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	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Integrated Care & Rehab	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure fasting blood glucose (BG) testing was performed before a meal for 1 of 2 residents (R28) observed who required insulin (medication used to lower blood glucose) based on a sliding scale.Findings include:R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 was cognitively intact, dependent on staff for most activities of daily living (ADLs), required insulin injections every day of the seven-day lookback period and had a diagnosis of diabetes mellitus (disease that leads to elevated blood glucose). R28's care plan revised 3/12/26, indicated R28 had diabetes mellitus type 2 and instructed staff to monitor blood sugars per provider order and as needed. R28's provider order dated 11/21/25, instructed, Monitor BG-Levels QID AC and HS [four times a day before meals and at bedtime]. R28's provider order dated 11/24/25, instructed, Insulin Aspart Pen-injector 100 units/milliliter (ML) inject as per sliding scale: if BG 0-139 = 0 units; 140-189=1 unit; 190-239=2units; 240-289=3units; 290-339=4units; 340-439=5units; 440+=7units, subcutaneously with meals for diabetes. During observation on 3/31/26 at 8:28 a.m., licensed practical nurse (LPN)-B entered R28's room to administer morning medications. R28 was sitting up in bed with his bedside table over the bed and a breakfast tray on the table. R28's breakfast included scrambled eggs, blueberry muffin, cereal, milk and juice. R28 had eaten approximately ninety percent of the scrambled eggs and had taken some of each of the beverages. LPN-B told R28 to go ahead and finish his eggs and then she handed him a cup containing his oral medications, which he took and swallowed. LPN-B then prepped the BG meter and pricked R28's finger and obtained a sample of blood to test for the level of blood sugar in his blood. R28's BG was 175. LPN-B reviewed R28's orders and stated he needed 1 unit of insulin as indicated by the ordered sliding scale and proceeded to inject the insulin. During interview on 3/31/26 at 8:45 a.m., R28 stated his BG should be checked prior to eating meals since the amount of one of the insulins he received was based on the BG result and a sliding scale. During interview on 3/31/26 at 8:49 p.m., LPN-B stated R28's BG should have been tested by 7:30 a.m., to ensure it was before breakfast. LPN-B stated testing prior to a meal would have provided a more accurate fasting BG. During interview on 4/1/26 at 7:14 a.m., registered nurse (RN)-C stated insulin administered per sliding scale should be based on a fasting BG (before a meal) in order to ensure an accurate amount of insulin was provided. During interview on 4/1/26 at 10:42 a.m., RN-A stated staff were expected to be checking BG before meals to get an accurate fasting BG result. RN-A stated a BG taken after a resident already started eating or completed a meal, could provide an inaccurate level and the amount of insulin provided based on the result and per sliding scale could be incorrect. During interview on 4/1/26 at 1:21 p.m., director of nursing (DON) stated expectation for fasting BG to be taken prior to a meal and that a BG taken during or after a meal could potentially indicate a wrong dose of insulin administered per sliding scale. Facility policy Blood Sugar Monitoring dated 4/25, instructed staff to monitor resident BG levels per provider order.

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure active interventions were implemented to reduce the risk of falls for 1 of 2 residents (R46) who had repeated falls and was reviewed for accidents.Findings include:R46's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and no behaviors. A walker and wheelchair were used, and substantial/maximal assist was required for transfers, ambulation, toileting, lower body dressing, and bed mobility. R46 had a diagnosis of vascular dementia (nontraumatic brain dysfunction). One fall occurred since the last assessment with two or more injuries.R46's annual Care Area Assessment (CAA) dated 6/2/25, identified falls triggered due to falls since previous MDS. R46 had two falls without injury due to poor balance, poor judgement, and wearing inappropriate footwear. Fall risk score was 12 and indicated high risk for falls. Dementia with severe cognitive impairment contributed to poor safety awareness and decision-making. He demonstrated shuffling gait and poor balance. Staff supervised his activity, provided reminders and redirection, and ensured he was wearing appropriate footwear. Additional contributing factors were incontinence and heart failure. R46 was at risk for further loss with all areas due to advancing disease process. Interventions were in place and the plan was to continue assisting with cares for R46 at present level. Reference care plan for goals and interventions.R46's Fall Risk assessment dated [DATE], identified he was at high risk for falls.R46's falls care plan dated 3/31/26, identified he was at risk for falls related to cognitive impairment, deconditioning, gait and balance instability, crisscross gait pattern, incontinence, incomplete bladder emptying, history of falls, and history of low blood pressure. Interventions effective 2/18/26, were to remove R45's feet from the footrests and place wheelchair footrests in upright position when not propelling.R46's progress notes dated 1/18/26 through 3/31/26, identified three falls from his wheelchair.On 1/18/26 at 8:27 p.m., R46 was found on the floor in TV lobby at 6:15 p.m., with no injury. R46 said he tried to get up to use the bathroom. The nursing assistant last checked on R46 10 minutes before the fall and denied toileting R46 after the evening meal. The root cause analysis included was standing up unassisted to try and use the bathroom without locking wheelchair brakes, and misjudgment of ability. The NA last checked on him 10 min ago and R46 was not toileted after the meal. Immediate interventions included frequent checks and to encourage R46 to ask for help