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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O19P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00066

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245370**

2.STATE VENDOR OR MEDICAID NO.
(L2) **533840900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN NORTH BRANCH 5379 -383RD**
(L4)
(L5) **STREET NORTH BRANCH, MN** (L6) **55056**

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)

6. DATE OF SURVEY **01/15/2014** (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 **67** (L18)

13.Total Certified Beds **67** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(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 :
Patricia Halverson, Unit Supervisor 03/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL MPM Date:
Mark Meath, Enforcement Specialist 03/23/2014 (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 **12/01/1986** (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.
03001 (L31)

30. REMARKS
Posted 04/02/2014 CO.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
01/22/2014 (L33)

DETERMINATION APPROVAL

CCN: 24-5370

On January 15, 2014, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on January 6, 2014, The Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the November 22, 2013 standard survey, effective January 1, 2014. Refer to the CMS-2567b for both health and life safety code.

Effective January 1, 2014 the facility is certified for 67 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5370

March 23, 2014

Mr. Nathan Johnson, Administrator
Ecumen North Branch
5379 -383rd Street
North Branch, Minnesota 55056

Dear Mr. Johnson:

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 January 1, 2014 the above facility is certified for:

67 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 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.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 4, 2014

Mr. Nathan Johnson, Administrator
Ecumen North Branch
5379 -383rd Street
North Branch, MN 55056

RE: Project Number s5370029

Dear Mr. Johnson:

On December 11, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 22, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)whereby corrections were required.

On January 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 6, 2014 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 November 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 1, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 22, 2013, effective January 1, 2014 and therefore remedies outlined in our letter to you dated December 11, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Patricia Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-302-6151 Fax: 218-723-2359

Enclosure: cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245370	A. Building B. Wing	1/15/2014

Name of Facility	Street Address, City, State, Zip Code
ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 01/01/2014	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 01/01/2014	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 01/01/2014
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 01/01/2014	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 01/01/2014	ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 01/01/2014
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 01/01/2014	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 01/01/2014	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 01/01/2014
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	Reviewed By 10762	Date: 3/4/14	Signature of Surveyor: 10762	Date: 3/4/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/22/2013				

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245370	A. Building 02 - BLDG 2 B. Wing	1/6/2014

Name of Facility	Street Address, City, State, Zip Code
ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 01/01/2014	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By ✓ State Agency	Reviewed By 10962	Date: 3/4/14	Signature of Surveyor: 10962	Date: 3/4/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
11/20/2013

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 ID: O19P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00066

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245370**
2.STATE VENDOR OR MEDICAID NO.
(L2) **533840900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN NORTH BRANCH**
(L4) **5379 -383RD STREET**
(L5) **NORTH BRANCH, MN** (L6) **55056**

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)

6. DATE OF SURVEY **11/22/2013** (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 **68** (L18)

13.Total Certified Beds **68** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	68			
(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 :
Cheryl Johnson, HFE NE II 01/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 01/17/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
12/01/1986
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5370

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). Post Certification Revisit to follow.
Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 6980

December 11, 2013

Mr. Nathan Johnson, Administrator
Ecumen North Branch
5379 - 383rd Street
North Branch, Minnesota 55056

RE: Project Number S5370029

Dear Mr. Johnson:

On November 22, 2013, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - 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:

Pat Halverson, Unit Supervisor
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Telephone: (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 January 1, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 1, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 February 22, 2014 (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 May 22, 2014 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Rec'd 12-13-14 PLH

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

PRINTED: 12/11/2013
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
	245370	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

(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 PLAN OF CORRECTION (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. 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. CENSUS: 62	F 000	OK with revision 1-15-14 PLH Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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 which 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.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative	F 157		

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

Nathan D. Johnson | Executive Director | 12/20/13

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
	245370	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

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F 157	Continued From page 1 or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the representative was notified of a change in pain medication treatment for 1 of 1 residents (R53) prior to starting oxycodone (a narcotic pain medication). Findings include:	F 157	F157 1. Corrective Action: A. The responsible party of resident #53 has been notified of the medication change. 2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. Physician orders of all residents since November 22, 2013 have been audited to assure the responsible party has been notified as appropriate. C. The Change of Condition Policy has been reviewed and revised. 3. Reoccurrence will be Prevented by: A. Staff education on the revised Change of Condition policy was provided at all staff meetings which occurred on December 26, 27, 30, 2013. B. The DON or Designee will complete random weekly audits x1 month, then monthly times 3 with findings presented to the QA committee for discussion. 4. The Correction will be Monitored by: A. DON or designee. 5. Date of Completion: January 1, 2014	

