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: 72IV
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 (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 **7/20/2017** (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:
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):

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 07/20/20177 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/18/2017 (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 **07/31/2017** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245471 August 23, 2017

Mr. Steve Baukner, Administrator
Ecumen Scenic Shores
402 - 13th Avenue
Two Harbors, MN 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 July 19, 2017 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 beds.

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.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
August 23, 2017

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

RE: Project Number S5471027

Dear Mr. Baukner:

On June 27, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 2, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F155. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on June 8, 2017. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On July 20, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 31, 2017 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 an extended survey, completed on June 8, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 19, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on June 8, 2017, as of July 19, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 19, 2017.

However, as we notified you in our letter of June 27, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 8, 2017.

Also, in our letter of June 27, 2017, we notified you that this Department recommended to the CMS

Region V Office the following actions related to the enforcement remedies:

- civil money penalty for the deficiency cited at F155. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

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(L3) **ECUMEN SCENIC SHORES**
(L4) **402 - 13TH AVENUE**
(L5) **TWO HARBORS, MN** (L6) **55616**

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3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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6. DATE OF SURVEY **06/08/2017** (L34)

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

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To (b) :

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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): At the time of the extended survey conditions in the facility constituted an immediate jeopardy to resident health and safety. The immediate jeopardy had been removed before survey exit.

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 07/10/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/31/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **07/31/2017** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 27, 2017

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

RE: Project Number S5471027

Dear Mr. Baukner:

On June 12, 2017, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

> **Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> **Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate**

jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on June 7, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Teresa Ament, Unit Supervisor
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: Teresa.Ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore,

this Department is imposing the following remedy:

- State Monitoring effective July 2, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F155. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Ecumen Scenic Shores is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 12, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to

conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 remedy be imposed:

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

Failure to submit an acceptable ePoC 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 September 8, 2017 (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 December 8, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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 ______	06/08/2017

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 A standard survey was completed by the Minnesota Department of Health on June 5, 2017 through June 8, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F155 when the facility failed to initiate cardiopulmonary resuscitation (CPR) and activate the emergency medical system (EMS) when 1 of 1 residents (R48) experienced a cardiac arrest (absence of respirations and pulse) in accordance with the resident's advance directives. This resulted in the death of R48. The facility's policies and practices placed 4 of 4 residents (R44, R23, R6, R7), whose advanced directives indicated full resuscitative status, at risk of potential harm or death. The IJ began January 21, 2017, at 8:25 p.m. and was removed on June 7, 2017, at 3:45 p.m. 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. An extended survey was conducted by the Minnesota Department of Health on June 7, 2017 and June 8, 2017.	F 000		
F 155	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO	F 155		7/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/06/2017

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.

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 ______	06/08/2017

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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REFUSE; FORMULATE ADVANCE DIRECTIVES

483.10
(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the

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individual’s resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

483.24
(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident’s advance directives.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to initiate cardiopulmonary resuscitation (CPR) and activate the emergency medical system (EMS) when 1 of 1 residents (R48) experienced a cardiac arrest (absence of respirations and pulse) in accordance with the resident's advance directives. This resulted in the death of R48. In addition, the facility's policies and practices placed 4 of 4 residents (R44, R23, R6, and R7) whose advanced directives indicated full resuscitative status, at risk of potential harm or death and was an immediate jeopardy situation.

The immediate jeopardy began on 1/21/17, at 8:25 p.m. when CPR was not initiated for R48 when he was found unresponsive and without a pulse or respirations, and staff did not administer CPR according to his advanced directives. The administrator and director of nursing (DON) were

F 155

F 155
1. Corrective Action:
A. R48 expired on 1/21/2017.
B. R23, R7, R6, R44 were assessed for their code status which was full code, audit completed 6/7/2017 of POLST and Electronic Medical Record. Heart stickers were placed on the headboard of their beds on 6/7/2017.

2. Corrective Action as it applies to Other Residents:
A. The policy/procedure for advance directives were updated on 6/7/2017 to include American Heart Association recommendations when CPR should not be initiated.
B. All nursing staff, RN/LPN, CNA, and TMA will be educated on the policy and procedures as it pertains to Advance

