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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PGW0

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: **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)

6. DATE OF SURVEY **12/04/2015** (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):

17. SURVEYOR SIGNATURE Date :
Chris Campbell, Unit Supervisor 01/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/07/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
11/13/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245370

January 7, 2016

Mr. Nathan Johnson, Administrator
Ecumen North Branch
5379 -383rd Street
North Branch, MN 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 November 16, 2015 the above facility is certified:

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 eNotice.

Sincerely,

Mark Meath

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

MDH
Minnesota
Department
of Health

January 7, 2016

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

RE: Project Number F5370029

Dear Mr. Johnson:

On December 22, 2015, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 15, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of December 22, 2015, 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 January 15, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on October 15, 2015 and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our December 22, 2015 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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 December 23, 2015, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 15, 2015, as of November 16, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of December 22, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 15, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 15, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 15, 2016, is to be rescinded.

In our letter of December 22, 2015, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 15, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 16, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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	12/4/2015

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 **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/13/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/13/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **11/16/2015**
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** CC/mm	**Date:** 12/22/2015	**Signature of Surveyor:** 13922	**Date:** 12/04/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 10/15/2015		**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

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 **02 - BLDG 2**	12/23/2015

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	Correction Completed **10/28/2015**	ID Prefix	Correction Completed **10/17/2015**	ID Prefix	Correction Completed **10/30/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0047		LSC K0050	
ID Prefix	Correction Completed **11/15/2015**	ID Prefix	Correction Completed **11/02/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0067		LSC K0076		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	01/07/2016	27200	12/23/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/16/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MDH
Minnesota
Department
of Health

Electronically delivered
December 22, 2015

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

RE: Project Number S5370031

Dear Mr. Johnson:

On October 26, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 15, 2015. 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 December 4, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 16, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on October 15, 2015.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the October 15, 2015 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard extended survey were found 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 15, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 15, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 15, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Ecumen North Branch is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 15, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any

questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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

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 April 15, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: PGW0

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 **10/15/2015** (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:
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
	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):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NE II 11/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 11/12/2015 (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

Electronically delivered
October 26, 2015

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

RE: Project Number S5370031

Dear Mr. Johnson:

On October 15, 2015, 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>Electronic 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:

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 24, 2015, 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 November 24, 2015 the following remedy will be imposed:

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

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 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 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. 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 ePoC 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 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.

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 January 15, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 15, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 electronic 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. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: gary.schroeder@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	10/15/2015

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'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.	F 000		
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		11/13/15

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

Electronically Signed | 10/30/2015

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F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow through with consultant pharmacy recommendations for 1 of 5 residents (R53) reviewed for unnecessary medications. Findings include: R53's Admission Record indicated R53 was diagnosed with Alzheimer's disease, major depressive disorder, supraventricular tachycardia (rapid hearty rhythm) and hypertensive heart disease. R53's physician orders dated 9/09/15, directed staff to administer Celexa 30 milligrams (mg) by mouth daily for depressive disorder. The Consultant Pharmacist's Medication Review form dated 4/5/15, directed the facility to reassess R53's risk versus benefits of the current dose of Celexa administered and to reduce the dose to 20 mg daily based on the Food and Drug Administration (FDA) guidelines. The FDA Drug Safety Communication for Celexa dated 3/28/12, recommends the maximum dose of Celexa is 20 mg daily for persons 60 years or older. Doses greater than 20 mg put persons at greater risk for cardiac arrhythmia and QT prolongation. There is	F 329	Corrective Action: R53¿s medications have been reviewed by Consultant Pharmacist on 10/21/15. Recommendation made by Pharmacist to reduce Celexa from 30mg to 20mg based on FDA guidelines or document risk versus benefits. On 10/27/15 R53¿s Celexa was reduced to 20mg. Corrective Action as it applies to all other residents: All residents that are prescribed Celexa have the potential to be effected by this deficient practice. Assessments have been completed on all residents medication regimen to ensure any resident currently taking Celexa is not on a dosage exceeding FDA recommendations. All residents having dosage in excess of 20mg have been reduced to 20mg or risk versus benefits documented in medical record. Reoccurrence will be prevented by: The Unnecessary Medication Polices has been reviewed and staff members will be educated on the policy at the Mandatory Education Meeting which will be held 11/4/15 and 11/5/15. Random daily audits will be conducted for two weeks, then weekly for four weeks, then monthly. Findings of audits will be presented to the	

