DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 27NF
Facility ID: 00844

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245471**
2. STATE VENDOR OR MEDICAID NO. (L2) **048540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN SCENIC SHORES**
(L4) **402 - 13TH AVENUE**
(L5) **TWO HARBORS, MN** (L6) **55616**

4. TYPE OF ACTION: **7**
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/01/2011**
6. DATE OF SURVEY **06/13/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **44** (L18)
13. Total Certified Beds **44** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 06/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/01/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **05/01/1987** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/15/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245471

August 1, 2016

Mr. Steve Baukner, Administrator
Ecumen Scenic Shores
402 - 13th Avenue
Two Harbors, Minnesota 55616

Dear Mr. Baukner:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 3, 2016 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility bed.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter / eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 28, 2016

Mr. Steve Baukner, Administrator
Ecumen Scenic Shores
402 - 13th Avenue
Two Harbors, Minnesota 55616

RE: Project Number S5471026

Dear Mr. Baukner:

On May 9, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 28, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On June 13, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 3, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 28, 2016, effective June 3, 2016 and therefore remedies outlined in our letter to you dated May 9, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245471	A. Building B. Wing	6/13/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 06/03/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	06/28/2016	29433	06/13/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245471	A. Building 01 - MAIN BUILDING B. Wing	6/27/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 05/03/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 05/03/2016	ID Prefix Reg. # NFPA 101 LSC K0066	Correction Completed 05/09/2016
ID Prefix Reg. # NFPA 101 LSC K0104	Correction Completed 05/24/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 06/28/2016	SIGNATURE OF SURVEYOR 27200	DATE 06/27/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/26/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 27NF
Facility ID: 00844

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2. STATE VENDOR OR MEDICAID NO. (L2) **048540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN SCENIC SHORES**
(L4) **402 - 13TH AVENUE**
(L5) **TWO HARBORS, MN** (L6) **55616**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/01/2011**

6. DATE OF SURVEY **04/28/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 06/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/14/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/15/2016** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5471

At the time of the April 28, 2016 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

In addition, at the time of the standard survey an investigation of complaint number H5471008 was conducted and found to be unsubstantiated.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 0961

May 13, 2016

Mr. Steve Baukner, Administrator
Ecumen Scenic Shores
402 - 13th Avenue
Two Harbors, MN 55616

RE: Project Number S5471026, H5471008
Dear Mr. Baukner:

On April 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the April 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5471008 that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: pam.kerssen@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 7, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 28, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

RECEIVED
MAY 2 5 2016
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	**402 - 13TH AVENUE TWO HARBORS, MN 55616**

(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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5471008 was completed and found not to be substantiated.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and	F 323	TA 5/25/16 Rec'd 6/3/16 OK	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Director
(X6) DATE: 5/24/16

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

(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
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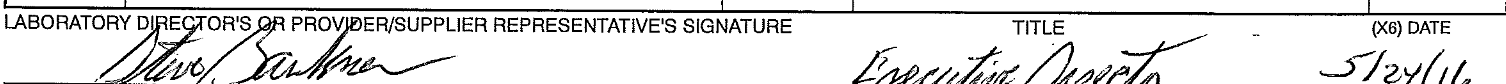
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and	F 323 TA 6/13/16 OK	F323 1. Corrective Action: A. Alarms were replaced for residents R56 and R36. B. Task placed for staff to document each shift that they checked the alarms for proper functioning and date. C. Nurses task was placed to change alarm prior to day 45. 2. Corrective Action as it applies to Other Residents:	