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F 157	Continued From page 2 R53's diagnosis list included Alzheimer's disease and stroke (CVA). The annual Minimum Data Set (MDS) dated 8/23/13, indicated R53 had severe cognitive impairment. The Record of Admission sheet dated 10/19/12, identified the representative/guarantor was family (F)-M. During interview on 11/20/13, at 11:41 a.m., F-M stated R53 was started on a new narcotic pain medication, but she was not notified until six days after the medication was started. The physician's orders dated 11/7/13, directed oxycodone 2.5 milligrams (mg) four times a day (QID). The order noted, "Discuss with [representative] 1st - goal to improve pain in back." R53's November 2013, Medication Record indicated the oxycodone was started on 11/8/13, and was administered QID. The medical records lacked evidence as to when F-M was notified of the change in pain medication. On 11/22/13, at 12:09 a.m. the registered nurse (RN)-A confirmed there was no documentation to indicate R53's representative was notified of the change in pain medication. On 11/22/13, at 1:15 p.m. the director of nursing (DON) stated the facility did not have a policy regarding notification of representatives upon changes in condition or changes in treatment.	F 157		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 3 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to address psychotropic medications for 1 of 5 residents (R96) reviewed for unnecessary medications; and to address diabetic nail care for 1 of 3 residents (R21) reviewed for activities of daily living (ADLs). Findings include: R96's care plan dated 9/13, did not address the	F 279	F279 1. Corrective Action: A. Diabetic nail care was provided to resident # 21 and the need to provide diabetic nail care to this resident was added to the group sheets, care plan and TAR. A Licensed Nurse performs diabetic nail care. B. The care plan of resident #96 was revised to include the use of psychotropic medications, target behavior monitoring and side effects. The responsible party was contacted and consent was obtained for this medication. C. The Nursing Care Standard Policy, Psychotropic Medication Policy, Behavior Monitoring Policy and Care Plan Policy had reviews completed with revisions to the policies as appropriate. 2. Corrective Action as it applies to Other Residents: A. All residents with Diabetes have the potential to be effected by this deficient practice. B. The medical records were audited and the group sheets, TAR and care plans of all residents with Diabetes were revised to reflect the need for Diabetic nail care.	

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F 279	Continued From page 4 use of Seroquel (antipsychotic medication) for hallucinations and delusions; potential side effects or target behaviors. R96's diagnosis list included dementia and Alzheimer's disease. On 11/11/13, the certified nurse practitioner (CNP) ordered Seroquel 12.5 milligrams at 4 p.m. and bedtime for hallucinations of being an ambassador to God, delusions of walking with the Lord, and associated behaviors of disrobing in public and slapping her breasts. On 11/21/13, at 5:44 p.m. registered nurse (RN)-A was interviewed and verified R96's care plan did not address the use of Seroquel, side effects, target behaviors or non-pharmacological interventions for hallucinations, delusions and behaviors. The facility policy and procedure on psychotropic medications dated 5/11, directed non-drug interventions are to be included on the care plan. The facility policy and procedure on care planning dated 5/11 directed the care plan be updated on an ongoing basis to meet the needs of the resident. R21's plan of care lacked direction for diabetic nail care. On 11/19/13, at 9:59 a.m. R21 was observed to have long, uneven fingernails with dark material under several of the nail finger tips.	F 279	C. All residents receiving Psychotropic Medications have the potential to be effected by this deficient practice. D. The medical records were audited and the care plans of all residents receiving psychotropic medications now reflect the use of the medication, target behavior monitoring and side effects monitoring. Consent has been obtained on all residents who are receiving psychotropic medications. 3. Reoccurrence will be Prevented by: A. Staff education on the revised Nursing Care Standard Policy, Psychotropic Medication Policy, Behavior Monitoring Policy and Care Plan Policy was provided at all staff meetings which occurred on December 26, 27, 30, 2013. B. DON or designee will conduct random weekly audits x1 month then monthly times 3 with findings presented to the QA committee for discussion. 4. The Correction will be Monitored by: A. DON or Designee 5. Date of Completion: January 1, 2014	

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F 279	Continued From page 5 R21's diagnosis list included diabetes type 2 and dementia. A quarterly Minimum Data Set (MDS) dated 10/5/13, indicated R21 had moderate cognitive impairment, required extensive assistance with personal hygiene, and was totally dependent with bathing activities. A care plan dated 6/11/13, indicated R21 needed extensive assistance of 1 with personal hygiene, but did not address diabetic nail care. On 11/22/13, at 3:44 p.m. registered nurse (RN)-A stated nursing staff provide diabetic nail care on bath day and document on the treatment administration record (TAR). RN-A confirmed R21's TAR lacked direction for the provision of diabetic nail care. A Nursing Care Standards policy reviewed and revised 5/2011, directed fingernails and toenails should be clean and trimmed.	F 279	F280. 1. Corrective Action: A. The need to assist resident #18 with flossing has been added to her group sheet and care plan. Her dental orders have also been reviewed. B. The need to provide resident #53 with Prevident Tooth Paste has been added to her group sheet and care plan. Her dental orders have also been reviewed. C. The Oral Care and Nursing Care Standards Policies have been reviewed and revised as appropriate.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280	2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. All resident group sheets and care plans were reviewed to include oral cares and specific dental orders were added to the care plans as appropriate.	

