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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PMWQ

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 **03/05/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **68** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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
	68			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Cheryl Johnson, HFE-NEII 03/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 03/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/26/2013 CO. PMWQ13

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/18/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

A standard survey was completed on December 6, 2012. Deficiencies were found, the most serious at a S/S level of G. The facility also had a S/S of a G at their last survey exited March 8, 2012, making this a NOTC survey.

As a result, we imposed State Monitoring effective December 24, 2012. In addition, we recommended to the CMS RO imposition of the following remedies:

- A Per Instance CMP in the amount of $3,000.00 for the deficiency cited at F314, effective December 6, 2012 for a total amount of $3,000.00.

In a letter dated January 11, 2013, CMS RO imposed the following remedies:

- A Per Instance CMP in the amount of $3,000.00 for the deficiency cited at F314, effective December 6, 2012 for a total amount of $3,000.00.
- Mandatory DOPNA, effective March 6, 2013

On Feb 1, 2013, a health PCR was conducted, which resulted in 3 re-issued deficiencies at a S/S of D. State monitoring therefore continued.

We also recommended the following additional remedies to CMS:

- A Per Instance CMP in the amount of $3,000.00 for the deficiency cited at F314, effective December 6, 2012 for a total amount of $3,000.00 remain in effect
- Mandatory DOPNA, effective March 6, 2013 remain in effect
- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F282, effective February 1, 2013 for a total amount of $1,000.00
- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F318, effective February 1, 2013 for a total amount of $1,000.00
- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F441, effective February 1, 2013 for a total amount of $1,000.00

On March 5, 2013, a second health PCR was conducted and all remaining deficiencies were found corrected. State monitoring is therefore discontinued. We are also recommending the following to the CMS RO:

- A Per Instance CMP in the amount of $3,000.00 for the deficiency cited at F314, effective December 6, 2012 for a total amount of $3,000.00 remain in effect
- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F282, effective February 1, 2013 remain in effect
- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F318, effective February 1, 2013 remain in effect
- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F441, effective February 1, 2013 remain in effect
- Mandatory DOPNA, effective March 6, 2013 be rescinded

See attached CMS-2567b for the results of the March 5, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5370

March 20, 2013

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

Dear Mr. Johnson:

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

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

Effective March 5, 2013 the above facility is recommended for:

68 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 68 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 20, 2013

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

RE: Project Number S5370028

Dear Mr. Johnson:

On December 19, 2012, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 24, 2012. (42 CFR 488.422)

On January 11, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $3,000.00 for the deficiency cited at F314, effective December 6, 2012, for a total penalty of $3,000.00. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 6, 2013. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on December 6, 2012. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 1, 2013, the Minnesota Department of Health 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 December 6, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 6, 2012. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey, completed on December 6, 2012. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

Also as a result of the February 1, 2013 revisit, we recommended to the CMS Region V Office of the following actions:

• Per instance civil money penalty of $3,000.00 for the deficiency cited at F314, effective December 6, 2012, for a total penalty of $3,000.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 6, 2013 remain in effect. (42 CFR 488.417 (b))

• Per instance civil money penalty of $1,000.00 for the deficiency cited at F282, effective February 1, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of $1,000.00 for the deficiency cited at F318, effective February 1, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of $1,000.00 for the deficiency cited at F441, effective February 1, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

On March 5, 2013, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 30, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 30, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 5, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

• Per instance civil money penalty of $3,000.00 for the deficiency cited at F314, effective December 6, 2012, for a total penalty of $3,000.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of $1,000.00 for the deficiency cited at F282, effective February 1, 2013, for a total penalty of $1,000.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of $1,000.00 for the deficiency cited at F318, effective February 1, 2013, for a total penalty of $1,000.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of $1,000.00 for the deficiency cited at F441, effective February 1, 2013, for a total penalty of $1,000.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 6, 2013, is rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

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

Enclosure

cc: Licensing and Certification File

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	3/5/2013

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 F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 03/05/2013	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 03/05/2013	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 03/05/2013
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 PH/NCS	Date: 3/20/13	Signature of Surveyor: 25479	Date: 3/5/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/6/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PMWQ

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 **02/01/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **68** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	68			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE-NEII 02/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 03/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/26/2013 CO.
PMWQ12

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/18/2013
(L33)

DETERMINATION APPROVAL

A standard survey was completed on December 6, 2012. Deficiencies were found, the most serious at a S/S level of G. The facility also had a S/S of a G at their last survey exited March 8, 2012, making this a NOTC survey.

As a result, we imposed State Monitoring effective December 24, 2012. In addition, we recommended to the CMS RO imposition of the following remedies:

- A Per Instance CMP in the amount of $3,000.00 for the deficiency cited at F314, effective December 6, 2012 for a total amount of $3,000.00.

In a letter dated January 11, 2013, CMS RO imposed the following remedies:

- A Per Instance CMP in the amount of $3,000.00 for the deficiency cited at F314, effective December 6, 2012 for a total amount of $3,000.00.

- Mandatory DOPNA, effective March 6, 2013

On February 1, 2013 a health PCR was conducted, which resulted in 3 re-issued deficiencies which were isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D). State monitoring will therefore continue.

We are also recommending the following additional remedies to CMS:

- A Per Instance CMP in the amount of $3,000.00 for the deficiency cited at F314, effective December 6, 2012 for a total amount of $3,000.00 remain in effect

- Mandatory DOPNA, effective March 6, 2013 remain in effect

- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F282, effective February 1, 2013 for a total amount of $1,000.00

- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F318, effective February 1, 2013 for a total amount of $1,000.00

- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F441, effective February 1, 2013 for a total amount of $1,000.00

See CMS-2567 and CMS-2567b for the results of the Feb 1, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5808

February 15, 2013

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

RE: Project Number S5370028

Dear Mr. Johnson:

On December 19, 2012, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 24, 2012. (42 CFR 488.422)

On January 11, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $3,000.00 for the deficiency cited at F314, effective December 6, 2012, for a total penalty of $3,000.00. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 6, 2013. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on December 6, 2012. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 1, 2013, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 6, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 16, 2013. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 6, 2012. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion
F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of January 11, 2013:

- Per instance civil money penalty of $3,000.00 for the deficiency cited at F314, effective December 6, 2012, for a total penalty of $3,000.00 will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 6, 2013 remain in effect. (42 CFR 488.417 (b))

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedies:

- Per instance civil money penalty of $1,000.00 for the deficiency cited at F282, effective February 1, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $1,000.00 for the deficiency cited at F318, effective February 1, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $1,000.00 for the deficiency cited at F441, effective February 1, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (218) 302-6151

Fax: (218) 723-2359

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 June 6, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an

informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

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

Enclosure

cc: Lcensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245370	A. Building B. Wing	2/1/2013

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0176** Reg. # **483.10(n)** LSC	**01/16/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	**01/09/2013**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	**01/16/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	**01/16/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**01/16/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	**12/27/2012**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	**01/10/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PH/NCS	**Date:** 2/15/13	**Signature of Surveyor:** 29433	**Date:** 2/1/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/6/2012

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

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 _____	R 02/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}	OK 2/26/13 PLN F282	
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT Is not met as evidenced by: 282Based on observation, interview and document review, range of motion (ROM) services were not provided as directed by the care plan for 1 of 3 residents (R29) reviewed for ROM. Findings include: R29 had multiple diagnoses including diabetes, stroke and unspecified joint contracture. The facility "Functional/Safety Assessment" which included ROM needs indicated R29 had impairments of his upper and lower extremities and a left above the knee amputation. The assessment more specifically indicated R29 had a left hand/wrist contracture and right ankle contracture. R29's current plan of care dated 12/15/12, directed restorative nursing services for "PROMs [Passive ROM] to right UE [upper extremity] - shoulder, elbow, wrist, and fingers, and LEs [lower extremities] all movements, 15 reps [repetitions] days and evenings and with awakenings every day supporting joints with all	{F 282}	1. Corrective Action: A. R29 care plan will be discussed with Therapy B. R29 to have ROM per care plan C. R29 care plans and assignment sheets checked to match each other 2. Corrective Action as it applies to other residents: A. Audit of restorative programs and care plan consistency 3. Reoccurrence will be prevented by: A. Mandatory education on following Plan of Care and Restorative on February 20 & 21. B. Random weekly audits to ensure compliance. 4. The Corrections will be monitored by: A. DON or Designee will conduct random weekly observations to ensure compliance with POC and Restorative for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater 5. Date of Completion: A. February 28, 2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nathan D. Johnson — TITLE: Executive Director — (X6) DATE: 2/25/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245370	A. BUILDING _____ B. WING _____	R 02/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 282}	Continued From page 1 movements." The care plan further directed the left hand splint was to be on when in bed and the right foot orthotic splint at all times. The plan of care indicated a "Gentle slow approach works with resident. Document in Care tracker all refusals for FMPs [functional maintenance plans]. Staff to provide PROM tid (three times a day) - once on days, once on PMS and once by awakenings-to left wrist and digits to increase ease of range prior to donning splint to wrist and digits." On 2/1/13 at 7:15 a.m. R29 was observed to be in bed watching television without his left hand splint or right foot splint in place. At 8:13 a.m. nursing assistants (NA)-B and NA-C arrived to provide morning cares for R29. R29's right foot brace was applied with his morning cares. At 10:00 a.m. R29 was observed to be returned to bed by NA-B and NA-C. His left hand splint was applied at that time. NA-C was observed to place the hand splint on stating "I need to bend your fingers here [R29] to get your splint on." Range of motion services were not observed for R29 during his morning cares on 2/1/13. Registered Nurse (RN)-B, interviewed on 2/1/13, at 11:10 a.m., stated R29 was to receive ROM services once on days, once on evenings and from the awakenings aide who worked from 10:00 a.m. to 6:00 p.m. RN-B stated R29 was to receive 15 reps per joint with his ROM services.R29 ' s CareTracker ROM documentation from 1/16/13, to 1/31/13, indicated R29 was offered ROM services three times a day on 9 of the 16 days reviewed. Further review indicated R29 received 15 reps of ROM 0/16 days. There was no documentation to indicate	{F 282}		