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F 155	Continued From page 3 informed of the immediate jeopardy on 6/7/17, at 9:52 a.m. The immediate jeopardy was removed on 6/7/17, at 3:45 p.m. but noncompliance remained at the lower scope and severity of a G, isolated actual harm that is not immediate jeopardy. Findings include: R48's admission Minimum Data Set (MDS) dated 1/4/17, indicated he was cognitively intact, required extensive assistance with all activities of daily living (ADLs) except for eating, had a diagnosis of end stage renal disease, and was receiving dialysis. R48's Provider Orders for Life Sustaining Treatment (POLST) directed, "Cardiopulmonary Resuscitation (CPR): Patient has no pulse and is not breathing. CPR/Attempt Resuscitation." The POLST was signed by the resident on 12/29/16, and by the physician on 1/3/17. R48's progress notes dated 1/21/17, at 11:46 p.m. indicated, "Resident had been down for dinner as usual and had been brought back to his room for the evening. He was in his recliner watching TV. Staff had been in and around his room throughout the evening shift. When the nurse on the east end went to give Resident his HS [hour of sleep] medications he was unresponsive. She came and got this writer and stated that she thought he had passed away. We both went to the resident and this writer listened to his chest with a stethoscope. The [sic] was no heart beat. Sternal rub elicited no response. The nurse on east noted the time to be 2025. Resident is a full code, however it is unknown how long Resident had expired. Nurse on East	F 155	Directives, Cardiopulmonary Resuscitation and Automatic External Defibrillator use immediately and prior to working on the floor their next shift. C. Residents who are determined to have a code status of CPR will have heart stickers placed on headboard to alert staff upon entering room. D. 100% audit was completed on 6/7/2017 for all residents in the facility to determine if POLST forms are present with resident advance directive wishes and physician signature. 3. Date of Completion: All staff working on 6/7/2017 were educated immediately and remaining nursing staff be educated prior to working next scheduled shift. 4. Reoccurrence will be Prevented by: A. All nursing staff, RN/LPN, CNA and TMA will be educated on CPR, AED use and Advance Directives will be completed immediately, annually, upon hire, and as needed. B. Mock codes will be completed monthly x3 and periodically thereafter as determined by the Quality Assurance Committee. 5. The Correction will be Monitored by: A. DON or designee will complete 100% audit of residents POLST forms with code status, sticker placement and code status information in the electronic medical record. Weekly x 4 weeks, monthly x9 and as determined by the Quality Assurance Committee thereafter.	

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F 155	Continued From page 4 and CNA [certified nursing assistant] were preparing to get Resident out of his recliner for CPR. This writer called DON who advised to not do CPR as we do not know how long he has been expired. Call placed to [name of medical director] on call for ok to release body." The progress note was written by registered nurse (RN)-A. When interviewed on 6/6/17, at 4:36 p.m. RN-A stated that she had been working on the other side of the building when RN-B (who is no longer employed at the facility) came and told her she thought R48 had died. RN-A then went to R48 and found him unresponsive, she attempted to shake him, did a sternal rub with no response, and found no pulse. RN-A then left the room and obtained R48's medical record to contact the family to let them know R48 had passed away. When she opened R48's chart, she discovered he had designated a full code status (staff to perform CPR). RN-A returned to R48's room to instruct RN-B to prepare for CPR. RN-A then returned to the nurse's desk and called the director of nursing (DON) as she was not sure if they should attempt CPR or not because they were uncertain how long it had been since R48 had stopped breathing. RN-A stated the DON instructed her not to do CPR as his cardiac arrest was not witnessed. RN-A stated after that several staff transferred R48 from his recliner to his bed to prepare the body for the funeral home. RN-A stated she is certified in CPR, and that in the CPR classes they do not teach when not to do CPR, it would be depend upon the facility policy. RN-A stated the facility policy at Ecumen Scenic Shores is to not initiate CPR unless the cardiac arrest is witnessed. Since R48's cardiac arrest was not witnessed, and there was no way to determine when the cardiac arrest had taken	F 155	B. DON or designee will complete audit of all residents who expire in the facility to monitor how the resident died and if the resident was a full code for a period of 9months. C. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed. 6. The DON is responsible.	

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place, CPR was not done. RN-A stated the facility does have a "Code Cart [CPR Cart]" and an automated external defibrillator (AED), but had never considered using it for R48 even though his POLST indicated his wishes were to attempt resuscitation if he were to have no pulse or respirations. RN-A stated R48's eyes were closed so she did not note if his pupils were fixed and dilated. When staff transferred him into his bed from the recliner to prepare for the funeral home, RN-A stated his hands and arms were becoming stiff.

On 6/6/17, at 1:40 p.m. the DON was interviewed and stated, "If there are no viable signs of life and didn't witness a resident taking their last breath, then we don't initiate [CPR]. We typically would not initiate unless we were just in there a minute prior." The DON could not say if this would be one minute, two minutes or longer. The DON did recall telling RN-A not to initiate CPR as they did not know when he last took a breath. The DON did not know why RN-B went all the way to the other end of the building to get RN-A and did not check code status.

On 6/8/17, at 9:00 a.m. the DON stated RN-B's CPR certification had lapsed and she was not certified at the time of R48's death. The DON stated typically, at least one nurse on each shift is CPR certified. RN-A had been certified.

On 6/6/17, at 2:20 p.m. RN-C was interviewed and stated she would, "maybe" do CPR if the resident had recently been seen by a nursing assistant, and then a nurse went in and vital signs had ceased. She stated she was uncertain. However, if no one had seen the resident for some time, then she would not do CPR. RN-C

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was unable to say at what point CPR would or would not be done if the cardiac arrest was not witnessed. RN-C indicated there was no way to determine code status unless you looked in the resident's paper or electronic medical record.