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



Executive Director 5/24/16

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F 323	Continued From page 1 implement a system for monitoring fall-prevention equipment for proper functioning and expiration dates to decrease the risk of falls for 2 of 3 residents (R56, R36) reviewed with pressure alarms as fall interventions. Findings include: R56's face sheet printed 4/28/16, indicated R56's diagnoses included Alzheimer's disease, delusional disorder, and repeated falls. R56's quarterly Minimum Data Set (MDS) assessment dated 2/29/16, indicated R56 had severe cognitive impairment, required extensive assist of 2 staff for transfers and ambulation, was unsteady and required assistance by others to stabilize, and had a fall in the previous quarter. R56's care plan revised 12/8/15, indicated R56 was at high risk for falls related to R56's history of falls, dementia, and unsteadiness while ambulating. R56's care plan included a revision dated 4/11/16, that indicated R56 had a bed alarm. The active care guide group sheet, indicated R56's equipment included a pressure alarm in bed. On 4/26/16, at 12:32 p.m. R56 was heard calling out for help. R56 was sitting on the floor in the hallway outside her room doorway. No alarms were heard sounding. On 4/26/16, at 12:55 p.m. R56's bed had a pressure alarm box on the right side of the bed. On 4/26/16, at 1:01 p.m. registered nurse (RN)-D stated R56 had been laying in bed prior to falling. The director of nursing (DON) asked if the bed	F 323	A. The policy/procedure for alarm use and monitoring created. B. All nursing staff will be education on the policy and procedures on 5/31/2016. C. 100% audit was completed for all residents with alarms on 4/26/16. 3. Date of Completion: 6/3/2016 4. Reoccurrence will be Prevented by: A. Staff education on the revised policy/procedure on 5/31/2016 and upon hire, and as needed. 5. The Correction will be Monitored by: A. DON or designee will complete audits weekly x4, monthly x3, and as needed of alarm functioning and expiration dates. B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 2 alarm was sounding at the time of the accident. R36's facesheet printed 4/28/16, indicated R36's diagnoses included dementia with behavioral disturbances, Parkinson's disease, and fracture of the right hip. R36's comprehensive significant change MDS dated 3/30/16, indicated R36 had moderately impaired cognitive skills for daily decision making, required extensive assist of 2 staff for transfers, was unsteady and required assistance from others to stabilize, and had 1 fall without injury, one fall with injury less than major, and one fall with a major injury. R36's care plan revised 4/3/16, indicated R36 was at high risk for falls related to dementia, Parkinson's, weakness, dizziness and a recent fall with a fracture. R36's care guide group sheet indicated R36's equipment included a pressure alarm in the wheelchair and in bed. On 4/26/16, at 2:30 p.m. nursing assistant (NA)-A stated he listened for the beeps when sitting R36 down to ensure the pressure alarm pad is working. NA-A was unsure if the pads were dated and thought R36 had a pressure alarm in the chair and one on the bed. NA-A checked the dates on the pressure alarms and found there wasn't an alarm on the bed. NA-A verified chair alarm pad was dated 7/17/14. On 4/26/16, at 2:37 p.m. the DON verified R36's chair alarm pad was dated 7/17/14, and stated the pressure alarm pads were dated when they were initiated. The DON sated they review falls and incidents in new employee orientation (NEO), but it was not on the written orientation education.	F 323		

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F 323	Continued From page 3 The DON further stated it should be taught by the employee's mentor. The storage area for bed and chair alarms was checked. The DON verified there were no bed or chair pressure alarm pads in storage and stated they must be on order. RN-D verified she had checked R56's bed alarm when she laid R56 down and it was working at that time. R56's pressure alarm did not initially work, but when turned over, it did sound. R56's alarm was dated 3/31/16. On 4/26/16, at 3:05 a.m. the DON stated the pressure alarm pads had not been re-ordered. On 4/26/16, at 2:39 p.m. NA-H stated she thought the alarms were checked daily in the morning, but was not sure who checked them. NA-H stated she did not check the alarms. NA-H stated she thought the alarms expired and knew they were dated, but did not do that either. NA-H stated she did not know where any of the alarm data would be documented. On 4/26/16, at 3:22 p.m. NA-G stated the nursing assistants check the alarms when they come on their shift. On 4/26/16, at 3:07 p.m. RN-B stated NAs check the alarms at the beginning of the shift to make sure they are working. RN-B stated the NAs have been told to check the alarms at the beginning of each shift and they know to do this because they communicate between themselves. RN-B verified it is not written anywhere for them to check the alarms. On 4/26/16, at 3:29 p.m. the DON provided Horizon HCS Universal 45 day bed sensor pad information. The manufacturer's information	F 323		