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F 280	Continued From page 6 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to address prescribed oral care treatments for 2 of 5 residents (R18, R53) reviewed for activities of daily living (ADLs). Findings include: R18's care plan was not revised to address increased frequency of teeth flossing. R18's dental assessment dated 2/1/13, noted R18 had a fractured number 6 tooth, required cleaning every three months, and recommended increased flossing and the use of over the counter mouth rinse. The care plan dated 9/12/13, directed staff assistance with oral care as resident has natural teeth. The care plan noted R18 needed extra time to process information and was alert but cognitively impaired. The nursing assistant care sheet dated 11/21/13, indicated R18 needed assist of one with oral care.	F 280	3. Reoccurrence will be Prevented by: A. Staff education on the revised Oral Care and Nursing Care Standards Policies was provided on December 26, 27, 30, 2013. B. Weekly audits x1 month then monthly audits x3 with findings presented to the QA committee for discussion. 4. The Correction will be Monitored by: A. DON or designee. 5. Date of Completion: January 1, 2014	

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F 280	Continued From page 7 The Dental Service policy dated as revised May 2011, indicated staff were to record dental visits including the name of the dentist or dental hygienist, date of service, specific dental services provided, medications administered, medical or dental consultations, and any follow-up orders are to be maintained in the clinical record. Interview on 11/22/13, at 10:45 a.m. with registered nurse (RN)-A clinical coordinator stated that the dental recommendation for flossing should have been added to the care plan. R53's care plan was not revised to address an oral care treatment (Prevident- a prescription strength toothpaste or rinse) as prescribed by the dentist on 7/17/13. R53's diagnosis list included Alzheimer's disease and stroke (CVA). The annual Minimum Data Set (MDS) dated 8/23/13, indicated R53 had severe cognitive impairment and required the extensive assistance of staff with personal hygiene. The Dental Chart Progress Notes dated 7/17/13, included orders for Prevident but did not indicate toothpaste or mouth rinse. The ADL care plan dated 8/23/13, did not address Prevident toothpaste or rinse. On 11/22/13, at 12:25 p.m. RN-A stated the prescribed Prevident treatment from 7/17/13, was not added to the care plan.	F 280		

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide diabetic nail care and/or physician ordered oral care for 3 of 5 residents (R21, R18, R53) reviewed for activities of daily living (ADLs). Findings include: R21 was not provided diabetic nail care. On 11/19/13, at 9:59 a.m. R21 was observed to have long, uneven fingernails with dark material under several of the nail finger tips. The quarterly Minimum Data Set (MDS) dated 10/5/13, indicated R21 had moderate cognitive impairment, required extensive assistance with personal hygiene, and was totally dependent with bathing activities and transfers. A plan of care dated 6/11/13, indicated R21 needed extensive assistance of 1 with personal hygiene.	F 312	F312 1. Corrective Action: A. The group sheet, TAR and care plan of resident #21 was revised to include the need for Diabetic Nail Care. A Licensed Nurse provides Diabetic Nail Care. B. The group sheet and care plan of resident # 18 was revised to include the need for assist with flossing during oral cares. C. The group sheet and care plan of resident #53 was revised to include the need to provide Prevident Toothpaste during oral cares. D. The Oral Care Policy, Nursing Care Standards Policies were reviewed and revisions were made as appropriate. 2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. The care plans of all residents were reviewed and diabetic and oral care needs were added as appropriate.	

F312

1. Corrective Action:
   A. The group sheet, TAR and care plan of resident #21 was revised to include the need for Diabetic Nail Care. A Licensed Nurse provides Diabetic Nail Care.
   B. The group sheet and care plan of resident # 18 was revised to include the need for assist with flossing during oral cares.
   C. The group sheet and care plan of resident #53 was revised to include the need to provide Prevident Toothpaste during oral cares.
   D. The Oral Care Policy, Nursing Care Standards Policies were reviewed and revisions were made as appropriate.

2. Corrective Action as it applies to Other Residents:
   A. All residents have the potential to be effected by this deficient practice.
   B. The care plans of all residents were reviewed and diabetic and oral care needs were added as appropriate.