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 _____	R 02/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 282)	Continued From page 2 why the ROM was not completed as directed by the plan of care. RN-B verified the lack of ROM services provided for R29.	(F 282)	F318 1. Corrective Action: A. R29 care plan will be discussed with Therapy B. R29 to have ROM per care plan C. R29 care plans and assignment sheets checked to match each other 2. Corrective Action as it applies to other residents: A. Audit of restorative programs and care plan consistency 3. Reoccurrence will be prevented by: A. Mandatory education on following Plan of Care and Restorative on February 20 & 21. B. Random weekly audits to ensure compliance. 4. The Corrections will be monitored by: A. DON or Designee will conduct random weekly observations to ensure compliance with POC and Restorative for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater 5. Date of Completion: A. February 28, 2013	
(F 318) SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, passive range of motion (PROM) was not provided for 1 of 3 residents (R29) in the sample reviewed for ROM. Findings include: R29 ' s diagnoses included stroke and unspecified joint contractures. The Functional/Safety Assessment included ROM needs and identified ROM impairment of the upper and lower extremities, specifically a left hand/wrist contracture and right ankle contracture. The current plan of care dated 12/15/12, directed, "PROMs to right UE [upper extremity] - shoulder, elbow, wrist, and fingers, and LEs [lower extremities] all movements, 15 reps [repetitions] days and evenings and with awakenings every day supporting joints with all movements." The	(F 318)		

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 _____	R 02/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 318}	Continued From page 3 care plan further directed the left hand splint on when in bed and the right foot orthotic splint on at all times. On 2/1/13 at 7:15 a.m., R29 was observed to be in bed watching television without his left hand splint or right foot splint in place. At 8:13 a.m. nursing assistants (NA)-B and NA-C arrived to provide morning cares for R29. R29's right foot brace was applied with morning cares. At 10:00 a.m. R29 was observed to be returned to bed by NA-B and NA-C. His left hand splint was applied at that time. NAR-C was observed to place the hand splint on stating "I need to bend your fingers here [R29] to get your splint on." Range of motion services were not observed for R29 during his morning cares on 2/1/13. When interviewed on 2/1/13 at 10:15 a.m. NA-B and NA-C stated they provide ROM services "sometimes after breakfast and sometimes after lunch." NA-B was aware of R29's splinting and ROM schedule. Registered Nurse (RN)-B, interviewed on 2/1/13, at 11:10 a.m., stated R29 was to receive ROM services once on days, once on evenings and on from the awakenings aide who worked from 10:00 a.m. to 6:00 p.m. She also verified R29 was to receive 15 reps per joint with his ROM services. RN-B indicated documentation of the ROM services provided should occur in CareTracker (the computerized documentation system), including resident refusals. The CareTracker ROM documentation from 1/16/13, to 1/31/13, indicated R29 was offered ROM services three times a day on only 9/16 days reviewed. Upon further review, R29 received 15	{F 318}		

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 _____	R 02/01/2013

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

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(F 318)	Continued From page 4 reps of ROM 0/16 days. There was no documented rationale for the lack of 15 reps of ROM or why ROM services were not offered three times a day. RN-B verified the findings and could find no information on the lack on ROM services.	(F 318)	F441 1. Corrective Action: A. Interview, audit and educate staff on hand washing and when to change gloves with R12 2. Corrective Action as it applies to other residents: A. Educate all staff hired and annually 3. Reoccurrence will be prevented by: A. Mandatory education on February 20, 21 on glove use/changing gloves B. Randomly weekly audits on hand washing and glove use/changing gloves 4. The corrections will be monitored by: A. DON or designee will conduct random audits on hand washing and glove use/changing gloves for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater. 5. Date of Completion: A. February 28, 2013	
(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)		

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 _____	R 02/01/2013

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

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{F 441}	Continued From page 5 (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 did not provided appropriate hand washing with glove changes during a dressing change observation for 1 of 3 residents (R12) reviewed for infection control. Findings include: R12's diagnoses included a sacral decubitus (pressure) ulcer. The practitioner's order for daily dressing change, dated 10/4/12, and updated 11/21/12, directed to impregnate 4 x 4 gauze with collagenase (an enzymatic ointment used to remove necrotic [dead] tissue from wounds), and loosely pack into wound. This was to be followed by skin prep or barrier cream to tissue surrounding wound, cover with dry 4 x 4 gauze, and foam adhesive dressing. Observation of the pressure ulcer dressing change at 10:28 a.m. on 2/1/13, revealed the following: Registered nurse (RN)-A and licensed practical nurse (LPN)-A entered R12's room, washed their hands and donned clean gloves. LPN-A positioned R12 on the right side and RN-A removed R12's soiled dressing. RN-A removed	{F 441}		

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 _____	R 02/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(F 441)	Continued From page 6 her soiled gloves and donned clean gloves. RN-used skin prep on the tissue surrounding the pressure ulcer removed the soiled gloves and left the room in search of more gloves. She returned in approximately 10 seconds with several pairs of gloves, donned a clean pair of gloves, and proceeded to place the collagenase ointment on several gauze 4 x 4's, and packed them into the pressure ulcer. RN-A removed her soiled gloves, donned clean gloves, and removed the foam adhesive dressing from the supplies. RN-A cut the foam adhesive dressing with a scissors, and LPN-A assisted to place the dressing over R12's pressure ulcer. RN-A removed her soiled gloves, donned clean gloves, removed a pen from her pocket and initialed and dated the dressing. RN-A did not wash her hands between glove changes at any time during the observation of the dressing change. Upon completion of the dressing change at 10:41 a.m. RN-A removed her soiled gloves and washed her hands. RN-A, interviewed at 10:43 a.m. on 2/1/13, stated she did not wash her hands when she removed the soiled gloves and donned clean gloves. RN-A stated she did not know what the policy stated, however, her understanding was if she washed her hands at the beginning of the dressing change she did not need to wash them again after removing soiled gloves and before donning clean gloves. The director of nursing (DON) was interviewed at 10:56 a.m. on 2/1/13, and stated staff had been educated to wash hands prior to putting on clean gloves, and after removing a soiled dressing to wash hands and put on clean gloves.	(F 441)		

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 _____	R 02/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(F 441)	Continued From page 7 The facility policy and procedure on Infection Control - Standard Practices dated May 2011, directed to wash hands immediately after gloves are removed, and to change gloves between tasks and procedures on the same resident after contact with material that may be contaminated.	(F 441)		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PMWQ

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 **12/06/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **68** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	68			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE-NEII 01/03/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 01/16/2013 (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
(L33)

DETERMINATION APPROVAL

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

A standard survey was completed on December 6, 2012. Deficiencies were found, the most serious deficiencies were isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). The facility also had a S/S of a G at their last survey exited March 8, 2012, making this a NOTC survey.

As a result, we are imposing State Monitoring effective December 24, 2012. In addition, we are recommending to the CMS RO imposition of the following remedies:

- A Per Instance CMP in the amount of $3,000.00 for the deficiency cited at F314, effective December 6, 2012 for a total amount of $3,000.00.