On 6/6/17, at 2:25 p.m. licensed practical nurse (LPN)-A was interviewed and stated she would probably not do CPR if she found a resident unresponsive and with no pulse and respirations, unless she had witnessed their last breath. Then LPN-A stated, maybe she would do CPR, "Just in case it had not been that long," she was not sure. LPN-A was unsure what the facility policy indicated. LPN-A indicated there was no quick way to determine code status, staff have to go and look at the resident's paper or electronic medical record.

On 6/6/17, at 2:30 p.m. RN-D stated she would not do CPR unless the resident was witnessed taking their last breath.

On 6/6/17, at 2:44 p.m. LPN-B stated she would not do CPR unless the resident was witnessed taking their last breath.

The facility's Emergency Procedures, revised April 2016, directed: 1. If an individual is found unresponsive, briefly assess for abnormal or absent of breathing. If sudden cardiac arrest is likely, begin CPR: A. Instruct a staff member to activate the ems [emergency medical system] and call 911. B. Instruct a staff member to retrieve AED. C. Verify or instruct a staff member to verify the DNR or Code status of the individual. D. Initiate the BLS [basic life support] sequence of events. 2. The BLS sequence of events is

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C-A-B (chest compressions, airway, breathing). The procedure also directed the facility would follow the American Heart Association guidelines of 2010.

The 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care; Part 3: Ethics, included: "Criteria for not starting CPR in all OHCA (out of hospital cardiac arrest). While the general rule is to provide emergency treatment to a victim of cardiac arrest, there are a few exceptions where withholding CPR might be appropriate, as follows:
1. Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril.
2. Obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity [a bluish discoloration of lowest part of body], decapitation, transection, or decomposition).
3. A valid, signed, and dated advanced directive indicating that resuscitation is not desired, or a valid, signed, and dated DNAR (do not attempt resuscitation) order.

The facility policy entitled, Advance Directives dated July 2016, directed every resident is informed of care issues such as CPR, DNR, and Supportive Care so they can make their own decision as to the level of care to be rendered for certain health conditions and where death is imminent. The procedure area under number 7 directed the interdisciplinary team members discuss with the resident circumstances under which CPR is normally done (in the event of an acute cardiac or respiratory arrest). To resuscitate does not include performing CPR when a death is unobserved or when a resident displays no

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apparent signs of life. The policy listed, "No apparent signs of life means when a resident is found to have: A. No response to external stimuli. B. No observable blood pressure, if cuff and stethoscope immediately available. C. No palpable or observable pulse. D. Pupils are fixed and dilated. E. No apparent respirations. The items listed differed from the 2010 American Heart Association guidelines.

R44's quarterly MDS dated 4/4/17, indicated he was cognitively intact with a diagnosis of diabetes. R44's POLST was signed by the resident on 10/6/16, and by the physician on 10/6/16. The POLST indicated R44 designated staff to attempt CPR if he had no pulse and was not breathing. R44 was at risk of death if he went into an unwitnessed cardiac arrest and staff followed their policy and practice of not performing CPR.

R23's quarterly MDS dated 5/2/17, indicated he was cognitively intact. R23's Face Sheet indicated a diagnosis of a brain hemorrhage. R23's POLST was signed by the resident on 11/17/16, and by the physician on 11/16/16. The POLST indicated R23 designated staff to attempt CPR if he had no pulse and was not breathing. R23 was at risk of death if he went into cardiac arrest unwitnessed and staff followed their policy and practice of not performing CPR.

R6's quarterly MDS dated 3/14/17, indicated she was cognitively intact with a diagnosis of diabetes. R6's POLST was signed by resident on 12/28/16, and by the physician on 1/24/17. The POLST indicated R6 designated staff to attempt CPR if she had no pulse and was not breathing. R6 was at risk of death if she went into cardiac

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arrest unwitnessed and staff followed their policy and practice of not performing CPR.

R7's admission MDS dated 4/10/17, indicated he was cognitively intact. R7's Face Sheet indicated he had a diagnosis of a brain hemorrhage. R7's POLST was signed by the resident on 4/3/17, and by the physician on 4/10/17. The POLST indicated R7 designated staff to attempt CPR if he had no pulse and was not breathing. R6 was at risk of death if he went into cardiac arrest unwitnessed and staff followed their policy and practice of not performing CPR.

A message was left for the facility's medical director on 6/8/17, at 8:21 a.m. The medical director returned the call at 4:30 p.m. and left a message indicating he would be unable to respond to questions about the incident and facility policies and practices until 6/13/17, when he will be able to review the information.