before transferring.The Post Fall IDT note dated 1/19/26 at 11:41 a.m., identified new Interventions included cue resident after every meal to go to the bathroom and offer assistance, and a request was sent to therapy to evaluate for strengthening.On 2/17/26 at 9:51 p.m., R46 had an unwitnessed fall to the floor from his wheelchair in the dining room at 7:15 p.m., and sustained a laceration to the left upper eyelid. R46 was toileted around dinner, and the root cause analysis included misjudgment of ability. Immediate interventions included staff to constantly check on R46.The Post Fall IDT note dated 2/18/26 at 10:07 a.m., identified R46's wheelchair footrests were in the down position, and R46 likely tripped when attempting to stand and walk from his wheelchair. A new intervention was placed for wheelchair footrests in upright position when not propelling R46 to destinations.On 3/3/26 at 4:15 p.m., R46 was witnessed by staff standing up in the dining room, his body leaned to the left, the wheelchair tipped over and he fell to the floor. The root cause analysis included misjudgment of ability and cognitive impairments. Lapses in memory about R46's physical limitations resulted in attempts to transfer/ambulate without assist. R46 had actual repeated falls due to weakness, deconditioning, poor balance, poor insight into deficit, and antiarrhythmic medication use. Immediate interventions included increased rounding and staff presence, especially before and after dinner time which were high risk times.The IDT Follow Up Incident progress note dated 3/4/26 at 10:22 a.m., identified occupational therapy would assess additional wheelchair safety. The note did not identify if the footrests were positioned up according to the care plan.During (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an observation on 3/30/26 at 1:52 p.m., R46 was observed to be lying face down on the floor next to his bed. R46's bed was in a low position, and his call light was on the bed and not activated. Surveyor went to alert staff and nursing assistant (NA)-A and NA-B alerted the nurse and both NAs came down to R46's room to check on him. At 1:54 p.m., licensed practical nurse (LPN)-A arrived at the room, saw he was waking up, and left to get the vital signs machine. At 1:55 p.m., R46 got up onto his knees and got back into bed independently, despite NA-A and NA-B advising him to be still until LPN-A returns to assess for any injuries. At 1:57 p.m., LPN-A re-entered the room with the vital signs machine. LPN-A stated R46 could not communicate well so staff had to look for non-verbal signs. LPN-A assessed range of motion, skin condition, and vital signs which were within normal limits. LPN-A stated R46 had been up most of the morning and was assisted into bed shortly before he fell out of bed.During an interview on 3/30/26 at 4:39 p.m., R46's family member (FM)-A stated she had concerns about R46 having repeated falls.During a continuous observation on 4/1/26 starting at 7:45 a.m. to 10:15 a.m., R46 was seated at the dining room table alone. Licensed practical nurse (LPN)-A was at the medication cart approximately 10 feet away. R46's feet were placed on the wheelchair footrests which were not in an upright position, which conflicted with the care plan intervention to place wheelchair footrests in upright position when not propelling.At 8:14 a.m., R46's breakfast tray was placed in front of him and began eating and drinking independently. One other resident was at the table along with a nursing assistant. R46's feet were still on the footrests which were not in an upright position. At 8:45 a.m., R46 finished with breakfast and was brought to the commons by nursing assistant (NA)-B to watch TV. R46's feet remained on the footrests while propelling and after being stopped near the television. NA-B was intermittently close to R46 but escorted residents to other places and intervened with other residents. R46 was awake and alert with his feet on the footrests which were not in the upright position. At 9:19 a.m., NA-B left the unit and LPN-A remained at her medication cart about 10 feet away from R46. At 9:22 a.m., LPN-A walked by R46 and had not corrected the position of his footrests. At 9:24 a.m., NA-B re-entered the dining room which was approximately 15 feet away from R46 and LPN-A left the area. R46 remained in his wheelchair with his feet in the footrests that were not in the upright position. At 9:33 a.m., NA-A took R46's shoes off, put on gripper socks on both of his feet, and then put his shoes back on while his feet remained on the footrest, then NA-A left the area. R46 remained in the commons area with intermittent staff in the area but no staff right next to him to intervene quickly if he attempted to self-transfer. Staff in the area had not corrected the position of the footrests.At 10:00 a.m., NA-A brought R46 from the commons area back to his room. Once in R46's room NA-A flipped up R46's footrests and angled them off to the side away from the front of the wheelchair and assisted R46 to transfer into bed using a gait belt and one staff assist. When NA-A was asked how she knew which fall interventions R46 had in place, she stated interventions showed up on their charting iPad, and the nurse would update them on new interventions. NA-A acknowledged she put R46's gripper socks on while the footrests were not in an upright position but R46 was not propelling.At 10:10 a.m., after NA-A left R46's room, NA-A was asked to show surveyor a list of R46's fall interventions from their iPad to verify if all interventions were visible on the NA's charting iPad. NA-A would not answer. R46's Kardex (list of cares) was shown to NA-A with the fall intervention of keeping feet off the footrests unless propelling in wheelchair. NA-A would not answer and deferred surveyor to LPN-A who was also in the hallway. LPN-A reviewed the Kardex and stated that fall intervention to keep feet off footrests unless propelling was in place because when R46 would stand up, he would trip over the footrests and had falls in the past related to this issue. LPN-A