Please see attached CMS-2567's for the results of the December 6, 2012 survey. PCR after January 16, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8984

December 19, 2012

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

RE: Project Number S5370028

Dear Mr. Johnson:

On December 6, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (218) 302-6151

Fax: (218) 723-2359

NO 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 they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on March 8, 2012. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective December 24, 2012. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Per instance civil money penalty of $3,000.00 for the deficiency cited at F314, effective December 6, 2012, for a total penalty of $3,000.00. (42 CFR 488.430 through 488.444)

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 March 6, 2013 (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 June 6, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

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

Enclosure

cc: Licensing and Certification File

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 _____	12/06/2012

RECEIVED DEC 31 2012 MN Dept of Health

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	1-3-13 phone interview with administrator – weekly random audits are being completed on each shift and for different staff: POC accepted 1-3-13 (PLN)	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R58) was assessed for the safe self administration of oral medications. Findings include: R58's diagnoses included weakness, fibromyalgia, dementia and osteoarthritis. The annual Minimum Data Set (MDS) dated 10/4/12, indicated R58 was cognitively intact and	F 176	F176 1. Corrective Action A. DON interviewed and educated LPN about SAM and #58 not having orders 2. Corrective Action as it applies to other Residents A. Mandatory Education on January 3, 7, 8 on observing SAM compliance and med passes. 3. Reoccurrence will be Prevented by: A. Education January 3, 7, 8 and all new hires on SAM compliance. B. Random weekly audits will be conducted on Medication Passes 4. The Corrections will be Monitored by: A. DON or Designee will conduct random weekly observations to ensure SAM compliance of Policy for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater. 5. Date of Completion A. 1/16/2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan D. Johnson	Executive Director	12/28/12

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.

PRINTED: 12/19/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245370	A. BUILDING _____ B. WING _____	12/06/2012

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

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F 176	Continued From page 1 required extensive assistance of two people for activities of daily living. The MDS also indicated R58 had no vision or hearing impairment, was able to feed self with minimal supervision, and had no impairment of range of motion of upper extremities. The current and signed Physician Orders for R58 included the following oral medications: Coumadin, Effexor XR, Senna-S, Amitiza, Lasix, Metformin, Simvastatin, Neurontin, Namenda, Lisinopril, Metoprolol, Iron Gluconate, and Norco. On 12/4/12, at 8:26 a.m. R58 was seated at the dining table in a wheel chair when licensed practical nurse (LPN)-A approached with two medication cups with pills in them. LPN-A approached R58, verbally spoke with R58, had set down the medication cups along with a cup of water in front of R58, and then walked away from the dining table, returning to the medication cart, approximately 25 feet away from the table. LPN-A turned away from R58 and faced the medication cart. LPN-A continued to pass medications to other residents in other area of the dining room. R58 swallowed the medications on the table and stated medications were usually passed with the breakfast meal in this fashion. On 12/4/12, at 8:34 a.m. LPN-A stated [he/she] usually passed R58's oral medications this way, leaving the medications on the table for R58 to take with food. On 12/5/12, at 7:55 a.m. LPN-A again left the medications on the table for F58 to take later. Review of R58's Medication Record dated 12/01/12, to 12/31/12, indicated R58 received the following medications at 8:00 a.m.: Senna-S,	F 176		

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F 176	Continued From page 2 Amitiza, Lasix, Neurontin, Namenda, Lisinopril, Metoprolol, Iron Gluconate, and Norco; and at 8:30 a.m. R58 received Metformin. Further review of R58's Medication Record indicated the above mentioned oral medications were administered to R58 on 12/4/12, and 12/5/12, at 8:00 a.m. as ordered. Review of R58's medical record noted no self-administration of medications (SAM) assessment. R58's care plan dated 9/2012, and 10/2012, lacked evidence SAM was included. Review of Self Administration of Medications policy reviewed and revised May, 2011, directed an assessment form will be initiated and forwarded to the unit registered nurse (RN) manager who will coordinate the assessment with the interdisciplinary team (IDT). The SAM policy further noted nursing would obtain an order from the physician for SAM, would record SAM doses in the resident's medical administration record (MAR), and would document the ability to self-administer medications on the care plan. R58's medical record lacked documentation of this information. On 12/5/12, at 8:15 a.m. the director of nursing (DON) was informed of R58's medications being left on the dining table without nursing supervision of administration. The DON was unable to locate a SAM assessment for R58 and stated R58 did have one for nebulizer administration earlier this year but not for oral medications. The DON confirmed R58 did not have a SAM assessment or plan of care and further verified nursing staff should not be leaving medications on the table for R58 to take without nurse supervision.	F 176		

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 1 of 2 residents (R4) who was observed with a mechanical lift sling in the wheelchair and bed. Findings included: The quarterly Minimum Data Set (MDS) dated 10/25/12, indicated R4 had severe cognitive impairment and required extensive assistance of two persons for transfers. The Functional/Safety Assessment dated 10/24/12, indicated R4 required the use of an EZ stand lift (mechanical lift) for transfers. The care plan dated 11/13/12, indicated R4 required total assistance with transfers with a mechanical lift and 2 staff persons. On 12/4/12, at 8:22 a.m. R4 was observed in the dining room seated in a wheelchair with a tan-colored, mechanical lift sling with long straps hanging out and over the back of the wheelchair as well as down towards the floor from the seat of the wheelchair. R4 was awake, awaiting breakfast service along with several other residents who resided in this section of the facility.	F 241	~~F241~~ 1. Corrective Action: A. R4 will have sling removed when not in use. B. If R4 refuses removal tuck straps into side of chair and covered while in bed for dignity purposes 2. Corrective Action as it applies to other Residents: A. Remove slings unless otherwise indicated on care plans 3. Reoccurrence will be Prevented by: A. Mandatory education on January 3, 7 and 8 on revised sling policy, dignity and risk factors. B. Random weekly audits of 1 resident using a lift (sit x walk) 2/1 1-31-13 4. The Corrections will be Monitored by: A. DON or Designee will conduct random weekly observations to ensure compliance with Dignity issues concerning slings for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater. 5. Date of Completion: A. 1/9/2013	

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 _____	12/06/2012

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F 241	Continued From page 4 On 12/4/12, at 1:09 p.m. R4 was again observed in the dining room seated in a wheelchair with a mechanical lift sling straps hanging over the back of the wheelchair as well as down towards the floor beneath the seat of the wheelchair. R4 was eating the lunch meal along with three other tablemates and other residents in the dining room. On 12/5/12, at 7:38 a.m. R4 was observed laying in bed with blankets on top and with a mechanical lift sling underneath R4's back and sticking out towards the floor the length of R4's body. On 12/5/12, at 9:03 a.m. nursing assistant (NA)-A and NA-B entered R4's room and transferred R4 from the bed to the wheelchair using the mechanical lift sling. The NA's tucked the lift sling in on R4's back and between and under R4's legs leaving the lift sling in place on the wheelchair. The NA's did not ask if R4 wanted the sling left underneath on the seat and back of the wheelchair. R4 was observed to be already dressed in day clothes when transferred by the NA's. On 12/6/12, at 5:08 a.m. R4 was observed to be asleep in bed with no lift sling visible. At 6:48 a.m. two NA's went into R4's room to perform morning cares. From 7:00 a.m. until 8:41 a.m. on 12/6/12, R4 was observed lying in bed with the lift sling under her back. At 8:41 a.m., NA-D and NA-K used the mechanical lift sling to transfer R4 into the wheelchair. On 12/6/12, at 9:30 a.m. R4 was observed after breakfast with the lift sling hanging over the back of the wheelchair and the ends of sling hanging down between R4's legs.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 5 At 9:46 a.m. R4 was transferred from wheelchair to bed using mechanical lift and sling was removed. Licensed practical nurse (LPN)-C came into R4's room to complete a skin assessment and noted many creases and reddened marks on R4's back, buttocks and back of thighs. LPN-C verified the creases and marks were from the lift sling being left underneath R4. LPN-C further stated that having the lift sling visible in the bed and wheelchair was undignified and increased the risk of skin breakdown. On 12/6/12, at 2:00 p.m., R4 stated sometimes the lift sling is left underneath and in place on the bed and the wheelchair and [he/she] has "got used to it." On 12/6/12, at 4:00 p.m. a service representative from the EZ stand company was contacted about the type of mechanical lift sling used for R4. The representative stated the lift sling should not be left underneath anyone sitting on a gel cushion due to the sling impeding the purpose of the cushion. The representative further stated the slings were designed to be easily removed once the resident was transferred into a wheelchair so the resident did not have to sit on the sling while up in a wheelchair. The representative also noted the only time the sling should be underneath a resident was when being transferred. Review of Mechanical Lift policy reviewed and revised May, 2011, did not address dignity concerns for residents who required use of lift slings or the practice of leaving the lift sling underneath a resident when laying in bed or seated in a wheelchair.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 6 On 12/6/12, at 2:15 p.m. the director of nursing (DON) stated the mechanical lift sling for R4 should not be left underneath a resident for any length of time. The DON further confirmed the sling should either be removed if possible or tucked into the wheelchair or sides to prevent the sling from hanging out over the back of the wheelchair or down between the legs. The DON verified the practice of leaving the lift sling visible in the bed or in the wheelchair was undignified for R4.	F 241	F242 1. Corrective Action: A. R8, R35 and (R135 Discharged) interviewed and offered alternate choices with frequency of a shower/bath on 12/28/12. 2. Corrective Action as it applies to other residents: A. Interview and offer all current residents the frequency of a shower or bath 3. Reoccurrence will be prevented by: A. Mandatory Staff education on January 3, 7 and 8. 4. The Corrections will be monitored by: A. DON or Designee will conduct random weekly observations to ensure compliance with asking residents the frequency of bathing/showering for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater. 5. Date of Completion: A. January 16, 2013	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide choices of frequency of a tub bath/shower for 3 of 4 residents (R8, R35, R135) who were reviewed for concerns regarding choices. Findings include: R8 was not given a choice of how many tub baths per week he/she would prefer. On 12/3/12, at 5:27 p.m. R8 was interviewed. R8	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 242	Continued From page 7 stated, "Everybody gets a bath once a week unless they have a skin problem or something." R8 stated staff do not offer a choice. R8 stated he/she preferred to have two or three baths per week; however, had never asked for additional baths because the staff were too busy. R8 stated, "I don't want to burden the staff, but would like to at least have my hair washed more than once a week if anything. My head gets itchy." On 12/6/12, at 6:15 a.m. R8 stated at home he/she took a bath every day. R8 added, "When you're in a nursing home you can't have everything you like there's not enough time in the day." R8's diagnoses included multiple sclerosis (MS), paralysis, and atopic dermatitis. The annual Minimum Data set (MDS) dated 6/4/12, indicated R8 had no cognitive impairment; required the extensive assistance of staff with transfers; and required one person physical assist with bathing. The MDS further indicated it was "very important" for R8 to choose between a tub bath, shower, bed bath, or sponge bath. Review of the Bath Aide schedules indicated R8 received one bath per week on Mondays. R35 was not given a choice of how many tub baths per week he/she would prefer. On 12/3/12, at 7:01 p.m. R35 was interviewed and stated he/she received a tub bath once a week. "If I would want more I would have to pay." On 12/5/12, at 1:18 p.m. R35 stated she had asked the aides for an extra bath per week in the past (unsure of how long ago or who was asked), and was told "I would have to pay extra." R35 stated before admission to the facility he/she took	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