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F 329	Continued From page 2 no limited additional therapeutic benefit to increased dosing. Persons with ventricular tachycardia are at greater risk for sudden death. The 5/4/15, nurse practitioner's (NP) written reply to the pharmacist's request read, "Please provide documentation for support as I have literature that states > 40 mg/day." On 10/14/15, at 5:29 p.m. registered nurse (RN)-C stated she reviewed the follow up actions on the Consultant Pharmacist's Medication Review forms after the practitioner completed their documentation and would then give the documentation to the director of nursing (DON) for follow up and filing. On 10/14/15, at 5:37 p.m. the DON reported the pharmacist provided her with the FDA recommendations and she provided them to the NP, who did not make any changes to the medication order. The DON stated a risk vs. benefit was not completed for the current Celexa 30 mg daily dose. The DON further stated the facility policy was to contact the medical director when there were discrepancies between practitioner and the consultant pharmacist. However, the DON stated she had not contacted the medical director regarding this discrepancy. When interviewed by telephone on 10/16/15, at 11:04 a.m. the consultant pharmacist (CP) verified that a reduction in the dosage of Celexa was not followed through by the NP. The CP stated a Celexa dose reduction would be	F 329	QAPI committee for review and comment. The QAPI Committee will determine when the auditing can be discontinued. Responsible Person: Director of Nursing or Designee	

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F 329	Continued From page 3 recommended again during the October 2015, drug regimen review. The CP stated if the response to a request was not sufficient and had not posed immediate harm to the resident he would allow some time to pass before reissuing another request.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a 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.	F 441		11/13/15

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F 441	Continued From page 4 (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 sanitation of a glucometer (blood sugar monitoring device) and proper disposal of a lancet for 1 of 1 residents (R90) in order to prevent the spread of infection. Findings include: On 10/12/15, at 7:24 a.m. licensed practical nurse (LPN)-A was observed to obtain a blood sugar sample from R90 using the Lake House community glucometer. After poking R90's finger with the lancet LPN-A placed the lancet into a blue plastic cup. When LPN-A finished the procedure, LPN placed the cup with the lancet into the resident's garbage can and left the room with the glucometer. LPN-A wiped off the glucometer with a Sani Wipe and placed the glucometer in the medication cart drawer. On 10/12/15, at 7:29 a.m. LPN-A verified the lancet was improperly disposed of in R90's garbage can and stated it should have been put into a puncture resistant sharps container. LPN-A stated the procedure for sanitizing community	F 441	R 90¿s blood sugar testing has been discontinued and resident has enrolled in hospice programming. All Glucometers have been sanitized properly. Lancet was removed from trash on 10/12/15 and disposed of in designated sharps container. LPN-A has been re-educated on sanitation of glucometers and disposal of lancets and items requiring disposal in puncture resistant sharps container. Corrective Action as it applies to all other Residents: All residents who receive blood sugar testing have the potential to be effected by this deficient practice. All nursing personnel responsible for performing blood sugar testing and utilizing needles and medical waste that requires proper disposal will be re-educated on infection control policies and sharps disposal. Reoccurrence will be Prevented By: The Infection Control Resident Care Equipment and Shaprs Disposal Policies have been reviewed and staff members will be educated on the policy during the Mandatory Education Meeting scheduled	