stated R46 had been calmer the last couple of days and that might by why R46's footrests remained in place with his feet on top, even though he was not propelling. NA-A then stated yes that was the reason why his footrests remained in use. During an interview on 4/1/26 at 10:15 a.m., (RN)-A stated fall interventions listed on the Kardex and care plan should be followed as written for safety reasons. All nursing staff had access to the interventions. RN-A stated R46 had a fall in the past from tripping over his footrests and since the intervention of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	keeping the footrests up was implemented, he has not had falls from tripping over the footrests. RN-A stated R46's vascular dementia was challenging because he could not process the dangers of self-transferring.During an interview on 4/1/26 at 2:28 p.m., the director of nursing (DON) stated staff should review the care plan or Kardex at the start of their shift. Fall risk interventions should be implemented as written for safety. Following a fall, the interdisciplinary team (IDT) would review any resident falls and see if the care planned interventions were in place. If documentation was lacking, the IDT would follow up with the staff working during the fall.During a follow up interview on 4/1/26 at 2:58 p.m., The DON stated keeping R46's feet off the footrests unless propelling was still an active intervention that should have been implemented.The facility's Fall Risk, Post Fall Investigation, Follow Up, and Care policy dated 1/26, identified Universal fall precautions are used for all patients based on individual patient needs. Interventions should be selected based on individual patient needs. Document interventions in the medical record. Falls risk and interventions should be noted on the plan of care.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assist in obtaining routine dental services for 1 of 1 resident (R1) reviewed for dental services. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, dependent on staff for oral hygiene, and did not exhibit rejection of care behavior. R1's diagnoses included hemiplegia and hemiparesis (weakness and paralysis affecting one side of the body). R1's care plan revised on 3/4/26, identified R1 had a self-care performance deficit and required substantial to dependent assistance with personal hygiene and oral care. R1's Oral/Dental Assessment ([NAME]) dated 9/23/25, indicated R1did not have any oral concerns, but was considering partials for his edentulous (lacking teeth) upper and lower premolars. R28's [NAME] indicated R28 had not seen a dentist in over two years and neither R28 nor a responsible party declined offer for routine dental appointment. R1's [NAME] dated 12/22/25, indicted R28 had no dental concerns, but had not seen a dentist in over two years and neither R28 nor a responsible party declined offer for routine dental appointment. R1's medical record lacked evidence of a dental appointment or any reference to an offer for dental referral. During interview on 3/30/26 at 12:43 p.m., R1 stated had not seen a dentist in at least a year and a half and had not been offered to see a dentist since admission. During interview on 3/31/26 at 12:35 p.m., registered nurse (RN)-B stated the MDS nurse would schedule the quarterly oral assessment, and the assigned nurse or charge nurse would complete the assessment as identified on the treatment administration record (TAR). If it was identified that the resident needed a dental referral due to oral issues or lack of routine dental evaluation, they would notify the provider to have a dental referral placed. RN-B further stated if the resident had a dental appointment while a resident, there would be documentation in the electronic medical record (EMR) indicating a summary of the appointment. RN-B stated if documentation could not be located, she would consult the health unit coordinator (HUC) who could determine if a referral had been made and/or an appointment scheduled or completed. RN-B stated regardless of a resident's dental status, if a resident had not seen a dentist in over two years and they did not decline an appointment; a referral should be made. During interview on 4/1/26 at 9:49 a.m., family member (FM)-B stated could not remember the last time R28 had seen a dentist and could not recall any discussion with the facility regarding offering dental services. FM-B further stated would expect R28 to be offered routine dental care and neither she nor R28 would decline those services. During interview on 4/1/26 at 10:13 p.m., HUC stated if a resident wanted to see a dentist, and did not have their own dental clinic, she would arrange for an appointment and transportation when she received a referral from their provider. HUC looked in R28's EMR and confirmed R28 did not have a dental appointment scheduled and had not seen a dentist since his admission. During interview on 4/1/26 at 10:42 a.m., RN-A stated if a resident was assessed and found to need or desire to see a dentist, the nurse would request a referral from the provider, and the facility would get a consent and make the arrangements. RN-A further stated R18 should have been offered a dental referral regardless of his dental status and that routine dental care could prevent oral issues in the future. During interview on 4/1/26 at 1:21 p.m., director of nursing (DON) stated dental referral should be recommended and arranged per resident preference. DON expected staff to address R28's lack of dental visits and offer to arrange a dental appointment. Facility policy Consultant Visit Policy - Audiology, Optometry, Podiatry, and Dental Services dated 6/25, identified the facility was responsible for scheduling and coordinating dental consultations for residents. The policy further indicated, Within 90 days of admission, staff will refer the resident for an initial dental examination, unless the resident has had a dental exam within six months before admission. After the initial exam, staff will offer an annual dental exam within one year of the previous exam.