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F 242	Continued From page 8 a bath or shower every day, and "then I came here and they [the staff] said you get one [a tub bath/shower] once a week unless you pay extra. I have never asked again because I didn't want to pay extra. I would like a bath twice a week. No one has ever asked how often I would like to have a bath." R35's diagnoses included osteoporosis, muscle weakness, and contracture of the hand. The significant change MDS dated 10/18/11, was incomplete and did not identify R35's daily preferences. The admission MDS dated 11/15/10, indicated it was "very important" for R35 to choose preferences regarding choice of a tub bath, shower, bed bath, or sponge bath (the 2011, significant change MDS was provided as the most recent MDS with Care Area Assessments). The quarterly MDS dated 9/29/12, indicated R35 had no cognitive impairment; required extensive assistance of staff with transfers; and required one person physical assist with bathing. Review of the Bath Aide schedules indicated R35 received one bath per week on Sundays. On 12/6/12, at 9:49 a.m. the registered nurse (RN)-E stated residents were asked if they prefer a tub bath or shower; however, were not routinely asked how often a bath/shower was preferred. RN-E stated, "If they ask we can arrange for them to have more, but they need to ask." RN-E confirmed residents were not routinely given a choice on bathing frequency, and stated the activities staff completed the preferences and customary routine section of the MDS regarding choices.	F 242		

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	245370	A. BUILDING _____ B. WING _____	12/06/2012

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F 242	Continued From page 9 R135 was admitted to the facility on 12/1/12, and the facility refused his requests to have a shower. On 12/4/12, at 2:27 p.m., R135 was interviewed and stated he had asked numerous times if he could take a shower, and was told Saturday was his shower day and he would have to wait until then. R135's diagnoses included therapy for recent total knee replacement. A pre-operative physical dated 11/18/12, indicated R135's cognitve status was alert. The initial care plan dated 12/4/12, indicated R135 required physical assist with transfers for bathing. The nursing assistant care sheet indicated R135's weekly shower was scheduled for Saturday evening. On 12/6/12, at 9:24 a.m., RN-B was interviewed and stated residents have a scheduled weekly bath or shower, but can have a bath or shower whenever they request. RN-B stated she was unaware R135 had not received a shower. On 12/6/12, at 9:45 a.m. the activities director (AD)-A verified activities completed the preferences and customary routine section of the MDS. AD-A stated residents were asked their preferences regarding if they would like a tub bath, shower, bed bath, or sponge bath; however; were not asked their preferences on frequency.. On 12/6/12, at 12:16 p.m. the director of nursing (DON) confirmed residents were not asked their preferences of how many tub baths/showers they would like, and stated "if they ask it could be	F 242		

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F 242	Continued From page 10 done." The facility was unable to provide a policy and procedure on resident choices and bathing.	F 242	F282	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R8) received restorative nursing range of motion (ROM) services as directed by the care plan; and failed to ensure 1 of 3 residents (R12) was offloaded [pressure removed from affected area] as directed by the care plan. Findings include: R8 was not provided restorative nursing ROM services as directed by the care plan. R8's diagnoses included multiple sclerosis (MS), generalized pain, muscle spasms, limb pain, and diabetes. The quarterly Minimum Data Set (MDS) dated 8/28/12, indicated R8 had no cognitive impairment; required extensive assistance of two staff with bed mobility, transfers, dressing, toilet use, and personal hygiene; was non-ambulatory; and had functional limitations in ROM in both lower extremities.	F 282	1. Corrective Action: A. R8 will be reassessed by Therapy on or before 1/4/2012 B. R12 to be repositioned/offloaded per Plan of Care C. R12 care plans and assignment sheets adjusted to match each other D. R12 to have sling removed while in chair and bed E. R8 and R12 POC was revised to indicated shift responsible for assignment 2. Corrective Action as it applies to other residents: A. 100% audit of restorative programs and care plan consistency 3. Reoccurrence will be prevented by: A. Mandatory education on following Plan of Care and Restorative on January 3, 7 and 8. B. Random weekly audits to ensure compliance. 4. The Corrections will be monitored by: A. DON or Designee will conduct random weekly observations to ensure compliance with POC	

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F 282	Continued From page 11 The restorative nursing care plan dated 6/5/12, indicated R8 was at risk for a decline in lower extremity ROM secondary to the diagnosis of MS and lower extremity weakness. The care plan directed staff to provide passive range of motion (PROM) to BLE [bilateral lower extremities] all joints 12 repetitions BID [twice a day], and indicated "Resident prefers early AM prior to getting up for the day and at HS with extensive A-1 [assist of one]. Further interventions included to provide extensive assist of one with the mechanical stand lift for transfers and encourage R8 to stand for at least four minutes BID. The undated nursing assistant (NA) care sheet directed staff to stand R8 in the EZ stand [standing mechanical lift] for four minutes BID to maintain strength and to provide lower extremity ROM with cares 12 repetitions each. The NA care sheet directed staff to "see attachment in NAR book." The lower extremity ROM directions for R8 in the NAR book directed staff to provide hip and knee flexion, hamstring stretches, hip abduction, and ankle dorsiflexion/heel cord stretches. On 12/5/12, at 7:21 a.m. R8 was observed sitting in an electric wheelchair in the dining room at a table. R8's right foot was on the foot pedal and noted to turn inward. R8 stated she gets up early every morning and the night aides complete the cares. R8 stated the night aide usually completed ROM to her legs by bending her legs at the hip joints about 10 times. R8 stated they don't range the knees, or ankles. "I don't think they really know how to do it, but that's OK they do what they can." On 12/6/12, at 5:14 a.m. nursing assistant (NA)-G	F 282	and Restorative for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater 5. Date of Completion: A. January 16, 2013	