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F 441	Continued From page 5 glucometers was to first scrub down the glucometer with a Sani Wipe and then place a moist wipe around the device for two minutes. LPN-A verified she had not placed a moist Sani Wipe around the glucometer for the required time of two minutes to ensure sanitization. On 10/15/15, at 12:19 p.m. the director of nursing (DON) stated she expected staff to place all used lancets in the sharps container. The DON also stated staff were directed to use the Sani Wipes to wipe down the glucometer after use then to leave a moist wipe on the device for two minutes followed by allowing the device to dry, in between each use. The Sharps Disposal Policy dated 1/12, directed staff to discard contaminated sharps into containers that were closable, puncture resistant and leak proof. The Infection Control - Resident Care Equipment policy dated 5/11, directed infection control procedures which included cleaning and sanitizing resident equipment were to be followed in order to prevent transmission of infection.	F 441	for 11/4/15 and 11/5/15. Random daily audits will be conducted for two weeks, then weekly for four weeks, then monthly. Findings of the audits will be presented to the QAPI Committee. The QAPI Committee will be responsible for determining when auditing may be discontinued. Responsible Person: Director of Nursing or Designee	
F 465 SS=F	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.	F 465		11/16/15

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F 465	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner to promote sanitation and food safety in the main kitchen. This practice had the potential to affect all 57 residents who received food from the kitchen. In addition the facility failed to maintain resident fall mats in good repair with a cleanable surface for 2 of 2 residents (R52, R53) observed to utilize torn fall mats. Findings include: During the kitchen tour with the dining coordinator (DC) on 10/12/15, at 8:00 a.m. the following sanitation concerns were observed and verified by the DC: -a large fan in the clean dish room and blowing towards three racks of clean, drying dishes was observed with a heavy buildup of dust which also hung off the grill. A second, smaller fan was also observed to have a heavy dust build up. The fan was located above the dirty dish line blowing towards the dirty and clean dish areas. -At the time of the observation, the DC verified both fans were dirty and stated "it's not good." The DC removed the larger fan from the area and turned off the small fan. During the follow-up kitchen tour with the dining director (DD) on 10/15/15, at 11:00 a.m. the following sanitation concerns were observed and	F 465	1. Corrective Action A. The Fans have been cleaned and removed from the Kitchens B. The Kitchen Equipment including knobs and outside of equipment have been cleaned. C. The filter and fans have been cleaned on the roast and hold oven. D. Dining Services Cleaning schedules updated to include more detailed instructions on cleaning of outside of each unit. E. R52 and R53¿s Fall mats in poor condition have been removed and disposed of and replaced with new fall mats. 2. Corrective action as it applies to others A. All residents have the potential to be effected by this deficient practice. B. The fans have been removed C. The kitchen equipment has been cleaned inside and outside. D. All residents that utilize fall mats have the potential to be affected by this deficient practice. Any fall mat in poor condition has been removed and replaced. 3. Recurrence will be prevented by: A. Dining Services staff have been educated related to the policy for cleaning. Dates of education November 2,3,4,5,6, 2015 B. Random weekly audits X 1 month and then Monthly X 3 months with findings reported to the QAPI Committee for discussion.	

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F 465	Continued From page 7 verified by the DD: - the corners of four of six stovetop burner grates on the Vulcan conventional oven/stove top unit were observed covered with a heavy buildup of a greasy black substance. All seven temperature control knobs were sticky with a buildup of a brown substance on and around the knobs. A buildup of black grime and burnt residue was noted on the front and backsplash of the stovetop. The outside of the oven door had food splatter down the front of it and there was grease and food debris caked on and around the corners of the handle. - The three square air vents on the right side and two circular air vents on the left side of the roast and hold two compartment oven had a heavy, dense buildup of dust particles. The DD stated "that's dirty." - the two compartment convection oven was observed to have a heavy buildup of a brown substance with food debris on and around the door handles, in all crevices/seams on the front of the ovens, with heavy buildup of dust particles in the top right corner of the unit. The entire right side of the unit was splattered with dried food debris and greasy dust particles. When interviewed on 10/15/15, at 11:20 a.m. the DD verified all units were dirty and needed to be cleaned. The DD stated the stove and ovens were deep cleaned on the weekends. When the greasy black substance on the grates was	F 465	C. Nursing staff will be educated on infection control policy related to resident equipment items during Mandatory Education scheduled for 11/4/15 and 11/5/15 D. Audits will be completed assessing condition of fall mats weekly x4 weeks, then monthly. Findings of Audits will be presented to QAPI Committee for review and comment. QAPI committee will determine when auditing can be discontinued. 4. Responsible person: A. Dining Services Director or Dining Coordinator B. Director of Nursing or Designee	