3. Reoccurrence will be Prevented by:
   A. Staff members were provided education related to the revised Oral

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F 312	Continued From page 9 On 11/21/13, at 6:40 p.m. nursing assistant (NA)-C and NA-G were observed to enter R21's room to assist with evening cares. NA-G stated that licensed nurses provide nail care for R21. R21's finger nails were observed again to be jagged with dark colored debris under the finger nail tips. On 11/22/13, at 1:30 p.m. R21's finger nails were observed with licensed practical nurse (LPN)-A. LPN-A confirmed R21's nails were dirty and needed trimming. On 11/22/13, at 3:44 p.m. registered nurse (RN)-A stated nursing staff provide diabetic nail care on bath day and document on the treatment administration record (TAR). RN-A confirmed R21's TAR lacked documentation of diabetic nail care. A Nursing Care Standards policy reviewed and revised 5/2011, directed fingernails and toenails should be clean and trimmed in order for every resident to reach their highest practicable level of function. R18 was not provided teeth flossing and over the counter mouth wash as prescribed by the dentist on 2/1/13. The quarterly MDS dated 9/1/13, indicated R18 was cognitively intact and required extensive assistance with personal hygiene. The oral dental status questions on the MDS were not answered.	F 312	3. Reoccurrence will be Prevented by: A. Staff members were provided education related to the revised Oral Care Policy and Nursing Care Standards Policies at all staff meetings held on December 26, 27, 30, 2013. B. Random weekly audits x1 month then monthly times 3 with findings presented to QA meeting for discussion. 4. The Correction will be Monitored by: A. DON or designee. 5. Date of Completion: January 1, 2014	

Care Policy and Nursing Care Standards Policies at all staff meetings held on December 26, 27, 30, 2013.
B. Multiple weekly audits x1 month then monthly times 3 with findings presented to QA meeting for discussion. Direct observations will be a part of this audit.

4. The Correction will be Monitored by:
   A. DON or designee.

5. Date of Completion: January 1, 2014

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F 312	Continued From page 10 R18 was interviewed on 11/20/13, at 9:21 a.m. and stated staff do not help with cleaning her teeth. R18 reported meat getting caught in the upper left teeth and staff did not offer assistance with flossing. R18 brushes her teeth but could not floss due to shaking hands. The care plan dated 9/12/13, and the nursing assistant care sheet dated 11/21/13, indicated R18 needed assistance of one for oral care. On 11/21/13, at 6:00 p.m. R18 stated that she had meat for supper and it got caught in her upper left tooth again. On 11/21/13, at 6:15 p.m., NA-E provided evening care. R18 asked to have her upper left teeth flossed. NA-E stated that there was no floss, but R18 provided dental floss. NA-E flossed R18's upper left teeth. Interview with NA-E at 6:30 p.m. said that she worked with R18 on a regular basis, but had never flossed her teeth before. The director of nurses (DON), interviewed on 11/22/13, at 9:30 a.m., stated there was dental floss available for residents. Interview 11/22/13, at 10:45 a.m. with RN-A clinical coordinator stated that the dentist recommendation from 2/11/13, should have been added to the MDS and added to the care plan. The Dental Service policy dated as revised May 2011, indicated staff were to record dental visits including the name of the dentist or dental	F 312		

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F 312	Continued From page 11 hygienist, date of service, specific dental services provided, medications administered, medical or dental consultations, and any follow-up orders were to be maintained in the clinical record. R53 was not provided dentist ordered Prevident (a prescription strength toothpaste or rinse) or mouthwash after meals. The annual MDS dated 8/23/13, indicated R53 had severe cognitive impairment and required the extensive assistance with personal hygiene. R53's family member (F)-A, interviewed on 11/20/13, at 11:35 a.m., stated R53 had natural teeth, regularly went to the dentist, and her teeth had been bothering her. Dental Chart Progress Notes dated 7/17/13, indicated R53 had an initial dental exam with recommendation for filling multiple cavities. The orders directed "Prevident." The bottom of the note indicated, "Please take note of the new rx [prescription] for [resident's name]." The order did not specify if Prevident toothpaste or mouth rinse should be used. The Comprehensive Assessment Summary dated 8/21/13, identified R53 had a dental visit on 7/17/13. The assessment indicated R53 had her own teeth and required assistance with all activities of daily living (ADL's). The assessment did not identify R53's prescription oral care	F 312		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

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F 312	Continued From page 12 treatment. The ADL care plan dated 8/23/13, indicated R53 required extensive assistance with personal hygiene, and could brush her own teeth after set-up. The care plan did not address Prevident toothpaste or rinse. The dental care plan revised 10/18/13, indicated R53 had her own teeth with likely cavities. Staff were directed to assist R53 with oral cares BID (twice a day) and PRN (as needed), and assist to use mouthwash following each meal. The nursing assistant care sheet updated 11/21/13, directed set-up and supervision of oral care with morning and evening cares and, "Use mouthwash following each meal." On 11/21/13, at 12:16 p.m. R53 was observed in a wheelchair (w/c) at the dining room table. R53's teeth were clean with no debris. R53 did have some missing teeth. At 12:36 p.m. R53 received lunch and ate independently without difficulty. At 1:47 p.m. R53 was finished and stated she needed to go upstairs. NA-C assisted R53 to her room to wash up and use the bathroom. R53 wheeled herself to the sink and brushed her teeth with a toothbrush and regular toothpaste (not Prevident toothpaste). No mouthwash (of any type) was observed in the room. On 11/22/13, at 12:25 p.m. RN-A confirmed the prescribed dental treatment from 7/17/13, was never started. The Physician Order Procedure policy revised	F 312		