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F 282	Continued From page 12 assisted R8 to sit up on the side of the bed and stand with the mechanical stand lift. R8 stood for 54 seconds and was assisted to sit in the electric wheelchair. No ROM of the lower extremity joints was observed to be completed throughout the cares. On 12/6/12, at 12:16 p.m. the director of nursing (DON) confirmed residents should receive cares as directed by the care plan. R12 was not provided offloading/repositioning as directed by the plan of care. R12 had diagnoses that included type 2 diabetes, paraplegia, end stage renal disease and stage 4 pressure ulcer located on coccyx. The most recent quarterly MDS, dated 9/13/12, identified R12 as cognitively intact and requiring extensive assistance with bed mobility and transfers and dependent upon staff for transfers and toileting. The MDS also noted a stage 4 pressure ulcer [full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling] and a history of healed pressure ulcers. The current plan of care dated 10/4/12, directed to turn and reposition every 2 hours and prn [as needed], side to side, keep off bottom. Off load for full 2 minutes every 2 hours if sitting in chair for extended period of time. The temporary care plan for skin risk/problems dated 11/27/12, directed staff to turn and reposition every 2 hours while in bed and off-load at least 1 minute, turn and reposition while in chair (frequency not indicated), and off load at least 1 minute. It also directed licensed staff weekly skin audit. Lastly, it directed no more than 30 degrees side lying position or head of bed elevated. The plan of care	F 282		

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F 282	Continued From page 13 did not direct leaving the mechanical lift sling underneath R12 in the wheelchair. The nursing assistant assignment sheet stated, "may leave sling under resident when up in chair or layed down for treatments." The nursing assistant assignment sheet also directed, "Must use extreme caution with transfers, bed mobility and cares as you are dislodging his wound Dressing..." "Do not wipe from front to back with BM's as you are rolling up the dressing and ruining it!..." "Offload for 2 mins q [every] 2 hrs while in w/c [wheelchair] or electric scooter d/t [due to] pressure sore on sacrum/coccyx." R12 was assisted into the wheelchair with a mechanical lift at 7:55 a.m. on 12/5/12. The cloth mechanical lift sling was left between R12's body and the pressure reduction cushion during continuous observation from 7:55 am. to 9:58 a.m. During observation on 12/6/12, R12 was observed to be lying flat on his back with head of bead elevated to 90 degrees.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	F314 1. Corrective Action: A. R12 new comprehensive skin assessment including Braden scale and tissue tolerance B. R12 given Gel cushion on 12/6/12 C. R12 checked weekly during wound rounds for measurements and staging D. R127 updated Care Plan 12/4/12 E. R127 discharged on 12/19/12 2. Corrective Action as it applies to other residents: A. Weekly skin checks to be done on bath day	

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

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F 314	Continued From page 14 Based on observation, interview and document review, the facility failed to ensure the care and services were provided for 2 of 3 residents (R12, R127) to prevent the development and promote the healing of pressure ulcers. This resulted in actual harm to R12 and R127. Findings include: R12 had a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) on his coccyx. R12 sustained actual harm with increased undermining/tunneling [passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound] between 11/28/12, and 12/6/12. On 11/28/12, the coccyx ulcer measured 2.4 cm x 2.5 cm with undermining/tunneling of 0.8 cm at 12 o'clock and 1.4 cm at 3 o'clock, and minimal purulent serous drainage and slough. On 12/6/12 at 7:29 a.m., LPN-B was observed to measure R12's coccyx pressure ulcer as 2.6 centimeters (cm) long and 2.5 cm wide with tunneling 2 cm deep at 9 o'clock position and 3.4 cm at 3 o'clock position. R12's pressure relieving gel wheelchair cushion was not evaluated as directed by the wound care physician. Every 2 hour offloading [remove pressure from the affected area] was not provided as directed by the care plan, and R12 was not assisted to remain lying on his side while in bed with the head of the bed up less than 30 degrees. In addition, assessments were not consistently documented. R12 was admitted on 9/23/11 with diagnoses that included type 2 diabetes, paraplegia, end stage renal disease and stage 4 coccyx pressure ulcer. The most recent quarterly Minimum Data Set (MDS) dated 9/13/12, identified R12 as	F 314	B. Comprehensive skin assessments as required 3. Reoccurrence will be prevented by: A. Mandatory education to all staff a. Licensed Nurses on measures to promote healing and preventing further breakdown b. NARs on repositioning and offloading B. Random weekly audits will be completed to ensure compliance on weekly skin checks and weekly wound round documents 4. The Corrections will be monitored by: A. DON or designee will conduct random weekly observations to ensure compliance of weekly skin checks and weekly wound round documents for a period of 12 weeks and then monthly for 9 months or until discontinued by Quality Assurance Committee, whichever period is greater. 5. Date of Completion: A. January 16, 2013	

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F 314	Continued From page 15 cognitively intact, requiring extensive assistance with bed mobility, transfers and toileting. The MDS also noted a stage 4 pressure ulcer and a history of healed pressure ulcers. The Care Area Assessment (CAA) completed on 12/18/11, identified R12 was cognitively intact, was incontinent of stool, had an indwelling urinary catheter, and required extensive assistance with bed mobility, transfers and toileting. Also, the CAA identified R12 had an unhealed pressure ulcer, was at risk for developing pressure ulcers, had a pressure relieving device in bed and chair, and was on a turn and repositioning program. The CAA referred to the skin assessment for further information. The current plan of care dated 10/4/12, directed turn and reposition every 2 hours and prn [as needed], side to side, keep off bottom. Off load for full 2 minutes every 2 hours if sitting in chair for extended period of time. The Temporary Care Plan for Skin Risk/Problems dated 11/27/12, directed staff to turn and reposition every 2 hours while in bed and off-load at least 1 minute, turn and reposition while in chair (frequency not indicated), and off load at least 1 minute. It also directed licensed staff weekly skin audit. Lastly, it directed no more than 30 degrees side lying position or head of bed elevated. The plan of care did not direct leaving the mechanical lift sling underneath R12 in the wheelchair. The nursing assistant assignment sheet stated, "May leave sling under resident when up in chair or layed down for treatments." The nursing assistant assignment sheet also directed, "Must use extreme caution with transfers, bed mobility and cares as you are dislodging his wound dressing..." "Do not wipe from front to back with BM [bowel movements] as you are rolling up the	F 314		

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F 314	Continued From page 16 dressing and ruining it!..." "Offload for 2 mins q [every] 2 hrs while in w/c [wheelchair] or electric scooter d/t [due to] pressure sore on sacrum/coccyx." During observation of morning cares for R12 on 12/5/12 at 7:21 a.m., the nursing assistant (NA)-C cleansed the peri-anal area and there was no stool or urine present. The pressure ulcer dressing was intact. The licensed practical nurse (LPN)-B was observed to provide wound care on 12/5/12 at 7:45 a.m. When the coccyx ulcer dressing was removed, there was a quarter sized piece of formed stool under the dressing. LPN-B cleaned the stool out of the wound bed, and without changing gloves or washing hands, reached in the tub of supplies and grabbed wound cleanser spray and sprayed the wound. LPN-B then wiped the wound and massaged Silvasorb cream around the wound bed. Still wearing the soiled gloves, LPN-B applied skin prep (for sensitive skin) around the wound and bloody drainage noted on wipes. LPN-B changed gloves, but did not wash hands before placing absorbent gauze in the wound bed and applying an Opsite dressing. During interview on 12/5/12, at 7:59 a.m., LPN-B verified the lack of glove changes or hand hygiene during the dressing change. R12 was assisted into the wheelchair with a mechanical lift at 7:55 a.m. on 12/5/12. The cloth mechanical lift sling was left between R12's body and the pressure reduction cushion. During continuous observation on 12/5/12, from 7:55 am. to 9:58 a.m., R12 was observed sitting in his wheelchair, in the dining room until he wheeled himself back to his room at 9:08 a.m. At 9:20 a.m., R12 wheeled himself to the dining room to obtain a glass of water and returned to his room	F 314		

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F 314	Continued From page 17 at 9:23 a.m. R12 was met by his guest when he returned to his room. At 9:25 a.m., NA-D offered to get R12 out of the wheelchair. NA-D stated R12 refused repositioning. NA-D stated that R12 said, "No, it's still morning." R12 remained sitting on the lift sling in the wheelchair, without repositioning, in his room until observation ended at 9:58 a.m.. On 12/6/12 at 7:29 a.m., LPN-B was observed to measure R12's coccyx pressure ulcer as 2.6 centimeters (cm) long and 2.5 cm wide with tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) 2 cm deep at 9 o'clock position and 3.4 cm at 3 o'clock position. R12's wheelchair gel cushion was noted to be flat and bottomed towards the back of the wheelchair. LPN-B, asked to evaluate R12's gel cushion, stated, "It's cracked, he needs a new one." The gel cushion was duct taped several times in the back, gel was falling out and noted to be scattered all over inside the cushion cover. LPN-B stated R12 brought the gel cushion from home. R12 was seen at wound clinic on 10/4/12, with recommendations for a wheelchair cushion evaluation since the gel part seemed to bottom out; however, there was no follow-up to obtain the evaluation. During interview on 12/6/12, at 9:31 a.m. the interim director of nursing (IDON) looked at the gel wheelchair cushion and stated, "That doesn't look good." "We should assess his tissue tolerance with the cushion under him in the wheelchair." A new gel cushion (Synergy Spectrum) was placed in the wheelchair. During observation on 12/6/12 at 11:26 a.m., RN-B provided coccyx pressure ulcer care. R12 was observed to be lying flat on his back with head of bed elevated to 90 degrees. RN-B	F 314		