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F 323	Continued From page 4 (Horizon HCS) indicated the sensor pad used on R56's bed and R36's bed and wheelchair was a Universal Bed Sensor Pad that should be changed every 45 days. On 4/28/16, at 10:54 a.m. the DON stated they had obtained new pressure alarm pads from their supply company and added a pressure alarm in R56's chair and put a new pressure alarm pad on R56's bed. R36's pressure alarm pad was also changed. The DON verified the pressure alarm pads expire in 45 days from the date they are initiated, and that staff are to date the pad when it is initiated. The facility policy and procedure for Fall Prevention revised 9/10, and the policy and procedure for Functional Safety Assessment revised 5/11, lacked directives for monitoring of proper functioning of safety devices and monitoring of expiration dates of safety devices.	F 323		

F5471025

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Ecumen Scenic Shores CC was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	APPROVED By Tom Linhoff at 2:11 pm, Jun 13, 2016 RECEIVED JUN - 1 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Dir	5/24/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	**402 - 13TH AVENUE** **TWO HARBORS, MN 55616**

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Ecumen Scenic Shores CC is a 1-story building that was constructed in 1979 with a partial basement, that was determined to be of Type II(111) Construction. In 1998 a one story addition with no basement was constructed that was determined to be of Type II(111). In 2001 a kitchen addition was constructed and was determined to be of Type II(111). In 2001 an assisted living building was added, that is properly 2 hour rated separated from the nursing home. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification.	K 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	Continued From page 2 The facility has a licensed capacity of 45 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 41 of 41 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 AM to 1:00 PM on	K 056	K 056 A. The gauges have been replaced as of 5/3/2016 by Viking Sprinkler. Will be monitored by Maintenance Director.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 056	Continued From page 3 04/26/2016, observations reveled that the gauge the is located on the facility's main fire sprinkler system riser was last tested or replaced on 05/03/2006 and not every 5 years as required by the NFPA 13 (99) code. This deficient practice was confirmed by the Maintenance Supervisor.	K 056		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 41 of 41 residents as well as an undetermined number of staff, and visitors to the facility. Findings Include: On facility tour between 10:00 PM to 1:00 PM on 04/26/2016, a review of documentation and an interview with the Maintenance Supervisor	K 062	K 062 A. The testing was done the documentation did not back that up. Viking Sprinkler had not provided the proper documentation. The Maintenance Director has developed a new system that will be three quarterly inspections and one annual inspection and corresponding paperwork according to regulations. Completed as of 5/3/2016. Will be monitored by Maintenance Director.	

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K 062	Continued From page 4 revealed that at the time of the inspection the facility could not provide any documentation for the annual fire sprinkler testing and for 2 of 4 quarterly fire sprinkler flow test verifying that they have been completed. This deficient practice was confirmed by the Maintenance Supervisor.	K 062		
K 066 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, the facility's written smoking policy is not in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code"	K 066	K 066 A. Removed trash receptacle from entrance area as 4/27/2016. Signs posted by employee entrance "NO SMOKING WITHIN 25 FEET" as of 4/27/2016. Approved cigarette butt containers purchased and in place as of 5/9/2016. Will be monitored by Maintenance Director.	

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K 066	Continued From page 5 (LSC) 2000 edition, Section 19.7.4. This deficient practice could affect 8 of 41 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 AM to 1:00 PM on 04/26/2016, observations revealed that the garbage can located inside the building at the employees' entrance had several cigarette butts thrown away in it and not in an approved metal self-closing container that is use only for spent cigarette butts. It was also found that outside of the employees' entrance by the door the wall had been blackened with ashes and appeared to be where the employees were extinguishing their cigarettes prior to entering the facility. According to the facility's smoking policy the property is a smoke free campus. This deficient practice was confirmed by the Maintenance Supervisor.	K 066		
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff	K 104	K 104 A. The maintenance staff misinterpreted the question that was asked. We have the proper documentation. ESC conducted their annual inspection as of 5/28/2015 and 5/24/2016. Maintenance Director will monitor.	