On 6/13/17, at 2:30 p.m. the medical director (MD) was interviewed and stated he knew there was a CPR policy in place at the time of R48's death, but did not know the actual wording of the policy dated 7/16, at that time. The MD stated he knew the American Heart Association (AHA) guidelines regarding when to perform CPR. The MD stated the facility followed their policy at the time of R48's death. Based on the guidelines, the MD stated the physician should talk with resident and family regarding their wishes for code status. The MD stated R48 was a do not resuscitate status (DNR) on previous admissions, but with this admission R48 indicated CPR status. The MD stated if any patient, who had designated CPR status, or whose code status was undetermined, was found without vital signs, time

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F 155	Continued From page 10 should not be spent assessing for rigor mortis, and CPR would be initiated. The MD stated he could see the concern since there was no documentation regarding signs of irreversible death, such as rigor mortis for R48. The MD stated he would expect the staff to follow their policy and procedure. The MD stated he is involved at a certain level with the development of policies and procedures, but was not involved in the development of the Advance Directive policy, and had not signed off on this particular policy at any time. The immediate jeopardy that began on 1/21/17, was removed on 6/7/17, at 3:45 p.m. when the facility updated their policy, trained staff, identified residents who had full code status designated in their advanced directives, and placed measures to ensure staff could easily identify who these residents were. The facility provided information indicating all current licensed nurses had a current CPR certificate. However, the noncompliance remained at the lower scope and severity level of G (isolated actual harm that is not immediate jeopardy) due to the death of R48.	F 155		
F 496 SS=F	483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING d)(4) Registry verification Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or	F 496		7/19/17

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F 496	Continued From page 11 (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. (d)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. (d)(6) Required retraining If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 nursing assistants (NA-E) was currently on the nursing assistant registry. This had the potential to affect all 41 residents residing in the facility. Findings include: On 6/7/17, and 6/8/17, a review of the current nursing assistant registry status indicated nursing assistant (NA)-E's nursing assistant registry had	F 496	F496 1. Corrective Action: a. NA-E was removed from the schedule until verification from previous employer was obtained. Worked with supervision until the MN Nursing Assistant Registry approved employee. 2. Corrective Action as it applies to others: a. 100% audit of NAR on the MN registry will be completed	

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F 496	Continued From page 12 expired on 3/13/17. NA-E's date of hire at the facility was 2/17/17. NA-E was on the nursing assistant registry on the date of hire. On 6/7/17, at 3:52 p.m. registered nurse (RN)-D stated NA-E's nursing assistant registry had expired, she had been working at the facility, and was scheduled to work the following day. On 6/8/17, at 10:04 a.m. the director of nursing (DON) stated they were working on updating the nursing assistant registry for NA-E. The DON verified they should have followed up on NA-E's nursing assistant registry when she was hired, knowing that it was due to expire one month after her date of hire. DON stated the facility submits their list to the nursing assistant registry in June or July, and they had previously sent it to the nursing assistant registry in January, 2017, before NA-E's date of hire. A policy was requested, and not provided.	F 496	3. Date of Completion: 7/19/17 4. Reoccurrence will be prevented by: a. All staff will be educated at facility training meeting on 7/13/17. Staff unable to attend will be educated in person. b. Upon hire will verify that NARs are on the MN registry. If found to be due for renewal will have employee and facility update the Registry form prior to expiration. 5. The Correction plan will be monitored by: a. DON or designee will complete a 100% audit of NAR verification on the MN registry. Ongoing audits will be completed monthly for 12 months. b. The QA committee will review the audit results on a quarterly basis and provide further direction, as needed. 6. The DON is responsible.	
F 497 SS=C	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 497	F497	7/19/17

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F 497	Continued From page 13 facility failed to ensure an annual performance review was completed for 1 of 5 staff (NA-G). This had the potential to affect all 41 residents residing in the facility. Findings include: On 6/8/17, a review of personnel records indicated nursing assistant (NA)-G lacked an annual performance review. On 6/8/17, at 10:04 a.m. the director of nursing (DON) verified she was unable to locate an annual performance review for NA-G, and NA-G should have had a annual performance review. A policy was requested, and not provided.	F 497	1. Corrective Action: a. Will contact NA-G to verify continued employment and if so will have her come in and complete her performance review. 2. Corrective Action as it applies to others: a. 100% audit of all NAR files to ensure annual performance reviews have been completed. 3. Date of Completion: 7/19/17 4. Reoccurrence will be prevented by: a. All staff will be educated at facility training meeting on 7/13/17. Staff unable to attend will be educated in person. b. Employees will receive performance reviews annually and as needed. 5. The correction will be monitored by: a. DON or designee will complete 100% audit of all NAR files to ensure annual performance reviews have been completed. 100% audits will be completed monthly for 12 months for all NAR performance reviews. b. The QA committee will review the audit results on a quarterly basis and provide further direction, as needed. 6. The DON is responsible.	
F 498 SS=F	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 498		7/19/17

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	245471	A. BUILDING ____ B. WING ____	06/08/2017