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F 314	Continued From page 18 assessed an "erosion" on R12's penis where the urinary catheter sits. The penis "erosion" . measured 0.5 cm x 4.5 cm with 20% eschar and some granulation. RN-B stated the "erosion" was stage 2, through the skin. The care plan dated 10/20/12, indicated an open area superficial between foreskin and penis. Goal: superficial open area will be healed within 30 days. The care plan and goal was updated 10/20/12. RN-B stated the coccyx pressure ulcer was unstageable with no slough and measured 3.8 cm x 3.5 cm., depth of tunneling at 3 o'clock position was 2.5 cm and the 12 o'clock position tunnel was closed. On 12/6/12, at 1:19 p.m., R12 was sitting on a cloth mechanical lift sling in his wheelchair. The Worksheet for Skin Checks Over Bony Prominence-Sitting dated 9/13/12, indicated the presence of a "wound" on the coccyx with some redness, zero open blanchable on cheeks/thighs after 2 hours. The assessment did not indicate the presence of pressure reduction cushioning during the observation. The Skin Assessment dated 9/17/12, indicated R12 had multiple risk factors for contributing to increased risk for skin breakdown. Weekly full assessments of the sacral/coccyx pressure ulcer were to be completed weekly; however, there was no evidence to indicate assessment was provided between 10/18/12 and 10/31/12, or between 10/31/12 and 11/20/12. On 11/28/12, the coccyx ulcer measured 2.4 cm x 2.5 cm with undermining/tunneling of 0.8 cm at 12 o'clock and 1.4 cm at 3 o'clock, and minimal purulent serous drainage and slough. Nursing documentation dated 10/31/12, indicated "Encourage resident to stay on his side/side positioning no supine d/t [due to] wound. Resident	F 314		

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F 314	Continued From page 19 states he will do what he wants to do. Explain risk slowed healing/outcome non compliance. Agreed he understood, but just shook his head. Cont [continue] to monitor and encourage." R12 was interviewed on 12/6/12, at 1:19 p.m., and when asked if staff had ever explained the risks of sitting in his chair and not offloading and repositioning every 2 hours, he shook his head no. No other information was provided from R12. The national sales manager for E/Z Weigh [lift manufacturer] was interviewed by phone on 12/6/12, at 4:27 p.m., and stated that it was recommended to use a mesh sling for anyone with a pressure ulcer. The sling was easily removed and the only time the sling should be underneath the resident is during the transfer. The canvas material does not allow air flow and moisture could build up between the sling and the resident. If the resident is using a gel cushion, the sling should not be left underneath the resident while they are the chair because it may impede the purpose of the cushion. R127 had intact skin on admission, but sustained actual harm with development of a Stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both) on the left heel. R127 was admitted with diagnoses that included sepsis, congestive heart failure, weakness, and pneumonia. The admission MDS dated 10/23/12, indicated R127 was cognitively intact, required assistance of two staff with bed mobility and transfers, did not ambulate, and required assistance of one staff for wheelchair mobility, dressing, toileting and personal hygiene. The MDS further identified R127 was at risk for the	F 314		

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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 314	Continued From page 20 development of pressure ulcers. The Care Area Assessment (CAA) dated 10/23/12, identified R127 at risk for skin breakdown. On 10/10/12, the facility completed a Braden scale for predicting pressure sore risk with a score of 18, identifying R127 at risk for development of pressure ulcers. Braden scales were also completed on 10/19/12, and 10/30/12, with scores of 20 on both assessments (indicated low risk for the development of pressure ulcers). The Braden scale data on 10/19/12, and 10/30/12, conflicted with the MDS indicating R127, "walks occasionally during the day but for very short distances, with or without assistance." A tissue perfusion check was completed on 10/11/12, with no areas of concern identified after sitting and lying down for two hours. The skin assessment completed on 10/18/12, indicated R127 had risk factors for skin breakdown including friction/shearing potential; and the only skin issue identified was the site where a previous intravenous line had been placed. The assessment also directed repositioning every two hours, and to offload every two hours when sitting. The skin deficit care plan dated 11/12/12, indicated R127 was at risk for skin breakdown due to bowel incontinence, Foley catheter use, and the need for assist with bed mobility. The care plan did not identify or have interventions related prevention of pressure ulcers. The care plan directed skin checks to be done weekly, the nurse to assess weekly and report any areas of redness, dryness or potential breakdown to the nurse.	F 314		

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F 314	Continued From page 21 The interdisciplinary progress notes (IPN) were reviewed from 10/10/12, through 12/3/12. There was no documented weekly skin monitoring, skin assessments, measurement or staging of the pressure ulcer. On 11/19/12, a physical therapy assistant note identified a full thickness wound on left lateral calcaneous (heel) measuring 1.2 centimeters (cm) wide x 1.0 cm in length. On 11/19/12, the nurse practitioner ordered heel protectors on at bedtime and a daily dressing change with Bactroban 2% ointment and a foam dressing secured with gauze roll and tubigrip. Physician documentation dated 11/30/12, indicated the open wound to the left heel was found by the nurse practitioner when she was trimming R127's toenails; however, the note did not include a description of the pressure ulcer. Nurse practitioner documentation on 11/27/12, indicated R127 had a wound with a small amount of drainage on the left heel and the base of the heel was boggy and whitish/yellowish in color. Nurse practitioner documentation on 12/3/12, indicated the left heel ulcer had no discharge but the heel was was boggy and whitish/yellowing in color. Nurse practitioner documentation did not include measurements or staging of the left heel pressure ulcer. The registered nurse (RN)-B, interviewed on 12/3/12, at 6:52 p.m., stated R127 developed a stage 2 pressure ulcer on the left heel after admission to the facility. On 12/5/12, at 12:03 p.m., RN-B verified the lack of weekly skin checks or assessments; and stated the pressure ulcer was not measured or staged since it developed.	F 314		

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F 314	Continued From page 22 The director of nursing (DON) was interviewed on 12/6/12, at 7:35 a.m. and stated she would expect weekly skin checks and skin assessments to be completed. At 8:45 a.m., the DON stated she was unable to find documentation of weekly skin checks or weekly skin assessments. Observation of the pressure ulcer on 12/5/12, at 10:58 a.m. with RN-B and licensed practical nurse (LPN)-D revealed a 2.5 cm x 1.4 cm stage 2 pressure ulcer to the left lateral heel, an increase in size from the initial measurement. The dietary manager (DM)-C was interviewed on 12/6/12, at 1:32 p.m., and stated she would add nutritional interventions to aid healing if she was notified of a resident pressure ulcer. The DM stated she had not been notified and nutritional interventions were not initiated. The DON, interviewed on 12/6/12, at 2:26 p.m., stated nursing staff were expected to inform the dietary department of any pressure ulcers, either through a phone call or an email. The facility policy and procedure on Skin Care/Pressure Ulcer Care revised 5/11, directed a registered nurse to oversee each resident's skin care in accordance with the comprehensive assessment and care plan.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further	F 318	F318 1. Corrective Action: A. R8 to be reassessed by Therapy on or before 1/4/2013 B. R8 will receive restorative per Therapy Assessment opinion C. R8 POC revised to indicate shift responsible for assignment	

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F 318	Continued From page 23 decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative nursing range of motion (ROM) services for 1 of 3 residents (R8) in the sample who had functional limitations in ROM. Findings include: R8's diagnoses included multiple sclerosis (MS), generalized pain, muscle spasms, limb pain, and diabetes. The quarterly Minimum Data Set (MDS) dated 12/3/12, indicated R8 had no cognitive impairment; required extensive assistance of two staff with bed mobility, transfers, dressing, toilet use, and personal hygiene; was non-ambulatory; and had functional limitations in range of motion (ROM) in both lower extremities. The Functional Safety Assessment dated 11/30/12, identified R8 used the EZ stand, and had functional limitations in ROM in both lower extremities. A physical therapy (PT) evaluation dated 5/25/11, indicated PT recommended a standing program with the EZ stand, and a ROM program for the lower extremities. At that time, R8 declined the lower extremity ROM program, but agreed to the standing program. The medical record lacked any indication as to when the restorative nursing ROM program started. The restorative nursing care plan dated 6/5/12,	F 318	2. Corrective Action as it applies to other residents: A. Mandatory education of importance of restorative programs for all residents on a program 3. Reoccurrence will be prevented by: A. Mandatory education on restorative and following plan of care B. Therapy education on appropriate ROM C. Random weekly audits on following Plan of Care for restorative 4. The Corrections will be monitored by: A. DON or Designee will conduct random weekly observations to ensure compliance with Restorative POC for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater. 5. Date of Completion: A. January 16, 2013	