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F 465	Continued From page 8 scraped off with a knife, the DD and Cook (C)-F verified it was food particle buildup. C-F stated "they must not have cleaned it last weekend." Review of facility cook cleaning schedules from 8/3/15, thru 10/11/15, indicated the conventional oven/stove top was to be cleaned on Saturday or Sunday by sending the grates through the dishwasher and the convection oven was to be cleaned on Saturday or Sunday by using oven cleaner on the interior of the oven, soaking and sending the five racks through the dishwasher. The inside and the outside of the roast and hold ovens were to be cleaned on Wednesday, Saturday or Sunday. The schedules revealed the conventional oven/stove top was cleaned only 6 of 10 weeks, the convection ovens 9 of 10 weeks and the roast and hold ovens only 3 of 10 weeks. The undated facility Cleaning Instructions: Range, indicated burned particles and grease would be scraped off with a non-metal scouring pad and the range top would be cleaned after each use. The undated facility Cleaning Instructions: Ovens, indicated the oven racks and inside of the units would be cleaned but lacked direction for cleaning the outside of the units. Fall Mats: On 10/12/15, at 9:30 a.m. R53's fall mat was observed on the floor, next to the bed with cracks throughout and all four corners were ripped with exposed foam.	F 465		

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F 465	Continued From page 9 On 10/13/15, at 9:19 a.m. R52's fall matt was observed on the floor next to the bed with rips and tears that exposed foam on the sides and ends of the mat. On 10/15/15, at 9:34 a.m. during an environmental tour the administrator and environmental services director verified R52 and R53's fall mats were in poor repair and needed to be replaced. The administrator stated nursing was responsible for reporting poor equipment conditions. On 10/15/15, at 12:32 p.m. the director of nursing (DON) verified the mats were in ill repair and uncleanable and stated it was expected that staff report any equipment in need of repair so it could be replaced. The Infection Control - Resident Care Equipment policy dated 5/11, directed "infection control procedures are followed to prevent transmission of infection including cleaning and sanitizing of resident - care equipment."	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 _____	**10/16/2015**

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 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 North 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 (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/30/2015

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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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us or 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 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.	K 000		

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K 000	Continued From page 2 The facility is licensed for 68 beds and 55 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 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 18.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 10/16/2015, observation revealed, that the door to the St Croix Wing soiled utility room did not self-close and latch into the frame.	K 029	1. Soiled utility room door on St. Croix now closes due to changing out the self-closing mechanism. 2. Date of Completion: October 28, 2015 3. The correction will be monitored by Maintenance Director or designee through random audits	10/28/15

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K 029	Continued From page 3 This deficient condition was verified by the Environmental Services Director (WE).	K 029		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1. This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to correctly position 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. This deficient practice could negatively affect residents, staff, and visitors, if the lack of properly positioned exit signs could misdirect and prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include: On facility tour between 10:30 AM to 2:30 PM on 10/16/2015, it was observed that the illuminate exit sign at the St Croix Wing parking lot exit was inoperative and was not illuminated. This deficient condition was verified by the Environmental Services Director (WE).	K 047	K047 1. St. Croix exit light now illuminates 2. Date of Completion: October 17, 2015 3. The correction will be monitored by Maintenance Director or designee through random audits	10/17/15
K 050 SS=D	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.	K 050		10/30/15