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 498	Continued From page 14 needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required in-service training for nurse aides. In-service training must- (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (g)(2) Include dementia management training and resident abuse prevention training. (g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 6 nursing nursing assistants (NA-M, NA-G, NA-L, NA-J, and NA-D) received the required 12 of hours of annual training. This had the potential to affect all 41 residents residing in the facility. Findings include: On 6/8/17, a review of nursing assistant (NA) training hours indicated the following NA's had not received 12 hours of annual training: 1) NA-M's date of hire was 1/20/98, and had completed 2 hours of annual training. 2) NA-G's date of hire was 6/22/16, and had completed 5 hours of annual training. 3) NA-L's date of hire was 3/20/96, and had	F 498	F498 1. Corrective Action: a. NA-M,NA-G,NA-L, NA-J, and NA-D will completed their required 12 hours of in servicing by July 19th. 2. Corrective Action as it applies to others: a. 100% audit of employee education files to ensure 12 hours of in servicing have been completed. 3. Date of Completion: 7/19/17 4. Reoccurrence will be prevented by: a. All staff will be educated at facility training meeting on 7/13/17. Staff unable to attend will be educated in person. b. New tracking form will be completed throughout the year with employee education hours to ensure compliance is met.	

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F 498	Continued From page 15 completed 10 hours and 10 minutes of annual training. 4) NA-J's date of hire was 2/5/11, and had completed 5 hours and 20 minutes of annual training. 5) NA-D's date of hire was 1/24/17, and had received orientation training on 1/27/17. NA-D's orientation checklist lacked documentation of training in confidentiality, resolving work issues, accident/incident reporting, HIPAA (privacy act), safety training, and vulnerable adult/abuse prevention training. NA-D did sign Ecumen's Abuse Prevention Plan. On 6/8/17, at 12:15 p.m. the director of nursing (DON) verified the findings. The DON provided the content outlines and times for completion of online training required annually. In addition, the facility provided vulnerable adult training and activity of daily living training. On 6/8/17, at 10:47 a.m. the DON stated the facility did not specifically track the training hours received. The DON stated the facility offers at least 12 hours of annual training. Course outlines indicated training is provided for fire safety, accidents, moving and lifting, patient/resident abuse, standard precautions, resident rights, TB prevention, bloodborne pathogens, disaster preparedness, hand hygiene, HIPAA, material safety data sheets, conflict resolution, lockout/tagout, infection control, resident falls, dementia care, elopement prevention, resident environment, oxygen safety, and workplace environment.	F 498	5. The correction will be monitored by: a. Don or Designee will complete 100% audit of all NAR employee education files. Ongoing audits will be completed monthly for 12 months. b. The QA committee will review the audit results on a quarterly basis and provide further direction, as needed. 6. The DON is responsible.	

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F 498	Continued From page 16 A policy was requested, and not provided.	F 498		
F 501 SS=E	483.70(h)(1)(2) RESPONSIBILITIES OF MEDICAL DIRECTOR (h) Medical director. (1) The facility must designate a physician to serve as medical director. (2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's medical director failed to ensure advanced directive policies were updated to reflect current standards of practice from the American Heart Association (AHA) for when cardiopulmonary resuscitation (CPR) would not be performed. This had the potential to affect 4 of 4 residents (R44, R23, R6, and R7) who had written advanced directives indicating they would like to have CPR attempted if they had no pulse or respirations. Findings include: The facility's Emergency Procedures, revised April 2016, directed 1. If an individual is found unresponsive, briefly assess for abnormal or absent of breathing. If sudden cardiac arrest is likely, begin CPR: A. Instruct a staff member to activate the ems [emergency medical system] and call 911. B. Instruct a staff member to retrieve AED. C. Verify or instruct a staff member	F 501	F501 1. Corrective Action: a. The facility Medical Director will be provided with education on what is required by the medical director as it pertains to policies and procedures. b. Advance directive policy was updated to reflect current standards of practice and Medical Director reviewed on 6/8/2017. Meeting held onsite on 6/13/2017 and signed new policy. c. R44, R23, R6 and R7 will be informed of the changes to our Advance Directive policy. 2. Corrective Action as it applies to others: a. Advance Directive policy will be reviewed with staff, physicians that round in the facility, residents and their responsible parties. 3. Date of Completion: 7/19/17 4. Reoccurrence will be prevented by:	7/19/17