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F 312	Continued From page 13 may 2011, indicated orders could be received through written communication in the resident's chart, verbally, Fax, or per the telephone. If the order was for a medication or treatment, it should be written in the Medication book or Treatment book. A notation should to be made in the resident's medical record as to the reason for the new order and a brief summary of what it was. All transcription of orders should be signed off by a nurse to assure that all of the steps have been carried out to avoid errors.	F 312	F329 1. Corrective Action: A. A drug regimen review has been completed by the Consulting Pharmacist with the focus on Gradual Dose Reductions and indications for continued use. The recommendations were forwarded to the physician for follow up and response for resident #96. B. Psychotropic Medication Assessments have been reviewed by a Registered Nurse and revised as appropriate for resident #96. C. The care plans of resident #96 was reviewed and revised as appropriate and non pharmacological interventions were added as appropriate. D. The Psychotropic Medication Policy and the Drug Regimen Review Policy has been reviewed and revised as appropriate. 2. Corrective Action as it Applies to Other Residents: A. All residents receiving psychotropic medications have the potential to be effected by this deficient practice.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify and monitor target behaviors to determine efficacy of antipsychotic medications for 1 of 5 residents (R96) reviewed for unnecessary medications. Findings include: R96 was not provided monitoring for potential side effects or target behaviors related to the use of Seroquel (antipsychotic medication) for hallucinations and delusions. R96's diagnoses included dementia and Alzheimer's disease. On 11/11/13, the certified nurse practitioner (CNP) ordered Seroquel 12.5 milligrams at 4 p.m. and bedtime for hallucinations of being an ambassador to God, delusions of walking with the Lord, and associated behaviors of disrobing in public and slapping her breasts. R96's clinical record lacked evidence of monitoring for side effects of Seroquel, or of target behaviors. On 11/21/13 at 5:44 p.m. registered nurse (RN)-A was interviewed and verified R96 was not monitored for side effects or target behaviors to determine effectiveness of Seroquel.	F 329	B. All residents receiving Psychotropic medications were reviewed by the Consulting pharmacist for the ability to complete GDR's and indications for continued use. C. Recommendations were sent to the physician for follow up and response. D. A Registered Nurse reviewed the Psychotropic Medication Assessments of all residents receiving Psychotropic Medications and also reviewed and revised the care plans as appropriate. 3. Recurrence will be prevented by: A. Staff members were provided with education related to the revised Psychotropic Medication Policy and Drug Regimen Policy during all staff meetings held on December 26, 27, 30, 2013. B. Random weekly audits x1month then monthly x3 with findings presented to the QA Committee for discussion.	

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F 329	Continued From page 15 The facility policy and procedure on psychotropic medications dated 5/11, directed an evaluation of the resident be conducted to determine whether non-pharmacological interventions have been considered or tried, target behavior data be collected, and side effects be monitored.	F 329	4. Responsible Person: A. DON or Designee 5. Date of Completion: January 1, 2014	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334	F334 1. Corrective Action: A. The responsible parties of residents #96 and #61 were provided education related to Influenza and/or Pneumococcal Immunizations. B. The Influenza and PPV Vaccination Policy was reviewed and revised as appropriate. 2. Corrective Action as it Applies to Other Residents: A. All residents have potential to be effected by this deficient practice. B. Educational materials related to Influenza and Pneumococcal Immunizations were mailed to responsible parties or delivered by hand to residents who are responsible for themselves.	

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F 334	Continued From page 16 The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 334	3. Recurrence will be prevented by: A. Staff members were educated on the Influenza and PPV Vaccination Policy at all staff meetings held on December 26, 27, 30, 2013. B. Random weekly audits x1 month then monthly x3 with findings presented to the QA Committee for discussion. 4. Responsible Person: A. DON or Designee 5. Date of Completion: January 1, 2014.	