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K 050	Continued From page 4 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 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to vary the times and conditions for the required fire drills within the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:30 AM to 2:30 PM on 10/16/2015, during a documentation review of the available fire drill reports for the last 12 months and interview with the Environmental Services Director (WE), it was revealed that the facility was missing a fire drill in the 1st calendar quarter for the day shift. This deficient condition was verified by the Environmental Services Director (WE).	K 050	1. Fire drills will continued to be conducted on each shift each quarter. 2. Date of completion: October 30, 2015 3. The correction will be monitored by Maintenance Director or designee through random audits	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA	K 067		11/15/15

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K 067	Continued From page 5 90A This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 10:30 AM to 2:30 PM on 10/16/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Environmental Services Director (WE), that the facility could not provide any documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years. This deficient condition was verified by the Environmental Services Director (WE).	K 067	1. Fire and smoke dampers will now be tested by private contractor, in process of contacting. 2. Date of completion: November 15, 2015 3. The correction will be monitored by Maintenance Director or designee through random audits	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than	K 076		11/2/15

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K 076	Continued From page 6 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 This STANDARD is not met as evidenced by: Observations revealed that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities (1999 edition) section 4-3.1.1.2. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, it was observed that the number of gaseous and liquid oxygen cylinders located in the oxygen storage/trans-filling room have a volume that is less than 3000 cubic feet. At the time of the inspection it could not be determined if the Oxygen storage/trans-filling room was equipped with a dedicated natural or mechanical ventilation system that vented to the exterior. This deficient condition was verified by the Environmental Services Director (WE).	K 076	1. Oxygen room motor will be replaced so it can vent the room 2. Date of completion: November 2, 2015 3. The correction will be monitored by Maintenance Director or designee through random audits	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 26, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5370031

Dear Mr. Johnson:

The above facility was surveyed on October 12, 2015 through October 15, 2015 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 Chris Campbell at (218) 302-6151 or email: chris.campbell@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00066	A. BUILDING: _____ B. WING _____	10/15/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 12, 13, 14, 15, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000		

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2 000	Continued From page 1 Certification Program; 11 East Superior Street; Suite 290, Duluth, MN 55802	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper	21390	R 90¿s blood sugar testing has been discontinued and resident has enrolled in	11/13/15

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21390	Continued From page 2 sanitation of a glucometer (blood sugar monitoring device) and proper disposal of a lancet for 1 of 1 residents (R90) in order to prevent the spread of infection. Findings include: On 10/12/15, at 7:24 a.m. licensed practical nurse (LPN)-A was observed to obtain a blood sugar sample from R90 using the Lake House community glucometer. After poking R90's finger with the lancet LPN-A placed the lancet into a blue plastic cup. When LPN-A finished the procedure, LPN placed the cup with the lancet into the resident's garbage can and left the room with the glucometer. LPN-A wiped off the glucometer with a Sani Wipe and placed the glucometer in the medication cart drawer. On 10/12/15, at 7:29 a.m. LPN-A verified the lancet was improperly disposed of in R90's garbage can and stated it should have been put into a puncture resistant sharps container. LPN-A stated the procedure for sanitizing community glucometers was to first scrub down the glucometer with a Sani Wipe and then place a moist wipe around the device for two minutes. LPN-A verified she had not placed a moist Sani Wipe around the glucometer for the required time of two minutes to ensure sanitization. On 10/15/15, at 12:19 p.m. the director of nursing (DON) stated she expected staff to place all used lancets in the sharps container. The DON also stated staff were directed to use the Sani Wipes to wipe down the glucometer after use then to	21390	hospice programming. All Glucometers have been sanitized properly. Lancet was removed from trash on 10/12/15 and disposed of in designated sharps container. LPN-A has been re-educated on sanitation of glucometers and disposal of lancets and items requiring disposal in puncture resistant sharps container. Corrective Action as it applies to all other Residents: All residents who receive blood sugar testing have the potential to be effected by this deficient practice. All nursing personnel responsible for performing blood sugar testing and utilizing needles and medical waste that requires proper disposal will be re-educated on infection control policies and sharps disposal. Reoccurrence will be Prevented By: The Infection Control Resident Care Equipment and Shaprs Disposal Policies have been reviewed and staff members will be educated on the policy during the Mandatory Education Meeting scheduled for 11/4/15 and 11/5/15. Random daily audits will be conducted for two weeks, then weekly for four weeks, then monthly. Findings of the audits will be presented to the QAPI Committee. The QAPI Committee will be responsible for determining when auditing may be discontinued. Responsible Person: Director of Nursing or Designee	