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F 501	Continued From page 17 to verify the DNR or Code status of the individual. D. Initiate the BLS [basic life support] sequence of events. 2. The BLS sequence of events is C-A-B (chest compressions, airway, breathing). The procedure also directed the facility would follow the American Heart Association guidelines of 2010. The 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care; Part 3: Ethics, included: "Criteria for not starting CPR in all OHCA (out of hospital cardiac arrest). While the general rule is to provide emergency treatment to a victim of cardiac arrest, there are a few exceptions where withholding CPR might be appropriate, as follows: 1. Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril. 2. Obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity [a bluish discoloration of lowest part of body], decapitation, transection, or decomposition). 3. A valid, signed, and dated advanced directive indicating that resuscitation is not desired, or a valid, signed, and dated DNAR (do not attempt resuscitation) order. The facility policy entitled Advance Directives dated July 2016, directed every resident is informed of care issues such as CPR, DNR, and Supportive Care so they can make their own decision as to the level of care to be rendered for certain health conditions and where death is imminent. The procedure area under number 7 directed the interdisciplinary team members discuss with the resident circumstances under which CPR is normally done (in the event of an acute cardiac or respiratory arrest). To resuscitate does not include performing CPR when a death is	F 501	a. All staff will be educated at the facility training meeting on 7/13/17. Staff unable to attend will be educated in person. b. The Medical Director will be included in all policy development and revisions. Will be notified of implementation dates. 5. The correction will be monitored by: a. DON or designee will complete audits bi weekly for 6 months and monthly for 6 months, to ensure Medical Director was notified and included in policy formation and revisions. b. The QA committee will review the audit results on a quarterly basis and provide further direction, as need 6. The DON is responsible.	

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F 501	Continued From page 18	F 501		

unobserved or when a resident displays no apparent signs of life. The policy listed, "No apparent signs of life means when a resident is found to have: A. No response to external stimuli. B. No observable blood pressure, if cuff and stethoscope immediately available. C. No palpable or observable pulse. D. Pupils are fixed and dilated. E. No apparent respirations. The items listed differed from the 2010 American Heart Association guidelines.

On 6/6/17, at 1:40 p.m. the DON was interviewed and stated, "If there are no viable signs of life and didn't witness a resident taking their last breath, then we don't initiate [CPR]. We typically would not initiate unless we were just in there a minute prior." The DON could not say if this would be one minute, two minutes or longer.

On 6/6/17, at 2:20 p.m. RN-C was interviewed and stated she would, "Maybe" do CPR if the resident had recently been seen by a nursing assistant, and then a nurse went in and vital signs had ceased. She stated she was uncertain. However, if no one had seen the resident for some time, then she would not do CPR. RN-C was unable to say at what point CPR would or would not be done if the cardiac arrest was not witnessed. RN-C indicated there was no way to determine code status unless you looked in the resident's paper or electronic medical record.

On 6/6/17, at 2:25 p.m. licensed practical nurse (LPN)-A was interviewed and stated she would probably not do CPR if she found a resident unresponsive and with no pulse and respirations, unless she had witnessed their last breath. Then LPN-A stated, maybe she would do CPR, "Just in case it had not been that long," she was not sure.

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F 501	Continued From page 19	F 501		

LPN-A was unsure what the facility policy indicated. LPN-A indicated there was no quick way to determine code status, staff have to go and look at the resident's paper or electronic medical record.

On 6/6/17, at 2:30 p.m. RN-D stated she would not do CPR unless the resident was witnessed taking their last breath.

On 6/6/17, at 2:44 p.m. LPN-B stated she would not do CPR unless the resident was witnessed taking their last breath.

R44's quarterly MDS dated 4/4/17, indicated he was cognitively intact with a diagnosis of diabetes. R44's POLST was signed by the resident on 10/6/16, and by the physician on 10/6/16. The POLST indicated R44 designated staff to attempt CPR if he had no pulse and was not breathing. R44 was at risk of death if he went into an unwitnessed cardiac arrest and staff followed their policy and practice of not performing CPR.

R23's quarterly MDS dated 5/2/17, indicated he was cognitively intact. R23's Face Sheet indicated a diagnosis of a brain hemorrhage. R23's POLST was signed by the resident on 11/17/16, and by the physician on 11/16/16. The POLST indicated R23 designated staff to attempt CPR if he had no pulse and was not breathing. R23 was at risk of death if he went into cardiac arrest unwitnessed and staff followed their policy and practice of not performing CPR.

R6's quarterly MDS dated 3/14/17, indicated she was cognitively intact with a diagnosis of diabetes. R6's POLST was signed by resident on

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F 501	Continued From page 20	F 501		

12/28/16, and by the physician on 1/24/17. The POLST indicated R6 designated staff to attempt CPR if she had no pulse and was not breathing. R6 was at risk of death if she went into cardiac arrest unwitnessed and staff followed their policy and practice of not performing CPR.

R7's admission MDS dated 4/10/17, indicated he was cognitively intact. R7's Face Sheet indicated he had a diagnosis of a brain hemorrhage. R7's POLST was signed by the resident on 4/3/17, and by the physician on 4/10/17. The POLST indicated R7 designated staff to attempt CPR if he had no pulse and was not breathing. R6 was at risk of death if he went into cardiac arrest unwitnessed and staff followed their policy and practice of not performing CPR.

R44, R23, R6, and R7 were at risk of not having CPR according to their advanced directives if the facility policy was followed.