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F 318	Continued From page 24 indicated R8 was at risk for a decline in lower extremity ROM secondary to the diagnosis of MS and lower extremity weakness. The care plan directed staff to provide passive range of motion (PROM) to BLE [bilateral lower extremities] all joints 12 repetitions BID [twice a day], and indicated "Resident prefers early AM prior to getting up for the day and at HS with extensive A-1 [assist of one]. Further interventions included to provide extensive assist of one with the mechanical stand lift for transfers and encourage R8 to stand for at least four minutes BID. The nursing assistant (NA) care sheet (not dated), directed staff to stand R8 in the EZ stand for four minutes BID to maintain strength and to provide lower extremity ROM with cares 12 repetitions each. The NA care sheet directed staff to, "See attachment in NAR book." The lower extremity ROM directions for R8 in the NAR book directed staff to provide hip and knee flexion, hamstring stretches, hip abduction, and ankle dorsiflexion/heel cord stretches. On 12/5/12, at 7:21 a.m. R8 was observed sitting in an electric wheelchair in the dining room at a table. R8's right foot was on the foot pedal and noted to turn inward. R8 stated she gets up early every morning and the night aides complete the cares. R8 stated the night aide usually completed ROM to her legs by bending her legs at the hip joints about 10 times. R8 stated they don't range the knees, or ankles. "I don't think they really know how to do it, but that's OK they do what they can." At 9:24 a.m. R8 was observed in the TV room attending the daily exercises. R8 independently performed the upper body exercises with good ROM; however, very little	F 318		

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F 318	Continued From page 25 movement was observed when R8 attempted to complete the lower body exercises (knees, ankles). On 12/6/12, at 5:14 a.m. nursing assistant (NA)-G obtained clean linens from linen cart, obtained the mechanical stand lift, knocked on R8's door, and entered the room. NA-G washed her hands at the sink, obtained a bin of water, and appropriately completed lower body morning cares. NA-G assisted R8 to sit up on the side of the bed and stood R8 with the mechanical stand. R8 stood for 54 seconds and was assisted to sit in the electric wheelchair. No ROM of the lower extremity joints was observed to be completed throughout the cares. NA-G assisted R8 with face, hands and upper body cares. R8 applied deodorant under arms and held her arms out in front of her to get the shirt on with assist. R8 wheeled herself into the bathroom and completed grooming independently. At 5:44 a.m. NA-G stated, "Ok you're done. Do you need anything else?" R8 stated, "No." NA-G left room. The surveyor questioned NA-G regarding R8's ROM program. NA-G confirmed she had routinely cared for R8 and stated R8 does not receive ROM in the morning. "Only at night. She doesn't like it." NA-G stated she had occasionally assisted R8 to bed at night and had provided lower extremity ROM. When questioned regarding what ROM was completed in the evening NA-G stated, "I lift her legs at the knees and bend them up and out at the hip a few times." NA-G confirmed that was all that was done and stated she had not been trained by the facility on how to complete R8's ROM. NA-G stated she was aware R8 should stand for four minutes, and confirmed she did not encourage R8 to stand because "it's too hard for	F 318		

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F 318	Continued From page 26 R8 to stand that long." NA-G stated she had reported it to the nurse (would not name) on the night shift about a week ago and the nurse was going to pass it on that R8 was having trouble standing for four minutes. NA-G stated she had worked with R8 for several months and R8 had always been able to stand four minutes until about a week ago. NA-G stated, "She has been having trouble with that right foot," and the night nurse was going to report it to the charge nurse so it (the right foot) could be evaluated. On 12/6/12, at 6:15 a.m. R8 reviewed the directions for her LE ROM and stated she did now know what was supposed to be done for ROM and thought it was only once a day. R8 confirmed ROM was not being completed as directed and stated "can you give staff a copy of the sheet so they know what to do?" On 12/6/12, at 11:30 a.m. NA-H stated she had taken care of R8 for several years on the day shift and had never completed ROM. NA-C stated she had routinely completed ROM for R8 on the day shift and explained how she would move R8's legs up and down and straighten them out usually 10 times each leg. On 12/6/12, at 11:45 p.m. the registered nurse (RN)-B stated staff had not reported any issues regarding R8 and she was unaware R8 was having difficulty standing. The documentation for R8's ROM on the Restorative Care Detail Reports for October, November, and December 2012, indicated ROM was documented as being completed for R8 on most days; however, through observation, and	F 318		

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F 318	Continued From page 27 resident and staff interviews, there was no evidence the ROM was consistently being provided correctly. On 12/6/12, at 12:16 p.m. the director of nursing (DON) confirmed R8 should receive ROM services as directed by the care plan, and stated the staff had been trained by therapy on how to complete ROM correctly about six months ago.	F 318	F329 1. Corrective Action: A. R128 MD updated and reviewed on 12/27/12 for Increased Lasix, labs ordered and cardiologist follow up. B. R45-having a trial reduction to 20mg per MD on 12/18/2012 2. Corrective Action as it applies to other residents: A. Medication review on all residents within the next 90 days 3. Reoccurrence will be prevented by: A. Mandatory education on January 3, 7 and 8 for MAR/TAR and compliance with MD orders B. MAR/TAR Audits 4. The Corrections will be monitored by: A. DON or Designee will conduct random weekly	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed adequately monitor response to Lasix (diuretic medication to remove excess fluid) for 1 of 10 residents (R128); and failed to ensure physician response to suggested dosage reduction of Prilosec (used for treatment of GERD [gastroesophageal reflux disease]) for 1 of 10 residents (R45) in the sample. Findings include: R128 was on Lasix 20 milligrams (mg) with specific ordered parameters to monitor daily weights, and to report a weight gain of three pounds or more in 24 hours or a weight gain of five pounds or more in one week to the physician. Daily weight monitoring was not consistently being completed and weight gains outside of the ordered parameters were not reported to the physician. R128's diagnoses included atrial fibrillation, heart disease, pulmonary hypertension, congestive heart failure (CHF), pneumonia, and pleural effusion (fluid in the space between the two linings of the lungs). The admission Minimum Data Set (MDS) dated 11/18/12, indicated R128 had no cognitive impairment and required the extensive assistance of staff for all activities of daily living (ADL's). A physician's order dated 11/19/12, directed staff to decrease R128's Lasix dose to 20 mg daily (from 40 mg twice a day) and complete a daily weight. The order further directed to notify the physician of a three pound or more weight gain in	F 329	observations to ensure compliance with MD orders for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater. 5. Date of Completion: A. January 16, 2013	

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F 329	Continued From page 29 24 hours, or a five pound or more weight gain in one week. Another physician's order dated 11/27/12, directed "daily weights see previous parameters." Review of the Medication Administration Records (MAR's) from 11/20/12, to 12/5/12, indicated as follows: 11/20/12, weight 149 pounds. 11/21/12, weight 147 pounds. There were no documented weights from 11/22/12, to 11/26/12. 11/27/12, weight 151 pounds. 11/28/12, weight 152.4 pounds. 11/29/12, weight 152.3 pounds. 11/30/12, weight 152.3 pounds. There was no weight documented on 12/1/12. 12/2/12, weight 157.6 pounds (a 5.3 pound gain from 11/30/12, weight). 12/3/12, weight 158.9 pounds (a 7.9 pound gain in one week). 12/4/12, weight 162.3 (a 3.4 pound gain in 24 hours). 12/5/12, weight 159.5 pounds. Weights were not monitored according to the physician ordered parameters from 11/20/12, to 11/26/12, and from 11/30/12, to 12/1/12. From 11/27/12, to 12/3/12, there was a 7.9 pound weight gain in one week, and from 12/3/12, to 12/4/12, there was a 3.4 pound weight gain in 24 hours. There was no documented evidence to indicate the physician was notified. On 12/6/12, at 4:09 p.m. the director of nursing (DON) confirmed R128's daily weights were not being monitored as directed by the physician's	F 329		