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0961

May 13, 2016

Mr. Steve Baukner, Administrator
Ecumen Scenic Shores
402 - 13th Avenue
Two Harbors, Minnesota 55616

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5471026, H5471008

Dear Mr. Baukner:

The above facility was surveyed on April 25, 2016 through April 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5471008. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: pam.kerssen@state.mn.us
Phone: (218) 302-6151   Fax: (218) 723-2359

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should contact Pam Kerssen at the phone number or email detailed above.**

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118   Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

PRINTED: 05/10/2016
FORM APPROVED

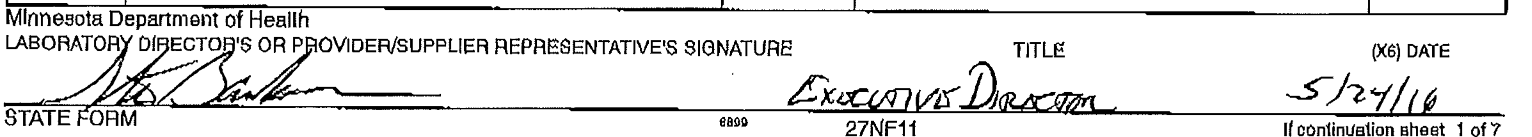
Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00844	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

(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) COMPLETE DATE
2 000	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 4/25/2016, through 4/28/2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE



Minnesota Department of Health

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2 000	Continued From page 1 Certification Program; 11 East Superior Street, Suite 290, Duluth, MN 55802. In addition, a complaint investigation was also completed at the time of the recertification survey. An investigation of complaint H5471008 was completed. The complaint was not substantiated.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.	2 302		

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2 302	Continued From page 2 (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided information regarding the facility's Alzheimer's training for staff. Findings include: On 4/26/16, at 9:06 a.m. the director of nursing (DON) verified they do not have information regarding Alzheimer's training in the admission packet. On 4/28/16, at 9:57 a.m. the social worker (SW) verified the facility has not provided communication to consumers regarding staff training in Alzheimer's. The facility was unable to provide a policy and procedure for Alzheimer's training and communication to consumers regarding the facility's Alzheimer's training.	2 302		

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2 302	Continued From page 3 SUGGESTED METHOD OF CORRECTION: The social worker and/or the director of nursing could review and/or revise facility policies and procedures related to Alzheimer's training and information provided to consumers. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward informing consumers of Alzheimer's training provided to employees. A documentation and monitoring system could be developed and implemented to ensure consumers have been informed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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21426	Continued From page 4	21426		

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure second step tuberculin skin testing (TST/Mantoux) was completed for three of five employees (EA, EB, EC).

Findings include:

EA was hired 2/24/16, and received a first step TST (a test that determines if a person has been exposed to the tuberculosis bacteria) on 2/21/16, with results read as negative and zero millimeters (mm) induration on 2/24/16. No second step TST was documented.
EB was hired 8/4/15, and received a first step TST on 8/19/15, with results read as negative and zero mm induration on 8/21/15. No second step TST was documented.

EC was hired 3/15/16, and received a first step TST on 4/13/16, with results read as negative and zero mm induration on 4/15/16. No second step TST was documented.

On 04/27/16, at 2:15 p.m. the director of nursing (DON) was interviewed and stated the facility was developing a better procedure for tracking TST/Mantoux testing for employees and resident immunizations. The DON further stated the second step Mantoux tests were given for some employees, but documentation was not completed. The DON further confirmed documentation was lacking for second step Mantoux test for three employees.
The facility Ecumen Employee Infection Control/Immunization standing orders dated

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21426	Continued From page 5 7/23/15, directed all employees will receive a two step Mantoux upon hire unless the employee has a history of a positive reaction to a Mantoux, is medically contraindicated from receiving a Mantoux, or has provided a copy of a negative Mantoux performed in the last twelve months. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure tuberculosis screening is completed for all new employees. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced	21942		

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21942	Continued From page 6 by: Based on interview and document review, the facility failed to ensure attempts to form a family council were conducted. Findings include: On 4/28/16, at 9:58 a.m. the social worker (SW) verified there was not a family council at the facility and there have been no formal attempts to form a family council since she began working at the facility in 3/15. The SW stated she had no information regarding previous attempts. The facility was unable to provide a policy and procedure regarding family council. SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review and/or revise facility policies and procedures related to family council. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward forming a family council. A documentation and monitoring system could be developed and implemented to ensure routine attempts have been made to form and establish a family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		