A message was left for the facility's medical director on 6/8/17, at 8:21 a.m. The medical director returned the call at 4:30 p.m. and left a message indicating he would be unable to respond to questions about the incident and facility policies and practices until 6/13/17, when he will be able to review the information.

On 6/13/17, at 2:30 p.m. the medical director (MD) was interviewed and stated he knew there was a CPR policy in place, but did not know the actual wording of the policy dated 7/16. The MD stated he knew the American Heart Association (AHA) guidelines regarding when to perform CPR. Based on the guidelines, the MD stated the physician should talk with resident and family regarding their wishes for code status. The MD

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F 501	Continued From page 21 stated if any patient, who had designated CPR status, or whose code status was undetermined, was found without vital signs, time should not be spent assessing for rigor mortis, and CPR would be initiated. The MD stated he would expect the staff to follow their policy and procedure. The MD stated he is involved at a certain level with the development of policies and procedures, but was not involved in the development of the Advance Directive policy, and had not signed off on this particular policy at any time. The facility's Medical Director Service Agreement dated 4/13/11, was signed by the facility's medical director. The agreement directed under number 6: "Periodically reviews resident care policies;" and number 17: "Assist in developing written policies governing the medical, nursing, and related health services provided in the facility."	F 501		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to train 5 of 5 newly hired employees (NA-D, NA-E, NA-F, RN-E, and Cook-A) on emergency procedures. This had the potential to affect all 41 residents residing in the facility. Findings include: The facility provided emergency plans for fire,	F 518	F518 1. Corrective Action: a. NA-D, NA-E,NA-F, RN-E and Cook-A will be educated on Emergency procedures. 2. Corrective Action as it applies to others: a. 100% audit of new employee files hired in the last 12 months to determine if	7/19/17

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severe weather, hazardous materials, bombs and bomb threats, disaster evacuation plan, missing person, and utility emergencies.

When interviewed on 6/8/17, at 11:00 a.m. the director of nursing (DON) and administrator were unable to provide any documentation that newly hired employees had been trained in the facilities emergency procedures.

Nursing assistant (NA)-D was hired on 1/24/17, and the facility was unable to provide documentation that she had been trained in emergency procedures.

NA-E was hired on 2/17/17, and the facility was unable to provide documentation that she had been trained in emergency procedures.

NA-F was hired on 2/17/17, and the facility was unable to provide documentation that she had been trained in emergency procedures.

Registered nurse (RN)-E was hired on 6/1/16, and the facility was unable to provide documentation that she had been trained in emergency procedures.

Cook-A was hired on 4/16/17, and the facility was unable to provide documentation that she had been trained in emergency procedures.

A policy was requested, but not provided by the facility.

documentation present related to education on emergency procedures.
3. Date of Completion: 7/19/17
4. Reoccurrence will be prevented by:
a. All staff will be educated at facility training meeting on 7/13/17.
b. All remaining staff will be educated on emergency procedures before July 19th, upon hire and annually their after.
c. New employee orientation form revised to include emergency procedures. Unannounced staff drills will be completed throughout the year.
5. The correction will be monitored by:
a. DON or designee will complete audit monthly for 12 months to ensure new employees have received Emergency procedure training and unannounced drills have been completed.
b. The QA committee will review the audit results on a quarterly basis and provide further direction, as needed.

