted and transferred to the wheelchair, was brought to the toilet, R1 stood, pivoted and transferred onto the toilet. R1 was provided privacy, five minutes later NA-C returned. NA-C couldn't get the wheelchair to fit in the bathroom with the walker. NA-C held her gait belt, R1 stood up and NA-C pulled the walker closer. R1 had to take a few steps while NA-C pulled the wheelchair closer. While NA-C was pulling the wheelchair closer R1 became unsteady. NA-C helped lower her to the ground and went to get help. NA-C was re-educated to follow the care plan and to ask for help if needed. NA-C stated she was re-educated that the wheelchair would fit in the bathroom when the foot pedals were removed. NA-C stated</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review, interview and observation, the facility failed to implement proper infection control when three staff were observed not following enhanced barrier precautions or hand hygiene during direct care for 2 of 4 (R3, R4, R5) residents reviewed for infection prevention. Findings include: Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be infected with multi-drug-resistant organisms as well as those at increased risk of multi-drug resistant organism acquisition (residents with wounds or indwelling medical devices) R2's face sheet dated 12/4/25, indicated R2 had diagnoses of cellulitis of unspecified part of limb, lymphedema (swelling), need for assistance with personal care, type II diabetes and rhabdomyolysis (breakdown of skeletal muscle tissue). R2's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R2 was moderately cognitively impaired and dependent on staff for activities of daily living, including transfers. R2's care plan dated 12/4/25, had a focus section, Enhanced barrier precautions indefinitely due to wounds. The interventions listed included gloves and gown prior to the high-contact care activity. High-contact resident care activities such as but not limited to: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use for central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care. R2's order set lacked orders for enhanced barrier precautions. During an observation on 12/4/25 at 8:54 a.m., R2 was in bed and was waiting for assistance with a transfer to his wheelchair. R2 had an EBP sign on his door that indicated when staff should practice EBP, and which PPE should be worn. Three staff, nursing assistant (NA)-A, NA-B and physical therapist (PT)-A were already in the room. They all had gloves on, but no gowns. R2's brief had leaked, and urine had soaked the bed linens. NA-A assisted R2 to change into a clean gown, the clean gown became soaked with urine immediately. NA-A left to get R2 a beverage, returned to the room and put on new gloves. NA-B and PT-A were working on obtaining a functioning mechanical lift, NA-B had left the room. At 9:03 a.m., NA-A removed R2's gown and placed a new one on without changing gloves or completing hand hygiene. NA-A adjusted the foot pedals on R2's wheelchair, changed her gloves and then adjusted the call light button. PT-A assists R2 in sitting up at the side of the bed. NA-A applied the mechanical lift sling. PT-A put on another gown to cover R2's back side. PT-A and NA-A both adjusted the sling and were questioning the size of the sling for the resident. R2 says he doesn't think the sling is the right size. At 9:10 a.m., PT-A left the room to obtain a different sling. R2 requested his morning supplement drink, NA-A shook the drink and opened it for R2. NA-A removed R2's gown on his back and put a larger size on to cover his back side. At 9:17 a.m., NA-B returned with a new sling, NA-B was not wearing gloves or a gown. NA-B operated the mechanical lift and NA-A removed the soiled linens. NA-B transfers R2 to the wheelchair, adjusted his oxygen tubing and removed the sling. NA-A started opening cabinets, adjusted the bedside table and set up R2's breakfast on the bedside table. NA-A removed the soiled linen from the room, removed her gloves and used hand sanitizer. PT-A and NA-B left the room. R3's face sheet dated 12/4/25, indicated R3 has diagnoses of type II diabetes, traumatic subdural hemorrhage with loss of consciousness, need for assistance with personal care, chronic pancreatitis and repeated falls. R3's Medicare 5-day MDS assessment dated [DATE], indicated R3 was cognitively intact and required partial moderate assistance with some activities of daily living. R3's care plan dated 12/4/25, had a focus section, Enhanced barrier precautions indefinitely due to wounds. The interventions listed included gloves and gown prior to the high-contact care activity. High-contact resident care activities such as but not limited to dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use for central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care. R3's order set lacked orders for enhanced barrier precautions. During an observation on 12/4/25 at 11:35 a.m., R3 was in her room sitting in a recliner. R3 had an EBP sign on her door that indicated when staff should practice EBP, and which PPE should be worn. NA-B was in the room tidying up for R3. NA-B was not wearing gloves or a gown. NA-B removed the dirty linen from R3's bed and placed it in a trash bag. NA-B then touched R3's walker, emptied the trash and put a new trash bag in. NA-B took the trash, soiled linen bag, nursing assistant tablet and exited the room. NA-B disposed of the trash and then washed her hands. During an interview on 12/4/25 at 1:01 p.m., NA-B stated hand hygiene should be completed when entering or leaving a resident room. Gloves should be changed anytime contact with a resident is stopped. FRP means that anytime personal cares or transfers are done, a gown and gloves</p>		