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21390	Continued From page 3 leave a moist wipe on the device for two minutes followed by allowing the device to dry, in between each use. The Sharps Disposal Policy dated 1/12, directed staff to discard contaminated sharps into containers that were closable, puncture resistant and leak proof. The Infection Control - Resident Care Equipment policy dated 5/11, directed infection control procedures which included cleaning and sanitizing resident equipment were to be followed in order to prevent transmission of infection. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures are maintained. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and	21426		11/13/15

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21426	Continued From page 4 maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 employees (ED, EE) were properly screened for tuberculosis signs and symptoms. In addition the facility failed to complete a 2-step tuberculin skin test (TST) for 1 of 5 employees (EC). This had the potential to affect all 57 residents residing in the the facility. Findings include: Personnel records of five newly hired staff were reviewed and the revealed the following: ED was hired 7/28/15, and had step 1 and step 2	21426	Corrective Action: The TB prevention and Control Policy has been reviewed. All staff will be educated on policy and procedure for TB prevention and screening at Mandatory Staff Education Meetings scheduled for 11/4/15 and 11/5/15. Auditing will be completed weekly for four weeks, then monthly. Audit findings will be presented to the QAPI Committee for review and comment. The QAPI Committee will be responsible for determining when auditing can be discontinued.	

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21426	Continued From page 5 TST completed, however ED's record lacked evidence that a tuberculosis symptomology screening was completed. EE was hired 6/16/15, and had a step 1 and step 2 TST completed, however EE's record lacked evidence that a tuberculosis symptomology screening was completed. EC was hired 7/28/15, had a tuberculosis symptomology screen and step 1 TST completed, however EC's record lacked evidence that a step 2 TST was administered and read. On 10/16/15, at 1:01 p.m. via telephone, the director of nursing (DON) verified the employee tuberculosis records were incomplete and stated it was her expectation that all symptomology screening were completed on hire and prior to the step 1 TST. The facility's Tuberculosis (TB) Prevention and Control Policy and Procedure dated 6/11, indicated the facility would screen and administer TST to employee's according to centers for disease control guidelines dated in 2005, which indicated all results of TB screening for paid and unpaid healthcare workers would be documented. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all employees are screened for physical signs and symptoms of active TB disease upon hire. The DON or designee could educate the	21426		

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21426	Continued From page 6 appropriate staff on the policies/procedures, and could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced	21535		11/13/15