6. The DON is responsible.

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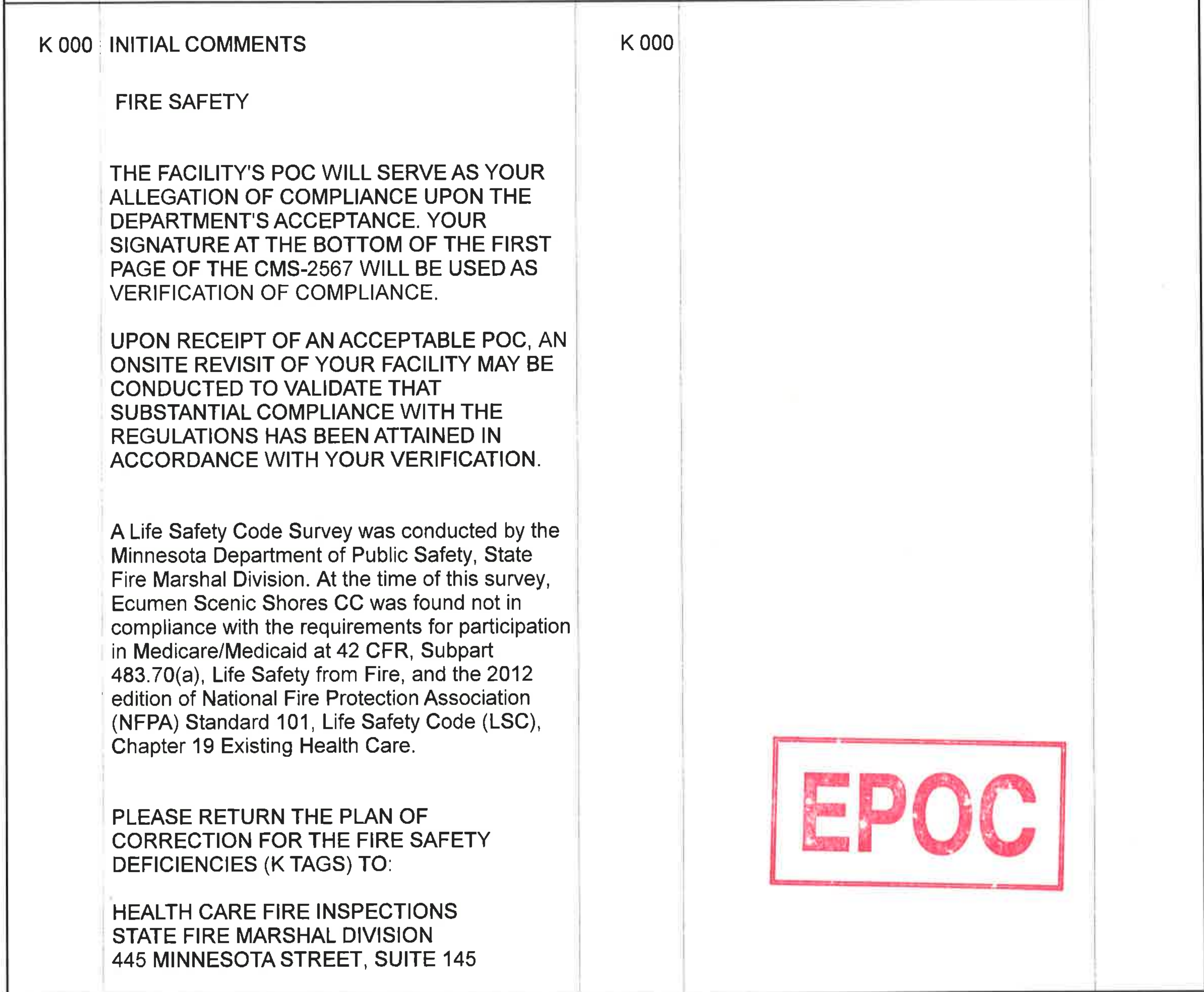

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT 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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/06/2017

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.

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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING 01 - MAIN BUILDING B. WING ______	06/12/2017

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
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 346 SS=F	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This **STANDARD** is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 44 of 40 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 06/12/2017, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm	K 346	K346 A. Fire Watch policy has been reviewed and revised to meet current code. All staff will be in-serviced on revised procedures at all staff on 7/13/2017. Environmental Supervisor will monitor for compliance.	7/13/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING 01 - **MAIN BUILDING** B. WING ______	**06/12/2017**

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
K 346	Continued From page 3 system out of service policy that included the current Deputy State Fire Marshal's contact information in the event of the fire alarm being out of service and the need for a fire watch to be initiated This deficient condition was verified by the Maintenance Supervisor.	K 346		
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in	K 351	K351 A. Two new sprinkler heads have been ordered and will be installed by July 12, 2017. This will be monitored by the environmental supervisor.	7/13/17

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	245471	A. BUILDING 01 - MAIN BUILDING B. WING ______	06/12/2017

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
K 351	Continued From page 4 the fire protection system capability in the event of an emergency that could affect 20 of 44 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 06/12/2017, observations reveled that the fire sprinkler head that is located in the laundry room and in the activities room there are quick response sprinkler heads mixed in with the rest of the 165 degree F. standard response type head within these areas. This deficient condition was verified by the Maintenance Supervisor.	K 351		
K 354 SS=F	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on a record review and staff interview, the	K 354	K354	7/13/17

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	245471	A. BUILDING **01 - MAIN BUILDING** B. WING	**06/12/2017**

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
K 354	Continued From page 5 facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 44 of 40 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 06/12/2017, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the current Deputy State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated. This deficient condition was verified by the Maintenance Supervisor.	K 354	A. Fire Watch policy has been reviewed and revised to meet current code. All staff will be in-serviced on revised procedures at all staff on 7/13/2017. Environmental Supervisor will monitor for compliance.	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent	K 712		7/7/17

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	245471	A. BUILDING **01 - MAIN BUILDING** B. WING	**06/12/2017**

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 712	Continued From page 6 persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 44 of 40 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 06/12/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was found that the facility did not conduct a day shift fire drill in the first quarter of the calendar year. This deficient condition was verified by the Maintenance Supervisor.	K 712	K712 A. New annual audit tool was developed. This tool will be used in conjunction with our already existing tools. It will be initialed and dated by environmental supervisor. This will be completed by July 7, 2017 and be monitored by the environmental supervisor.	