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F 329	Continued From page 30 orders. The DON verified the lack of documentation to indicate the physician was notified of the weight changes that were outside the ordered parameters. R45's physician orders included Prilosec 40 mg daily since 4/1/11. R45's diagnoses included GERD The director of nurses (DON), interviewed on 12/6/12, at 1:47 p.m., stated the interdisciplinary team (IDT) met in August, 2012, and discussed lowering R45's dose of Prilosec from 40 mgs to 20 mgs daily. The DON stated R45 had no symptoms of GERD, and the physician was notified of this request on 8/21/12. Physician progress notes from 12/14/11, through 11/14/12, did not address the use of the Prilosec or the IDT team recommendation to reduce the dose.	F 329	F356 1. Corrective Action: A. Total hours worked by licensed and unlicensed staff per shift were posted on 12/27/2012 and a system was set up to have Staffing Coordinator or designee responsible to post hours each day 2. Corrective Action as it applies to other residents: A. Mandatory education January 3, 7 and 8 3. Reoccurrence will be prevented by: A. Business office staff educated 12/27/2012 B. Random weekly audits on posting of hours 4. The Corrections will be monitored by: A. DON or designee B. QA meetings will review audits and advise on when monitoring can cease. 5. Date of Completion: A. December 27, 2012	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356		

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F 356	Continued From page 31 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to accurately post the required nurse staffing information which included the total and actual number of hours worked by licensed and unlicensed staff directly responsible for resident care per shift and the correct census number of residents. This had the potential to affect all 64 residents who resided in the facility. Findings include: On 12/3/12, at 1:10 p.m. upon entrance to the facility, the nurse staff posting information was not observed on the wall next to the conference room near the front entrance to the facility. On 12/3/12, at 1:30 p.m. during the initial tour of the facility, a Nurse Staff Posting form was observed on a 8 x 11 sheet of paper enclosed in a clear plastic holder on the wall next to the	F 356		

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F 356	Continued From page 32 conference room near the front entrance to the facility. The posted nurse staffing information lacked the total number and the actual hours worked per shift by the licensed and unlicensed nursing staff directly responsible for resident care. The resident census number noted on the posted form for each shift was 63 residents. Review of the Nurse Staff Posting form, dated 12/3/12, noted the facility reported the number and shift the licensed and unlicensed staff were scheduled to work; however, did not report the actual total number of hours worked for licensed and unlicensed nursing staff. Upon entrance of the survey team to the facility, the administrator reported the resident census to be 62 with two bed holds. On 12/4/12, at 8:00 a.m. the Nurse Staff Posting form was noted to be dated 12/3/12, with the same information posted. On 12/6/12 at 2:15 p.m. the director of nursing (DON) reported the facility had no policy on posting the nurse staffing and resident census information. The DON and verified the staff posting had the wrong census and lacked the total number of hours worked by licensed and unlicensed nursing staff.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 1. Corrective Action: A. DM interviewed and educated Dietary staff and DA-A member involved with incident on 12/4/2012 2. Corrective Action as it applies to other residents: A. Mandatory education for all staff January 3, 7 and 8 on	

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	245370	A. BUILDING _____ B. WING _____	12/06/2012

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

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F 371	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not serve food under sanitary conditions for 30 residents in 2 of 4 dining rooms. Findings include: During observation of the supper meal on 12/3/12, a dietary aide (DA)-A was observed touching biscuits after handling papers and answering the telephone without changing gloves or washing hands. The meal served was chicken pot pie, a biscuit with chicken and vegetables in gravy. The alternate was glazed ham with baked potato and squash. On 12/3/12, at 4:36 p.m. in the St. Croix and Wild River Dining rooms, DA-A was observed touching and tearing pieces of paper with gloved hands before reaching into the steam table, taking out a biscuit, breaking the biscuit in half and placing it on a plate. DA-A continued to do this with five to six more biscuits. At 4:50 p.m. DA-A continued to handle and tear the slips of paper. Then DA-A picked up and turned over a plastic covered sheet of paper with the same gloved hands. At 4:51 p.m. DA-A answered the telephone with the same gloved hands before returning to handling the slips of paper and the plastic covered sheet of	F 371	F371 3. Reoccurrence will be prevented by: A. Mandatory education on glove use/hand washing/ food handling upon hire and annually. B. Review and revise policy 4. The Corrections will be monitored by: A. Dietary Manager or designee will conduct random weekly audits on food handling/glove use/hand washing for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater. 5. Date of Completion A. January 10, 2013	

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F 371	Continued From page 34 paper. DA-A continued the meal service, handling biscuits and plates without changing gloves or washing hands until 5:05 p.m. when the meal service was finished. The dietary manager (DM) was observed walking in and out of the serving area at 4:48 p.m., 4:55 p.m. and 5:02 p.m. without observing DA-A handling food with soiled gloves. DA-A., interviewed on 12/3/12, at 5:06 p.m., stated that the nursing assistants usually tear the sheets of paper and the phone usually did not ring, "But it was so hectic and we usually don't have biscuits. It's usually not this hectic." DA-A stated the paper had the resident's name and menu choice. The plastic covered paper had the resident's name, what side they were on, their diet and any notes about them. DA-A verified she did not change her gloves after touching the papers and answering the telephone. The DM was interviewed on 12/5/12, at 11:20 a.m. and stated staff should be using gloves or tongs to handle food. The DM verified DA-A should have changed gloves after handling papers and answering the phone. The DM stated DA-A had received training on food handling during general orientation and with on the job training. The facility's undated Food Products Purchase, Storage, Handling, Preparation and Serving policy indicated all food products shall be handled with utensils, not with hands as far as possible. When food must be handled, personnel shall wash their hands well and wear gloves. Gloves will be provided and it is required to	F 371		

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F 371	Continued From page 35 change gloves often between tasks.	F 371	F441 1. Corrective Action: A. Interview and educate staff on hand washing and when to change gloves 2. Corrective Action as it applies to other residents: A. Educate all staff hired and annually 3. Reoccurrence will be prevented by: A. Mandatory education on January 3, 7, 8 glove use/changing gloves B. Randomly weekly audits on hand washing and glove use/changing gloves 4. The corrections will be monitored by: A. DON or designee will conduct random audits on hand washing and glove use/changing gloves for a period of 4 weeks and then monthly for 3 months or until discontinued by Quality Assurance Committee, whichever period is greater. 5. Date of Completion: A. January 16, 2013	
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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 36	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure staff completed appropriate glove use and hand hygiene for 1 of 6 resident (R12) in the sample reviewed for infection control.
Findings include:
During observation on 12/6/12, at 7:21 a.m. nursing assistant (NA)-C prepared two basins of water and supplies for R12's morning cares. NA-C performed front peri-care, withdrew foreskin and cleansed catheter tubing. NA-C applied leg catheter bag and stabilized tubing with straps. NA-C did not change her gloves after frontal peri-care, and continued to touch clean items. NA-C put a pair of sweat pants on R12, still wearing the soiled gloves. NA-C rolled R12 over and performed anal peri-care. After this was done, NA-C retrieved the Calmoseptitc cream, placed cream on glove and applied cream on coccyx. NA-C changed gloves after cream applied and did not wash hands. R12 had a 4x4 intact dressing with visible drainage on the coccyx. NA-C pulled up R12's pants, cleansed and dried the basins, then washed hands.
During observation on 12/6/12 at 7:45 a.m., licensed practical nurse (LPN)-B came in to test R12's blood sugar. After testing, LPN-B removed the gloves but did not wash hands. LPN-B put on clean gloves and performed wound care. R12 had quarter size piece of formed stool under the dressing. LPN-B cleaned the stool, and wearing the same soiled gloves, reached in the tub of supplies and grabbed spray and sprayed the wound. LPN-G wiped the wound and massaged

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F 441	Continued From page 37 Silvasorb cream into the wound, still wearing the same soiled gloves. Skin prep used for sensitive skin was applied around the wound and bloody drainage was observed on the wipes. LPN-B then removed the soiled gloves, and without washing hands, donned clean gloves. LPN-B applied Opsite (transparent dressing) over clean 4x4 absorbent gauze on the wound. LPN-B continued to reach into the supply tub with soiled gloves. LPN-B assisted NA-C with transfer, cleaned up the area, removed her gloves, but did not wash her hands before leaving the room to perform a skin check on another resident. LPN-B then washed her hands. During interview on 12/5/12, at 7:59 a.m., LPN-B stated she did not wash hands between glove changes, or between residents. The director of nurses (DON), interviewed on 12/6/12, at 4:40 p.m., acknowledged that staff should have washed hands after she cleaned stool from R12, states that it is expected to be done.	F 441		

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	245370	A. BUILDING 02 - BLDG 2 B. WING _____	12/04/2012

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Ecumen North Branch was found 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. The Villages of North branch was constructed in 2006 & 2007, with opening in 2007. It is a one story building with no basement. The construction type is determined to be type V(111). The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire doors. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 68 beds and 63 were occupied at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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.