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21535	Continued From page 7 by: Based on interview and document review, the facility failed to follow through with consultant pharmacy recommendations for 1 of 5 residents (R53) reviewed for unnecessary medications. Findings include: R53's Admission Record indicated R53 was diagnosed with Alzheimer's disease, major depressive disorder, supraventricular tachycardia (rapid hearty rhythm) and hypertensive heart disease. R53's physician orders dated 9/09/15, directed staff to administer Celexa 30 milligrams (mg) by mouth daily for depressive disorder. The Consultant Pharmacist's Medication Review form dated 4/5/15, directed the facility to reassess R53's risk versus benefits of the current dose of Celexa administered and to reduce the dose to 20 mg daily based on the Food and Drug Administration (FDA) guidelines. The FDA Drug Safety Communication for Celexa dated 3/28/12, recommends the maximum dose of Celexa is 20 mg daily for persons 60 years or older. Doses greater than 20 mg put persons at greater risk for cardiac arrhythmia and QT prolongation. There is no limited additional therapeutic benefit to increased dosing. Persons with ventricular tachycardia are at greater risk for sudden death. The 5/4/15, nurse practitioner's (NP) written reply to the pharmacist's request read, "Please provide	21535	Corrective Action: R53¿s medications have been reviewed by Consultant Pharmacist on 10/21/15. Recommendation made by Pharmacist to reduce Celexa from 30mg to 20mg based on FDA guidelines or document risk versus benefits. On 10/27/15 R53¿s Celexa was reduced to 20mg. Corrective Action as it applies to all other residents: All residents that are prescribed Celexa have the potential to be effected by this deficient practice. Assessments have been completed on all residents medication regimen to ensure any resident currently taking Celexa is not on a dosage exceeding FDA recommendations. All residents having dosage in excess of 20mg have been reduced to 20mg or risk versus benefits documented in medical record. Reoccurrence will be prevented by: The Unnecessary Medication Polices has been reviewed and staff members will be educated on the policy at the Mandatory Education Meeting which will be held 11/4/15 and 11/5/15. Random daily audits will be conducted for two weeks, then weekly for four weeks, then monthly. Findings of audits will be presented to the QAPI committee for review and comment. The QAPI Committee will determine when the auditing can be discontinued. Responsible Person: Director of Nursing or Designee	

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21535	Continued From page 8 documentation for support as I have literature that states > 40 mg/day." On 10/14/15, at 5:29 p.m. registered nurse (RN)-C stated she reviewed the follow up actions on the Consultant Pharmacist's Medication Review forms after the practitioner completed their documentation and would then give the documentation to the director of nursing (DON) for follow up and filing. On 10/14/15, at 5:37 p.m. the DON reported the pharmacist provided her with the FDA recommendations and she provided them to the NP, who did not make any changes to the medication order. The DON stated a risk vs. benefit was not completed for the current Celexa 30 mg daily dose. The DON further stated the facility policy was to contact the medical director when there were discrepancies between practitioner and the consultant pharmacist. However, the DON stated she had not contacted the medical director regarding this discrepancy. When interviewed by telephone on 10/16/15, at 11:04 a.m. the consultant pharmacist (CP) verified that a reduction in the dosage of Celexa was not followed through by the NP. The CP stated a Celexa dose reduction would be recommended again during the October 2015, drug regimen review. The CP stated if the response to a request was not sufficient and had not posed immediate harm to the resident he would allow some time to pass before reissuing another request.	21535		

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21535	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure all residents are free of unnecessary medications. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21535		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner to promote sanitation and food safety in the main kitchen. This practice had the potential to affect all 57 residents who received food from the kitchen. In addition the facility failed to maintain resident fall mats in good repair with a cleanable surface for 2 of 2 residents (R52, R53) observed	21685	1. Corrective Action A. The Fans have been cleaned and removed from the Kitchens B. The Kitchen Equipment including knobs and outside of equipment have been cleaned. C. The filter and fans have been cleaned on the roast and hold oven. D. Dining Services Cleaning schedules	11/13/15