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F 334	Continued From page 17 facility did not provide the required education related to influenza vaccination for 1 of 5 residents (R96). In addition, pneumococcal vaccination status was not determined and education was not provided related to pneumococcal vaccination for 1 of 5 residents (R61) reviewed for influenza and pneumococcal immunizations. Findings include: R96's admission documentation was dated 9/12/13. An influenza consent form was signed by R96's responsible party on 10/4/13. R96 received the influenza vaccine on 11/5/13. There was no evidence to indicate the benefits and potential risks were explained to the responsible party prior to administration of the vaccine. R61's admission documentation was dated 3/29/11. The director of nurses (DON), interviewed on 11/21/13, at 7:30 p.m., stated R61's pneumococcal vaccination status was not determined upon admission. There was no evidence the risk/benefits related to pneumococcal vaccination were explained to R61 or the responsible party. Registered nurse (RN)-A, interviewed on 11/21/13, at 5:42 p.m., stated residents/responsible parties were not routinely provided education related to the risk/benefit of influenza or pneumococcal vaccination.	F 334		

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F 334	Continued From page 18 The policy and procedure on influenza and pneumococcal vaccinations dated 6/11, directed residents be informed about the benefits and risks of immunizations, and the education documented in the resident's medical record.	F 334	F 371 1. Corrective Action: A. The can opener has been replaced. B. The kitchen equipment has been cleaned. C. Food has been dated and is being stored according to policy. D. The policy for cleaning and replacement of equipment has been reviewed and revised as appropriate. E. The policy for labeling and storage of food has been reviewed and revised as appropriate. 2. Corrective Action as it Applies to Others: A. All residents have the potential to be effected by this deficient practice. B. The can opener has been replaced, the kitchen equipment has been cleaned and food is now being dated and stored according to policy. 3. Recurrence will be prevented by: A. Kitchen Staff members have been educated related to the	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure sanitization of the commercial can opener or label, date and cover stored food. This had the potential to affect 61 of 62 residents in the facility. Findings include: During the initial tour of the kitchen on 11/19/13, at approximately 7:30 a.m. with the dietary manage (DM), the reach in refrigerator contained the following items: Lettuce and sliced tomatoes in one metal container with plastic wrap half covering the top; An undated zip lock plastic bag of 11 hamburgers; Another undated zip-lock	F 371		

A. Kitchen Staff members have been educated related to the policy for cleaning and replacement of equipment as well as the policy for labeling and storage of food. Date of Education: December 26, 27, 30, 2013.
B. Multiple weekly audits x1 month then monthly times 3 with findings presented to QA meeting for discussion. Direct observations will be a part of this audit.

4. Responsible Person:
A. Dietary Manager or Designee.

5. Date of Completion: January 1. 2014

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F 371	Continued From page 19 plastic bag with eight strips of bacon; An undated, open plastic bag containing 2 cups of fresh bacon bits; An open bag with four pieces of cooked chicken dated 11/13/13; A pound of sliced cheese open to the air with dried out cheese slices on the top dated 11/10/13. The DM verified the food found without dates or covers. The large commercial can opener was observed to be soiled on 11/19/13, at 7:20 a.m.. The cutting blade that punctured the can had a sticky substance with solid bits of debris. The cutting metal blade coating was partially chipped off to expose the base metal. The area around the blade had tan food debris and a thick black substance that was solid when picked off by the DM. The dietary assistant (DA-A), interviewed on 11/19/13, at 7:20 a.m. stated the can opener was was, "Gross!" On 11/19/13, at approximately 7:30 a.m. the DM stated the can opener should be sent through the dish washer daily. The policy for General Sanitation of Kitchen dated 1/5/13, indicated the frequency of cleaning would be addressed and the cleaning schedule would be posted. The schedule included checking dates on cooler foods, sanitizing the sinks to sanitize and cleaning the reach in refrigerator. The professional can opener was not on the cleaning list.	F 371	policy for cleaning and replacement of equipment as well as the policy for labeling and storage of food. Date of Education: December 26, 27, 30, 2013. B. Random weekly audits x1 month then monthly x3 with findings presented to the QA Committee for discussion. 4. Responsible Person: A. Dietary Manager or Designee. 5. Date of Completion: January 1. 2014	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	F 441 1. Corrective Action: A. The Infection Control Log has been updated to include the site of infections and the monthly log will be reviewed for tracking and trending purposes.	

F 441

1. Corrective Action:
   A. The Infection Control Log has been updated to include the site of infections and the monthly log will be reviewed for tracking and trending purposes.
   B. The nurse who failed to wash her hands after removing her gloves during a procedure has received education on hand washing and infection control.
   C. The Hand Washing and Infection Control Policy was reviewed and revised as appropriate.

2. Corrective Actions as is Applies to Other Residents:
   A. All residents have the potential to be effected by these deficient practices.
   B. The Infection Control log was updated for tracking and trending purposes.
   C. Staff members are being monitored routinely and educated on the spot when they fail to perform hand washing appropriately.

3. Recurrence will be prevented by:

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F 441	Continued From page 20 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper	F 441	B. The nurse who failed to wash her hands after removing her gloves during a procedure has received education on hand washing and infection control. C. The Hand Washing and Infection Control Policy was reviewed and revised as appropriate. 2. Corrective Actions as is Applies to Other Residents: A. All residents have the potential to be effected by these deficient practices. B. The Infection Control log was updated for tracking and trending purposes. C. Staff members are being monitored routinely and educated on the spot when they fail to perform hand washing appropriately. 3. Recurrence will be prevented by: A. Staff members were educated related to the Infection Control and Hand Washing Policy at all staff meetings held on December 26, 27, 30, 2013.	