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21685	Continued From page 10 to utilize torn fall mats. Findings include: During the kitchen tour with the dining coordinator (DC) on 10/12/15, at 8:00 a.m. the following sanitation concerns were observed and verified by the DC: -a large fan in the clean dish room and blowing towards three racks of clean, drying dishes was observed with a heavy buildup of dust which also hung off the grill. A second, smaller fan was also observed to have a heavy dust build up. The fan was located above the dirty dish line blowing towards the dirty and clean dish areas. -At the time of the observation, the DC verified both fans were dirty and stated "it's not good." The DC removed the larger fan from the area and turned off the small fan. During the follow-up kitchen tour with the dining director (DD) on 10/15/15, at 11:00 a.m. the following sanitation concerns were observed and verified by the DD: - the corners of four of six stovetop burner grates on the Vulcan conventional oven/stove top unit were observed covered with a heavy buildup of a greasy black substance. All seven temperature control knobs were sticky with a buildup of a brown substance on and around the knobs. A buildup of black grime and burnt residue was noted on the front and backsplash of the stovetop. The outside of the oven door had food	21685	updated to include more detailed instructions on cleaning of outside of each unit. E. R52 and R53¿s Fall mats in poor condition have been removed and disposed of and replaced with new fall mats. 2. Corrective action as it applies to others A. All residents have the potential to be effected by this deficient practice. B. The fans have been removed C. The kitchen equipment has been cleaned inside and outside. D. All residents that utilize fall mats have the potential to be affected by this deficient practice. Any fall mat in poor condition has been removed and replaced. 3. Recurrence will be prevented by: A. Dining Services staff have been educated related to the policy for cleaning. Dates of education November 2,3,4,5,6, 2015 B. Random weekly audits X 1 month and then Monthly X 3 months with findings reported to the QAPI Committee for discussion. C. Nursing staff will be educated on infection control policy related to resident equipment items during Mandatory Education scheduled for 11/4/15 and 11/5/15 D. Audits will be completed assessing condition of fall mats weekly x4 weeks, then monthly. Findings of Audits will be presented to QAPI Committee for review and comment. QAPI committee will determine when auditing can be discontinued.	

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21685	Continued From page 11 splatter down the front of it and there was grease and food debris caked on and around the corners of the handle. - The three square air vents on the right side and two circular air vents on the left side of the roast and hold two compartment oven had a heavy, dense buildup of dust particles. The DD stated "that's dirty." - the two compartment convection oven was observed to have a heavy buildup of a brown substance with food debris on and around the door handles, in all crevices/seams on the front of the ovens, with heavy buildup of dust particles in the top right corner of the unit. The entire right side of the unit was splattered with dried food debris and greasy dust particles. When interviewed on 10/15/15, at 11:20 a.m. the DD verified all units were dirty and needed to be cleaned. The DD stated the stove and ovens were deep cleaned on the weekends. When the greasy black substance on the grates was scraped off with a knife, the DD and Cook (C)-F verified it was food particle buildup. C-F stated "they must not have cleaned it last weekend." Review of facility cook cleaning schedules from 8/3/15, thru 10/11/15, indicated the conventional oven/stove top was to be cleaned on Saturday or Sunday by sending the grates through the dishwasher and the convection oven was to be cleaned on Saturday or Sunday by using oven cleaner on the interior of the oven, soaking and sending the five racks through the dishwasher.	21685	4. Responsible person: A. Dining Services Director or Dining Coordinator B. Director of Nursing or Designee	

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21685	Continued From page 12 The inside and the outside of the roast and hold ovens were to be cleaned on Wednesday, Saturday or Sunday. The schedules revealed the conventional oven/stove top was cleaned only 6 of 10 weeks, the convection ovens 9 of 10 weeks and the roast and hold ovens only 3 of 10 weeks. The undated facility Cleaning Instructions: Range, indicated burned particles and grease would be scraped off with a non-metal scouring pad and the range top would be cleaned after each use. The undated facility Cleaning Instructions: Ovens, indicated the oven racks and inside of the units would be cleaned but lacked direction for cleaning the outside of the units. Fall Mats: On 10/12/15, at 9:30 a.m. R53's fall mat was observed on the floor, next to the bed with cracks throughout and all four corners were ripped with exposed foam. On 10/13/15, at 9:19 a.m. R52's fall matt was observed on the floor next to the bed with rips and tears that exposed foam on the sides and ends of the mat. SUGGESTED METHOD OF CORRECTION: The Dietary Manager (DM) or designee could develop, review and/or revise policies and procedures to ensure a sanitary environment in the kitchen.	21685		

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21685	Continued From page 13 The DM or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. The director of nursing or designee could review and revise policy and procedures related to equipment maintenance and reporting procedures. The director of nursing or designee could provide staff education and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		