A. Staff members were educated related to the Infection Control and Hand Washing Policy at all staff meetings held on December 26, 27, 30, 2013.
B. Multiple weekly audits x1 month then monthly times 3 with findings presented to QA meeting for discussion. Direct observations will be a part of this audit.

4. Responsible Person:
   A. DON or Designee

5. Date of Completion: January 1, 2014

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F 441	Continued From page 21 handwashing was completed after a blood glucose monitor procedure for 1 of 1 residents (R151) observed to have blood glucose checked. In addition, the facility failed to implement an infection control surveillance plan to identify and monitor resident infections. Findings include: R151 was observed, on 11/21/13, at 4:43 p.m. when registered nurse (RN)-B completed the blood glucose test. RN-B entered R151's room, washed hands in the bathroom, and donned gloves. RN-B explained the procedure to R151, wiped R151's right index finger with an alcohol swab, and poked the wiped finger with a lancet obtaining blood. RN-B applied the blood to a prepared blood glucose monitor strip and placed the monitor on R151's bed side table. RN-B applied a cotton ball to R151's finger and assisted R151 to press the cotton ball to stop bleeding. RN-B obtained the blood glucose level, removed the gloves, and disposed of the supplies. Without handwashing, RN-B took the blood glucose monitor into the hallway and placed it on the medication cart. RN-B reached into her pocket, retrieved the medication cart keys, opened the cart, and applied new gloves. RN-B opened the bottom drawer of the cart, removed a sanitary wipe from a purple-topped container, disinfected the blood glucose monitor and returned it to the top drawer of the cart. RN-B removed the gloves, reached into the medication cart for the bottle of insulin and syringe, cleaned the top of the insulin bottle with alcohol, inserted the needle into the bottle and withdrew 2 units of insulin. RN-B returned the insulin bottle to the top drawer of the	F 441	B. Random weekly audits x1 month then monthly x3 with findings presented to the QA Committee for discussion. 4. Responsible Person: A. DON or Designee 5. Date of Completion: January 1, 2014	

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F 441	Continued From page 22 medication cart, picked up another alcohol wipe and pair of gloves, closed up the medication cart and locked it. RN-B re-entered R151's room, donned new gloves and administered the insulin into R151's abdomen. RN-B removed the gloves, placed the used syringe on the bedside table, disposed of supplies into the bathroom garbage can and washed her hands. On 11/21/13, at 5:00 p.m. RN-B stated she should have washed her hands with glove change after monitoring blood glucose and before drawing up and administering the insulin. On 11/21/13, at 6:05 p.m. the director of nursing (DON) stated hands should be washed after removal of gloves when completing any procedure, and especially when in contact with blood or body fluids. A Glove Use policy reviewed and revised 5/2006, directed gloves should be changed and hands washed between changes; when gloves become contaminated; and always before leaving a room or a resident, and whenever in doubt. The monthly infection log for February 2013 through the present time were incomplete. The entries lacked site of the infection, date of onset of symptoms, signs and symptoms of the infection, microorganisms and if the infection had resolved. On 11/22/13, at 12:59 p.m. DON was interviewed and verified there was no surveillance system to	F 441		

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F 441	Continued From page 23 monitor and identify resident infections. The facility policy and procedure on infection control program dated 5/11, directs the facility to develop, implement and maintain an infection control program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The policy further directs staff to oversee the tracking of infections and monthly infection reports.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure painting, repair of gouged wood doors, and intact resident furniture for 8 of 62 resident's (R94, R21, R48, R26, R38, R59, R64, R53) living in the facility. Findings include: On 11/22/13 at 2:30 p.m., during tour of the facility with the maintenance director (MD) the following resident areas had walls or furniture in disrepair.	F 465	F 465 1. Corrective Action: A. The damaged walls and equipment in resident rooms #94, 21, 48, 26, 38, 59, 64, 53 were repaired and painted. B. The wheelchair armrest #53 was repaired. C. The policy on maintaining cleaning and repairing equipment was reviewed and the standards on a clean, well maintained facility were reviewed. 2. Corrective Action as it Applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. Walls and Equipment in resident rooms were checked and repaired/painted as necessary. C. Wheelchairs in need of new parts have had these items ordered and they will be replaced as the parts come in.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245370	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

(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 465	Continued From page 24 R94's room had paint and sheet rock paper missing in an area four inches by three inches on the wall at the head of the bed. R21's room had paint and sheet rock paper missing in an area three inches by ten inches on the wall at the head of the bed. R48's wood bathroom door had rough and chipped corners from the floor to 14 inches from the floor. The bathroom wall had six scrapes from close to the floor to 12 inches up the wall in an area 20 inches long with missing paint and sheet rock paper. The damage matched the height of the wheel chair foot rest and posed a risk of injury to R48's feet and ankles. R26's wood dresser had the bottom drawer loose and with missing veneer. The wood bathroom door edge was rough and chipped with the finish gone from the floor to approximately 12 inches high. R38's bathroom wall had paint scraped off in two areas at wheel chair foot rest height. One area measured 21 inches long by 1/4 inch wide and the other measured 30 inches long by 3/4 inch wide. R59's bathroom walls had paint scraped off a line approximately two feet long, about a foot from the floor, on the wall to the right of toilet. There were small areas of gouged sheet rock paper in bathroom to the right of the sink, approximately 6	F 465	3. Recurrence will be prevented by: A. Staff members were educated on the need to report damaged walls and equipment to the maintenance department so they can be repaired. This education occurred at all staff meetings held on: December 26, 27, 30, 2013. B. Random weekly audits x1 month and then monthly audits x3 with findings presented to the QA Committee for discussion. 4. Responsible Person: Maintenance Director or Designee 5. Date of Completion: January 1, 2014	

replaced as the parts come in.

3. Recurrence will be prevented by:
   A. Staff members were educated on the need to report damaged walls and equipment to the maintenance department so they can be repaired. This education occurred at all staff meetings held on: December 26, 27, 30, 2013.
   B. Multiple weekly audits x1 month then monthly times 3 with findings presented to QA meeting for discussion. Direct observations will be a part of this audit.

4. Responsible Person: Maintenance Director or Designee

5. Date of Completion: January 1, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245370	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 25 inches from floor. R64's bathrooms walls had scrapes in a thin band 1/4 inch wide by four feet long. R53's wheelchair was missing the cover on the left arm rest exposing an un-cleanable surface. The MD verified the walls were scraped with absent paint and sheet rock paper; the dresser was in disrepair, and R53's wheelchair arm was un-cleanable. The MD stated that resident rooms were cleaned and repainted when residents moved out. Other maintenance requests were filed by staff and there were no maintenance requests for repair of the walls.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245370	A. BUILDING **02 - BLDG 2** B. WING _____	**11/20/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN NORTH BRANCH	**5379 -383RD STREET NORTH BRANCH, MN 55056**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Ecumen Borth Branch 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 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Health Care Fire Inspections STATE FIRE MARSHAL DIVISION 444 CEDAR ST., SUITE 145 ST. PAUL, MN 55101-514, or By E-Mail to: Barbara.lundberg@state.mn.us, and Marian.Whitney@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	K 000	POC ok PB 12-23-13 RECEIVED DEC 23 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

1-1-14

Dc:

Exit: 11-22-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan J. Johnson	Executive Director	12/20/13

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
	245370	A. BUILDING **02 - BLDG 2** B. WING _____	**11/20/2013**

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K 000	Continued From page 1 responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ecumen North Branch was constructed in 2006 & 2007, with opening in 2007. It is a one story building with no basement. The construction type is determined to be type V(111). The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire doors. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 68 beds and 65 were occupied at the time of inspection. The requirement at 42 CFR, Subpart 483.70(a)) is NOT met by evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2	K 050	K050 1. Corrective Action: A. Fire drill records and documentation of them will be conducted at a quarterly basis. 2. Corrective Action as it applies to Other Residents: A. Fire drill records will continue to be done and documented on a quarterly basis. 3. Reoccurrence will be Prevented by: A. This will be prevented by conducting fire drills and recording and documenting them on a quarterly basis. 4. The Correction will be Monitored by: A. Maintenance Director or designee 5. Date of Completion: January 1, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245370	A. BUILDING **02 - BLDG 2** B. WING _____	**11/20/2013**

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K 050	Continued From page 2 This STANDARD is not met as evidenced by: Based on review of available fire drill records the facility has not been conducting fire drills as required by LSC(00) section 18.7.1.2. This deficient practice could effect all building occupants, including patients, visitors and staff in the event of a fire. Findings include: At the conclusion of the inspection tour 11-20-13 at 10:00AM, based on a review of available fire drill records the facility has failed to properly document fire drills for the first 6 months of 2013. A computer generated log show when the fire drill should have been conducted. However, the facility did not have any back-up documentation to indicate the drills had actually been done. Fire drill forms were not available for any of these drills. This deficient practice was confirmed by the administrator (NJ) at the time of exit.	K 050		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 6980

December 11, 2013

Mr. Nathan Johnson, Administrator
Ecumen North Branch
5379 - 383rd Street
North Branch, Minnesota 55056

Re: Enclosed State Nursing Home Licensing Orders - Project Numbers S5370029

Dear Mr. Johnson:

The above facility was surveyed on November 19, 2013 through November 22, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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:

Pat Halverson, Unit Supervisor
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Telephone: (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 immediately contact me.

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.

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File