DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

						AND TRANSMITTAL TE SURVEY AGENCY		ID: U7EI Facility ID:	00844
1. MEDICARE/MEDICAID P. (L1) 245471 2.STATE VENDOR OR MEDICAL (L2) 048540300 5. EFFECTIVE DATE CHAN	ICAID NO.		3. NAME AND ADDRESS OF FACILITY (L3) ECUMEN SCENIC SHORES (L4) 402 - 13TH AVENUE (L5) TWO HARBORS, MN 7. PROVIDER/SUPPLIER CATEGORY			(L6) 55616	4. TYPE OF ACTION: 7 (L8 1. Initial 2. Recei 3. Termination 4. CHO 5. Validation 6. Comp 7. On-Site Visit 9. Other 8. Full Survey After Complaint		rtification DW plaint
	03/20/201 S: TJC Other	5 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE		ENDING DATE:	(L35)
11LTC PERIOD OF CERTIFIFE From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	CATION	45 (L18) 45 (L17)	Compliance1. Ac B. Not in Com		gram	And/Or Approved Waivers O 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code * Code: A	1 6. Scope 7. Medic	e of Services Limit cal Director at Room Size	:
	EAKDOWN 9 SNF 45 438)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	ı	
16. STATE SURVEY AGENC	Y REMARK	S (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):				
17. SURVEYOR SIGNATURI Chris Campbell,		pervisor	Date : 0	3/26/2015	(L19)	18. STATE SURVEY AGENCY		Date:	/26/2015 (L20
	PART I	I - TO BE (COMPLETED E	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENC	Y	
19. DETERMINATION OF E. 1. Facility is Elig 2. Facility is not	gible to Partici	pate (L21)		IPLIANCE WITI ITS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Abov	rol Interest Disclosure		3)
22. ORIGINAL DATE OF PARTICIPATION 05/01/1987 (L24)	23	LTC AGREEN BEGINNING (L41)		4. LTC AGREEN ENDING DA (L25)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburg	0 <u>INV</u> 05-F	(L30) COLUNTARY Fail to Meet Health	-
25. LTC EXTENSION DATE	27.	ALTERNATIV A. Suspension	/E SANCTIONS of Admissions:	(L44) (L45)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	07-P	<u>HER</u> Provider Status Ch Active	ange
				(L43)					

30. REMARKS

Posted 04/02/2015 Co.

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

00320

03/24/2015

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245471

March 26, 2015

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

Dear Mr. Baukner:

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

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

Effective March 17, 2015 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Weath

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

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 26 2015

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

RE: Project Number S5471025

Dear Mr. Baukner:

On February 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 5, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 20, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 23, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 17, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 5, 2015, effective March 17, 2015 and therefore remedies outlined in our letter to you dated February 20, 2015, will not be imposed.

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

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

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

Sincerely,

Mark Meath

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

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

Enclosure

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245471	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/20/2015
Name	e of Facility		Street Address, City, State, Zip Code	
EC	CUMEN SCENIC SHORES		402 - 13TH AVENUE TWO HARBORS, MN 55616	

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

(Y4) Item	()	(5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5	5) I	Date
ID Prefix	F0156	Correction Completed 03/13/2015	ID Prefix	F0176		Correction Completed 03/17/2015		ID Prefix	F0250		Correction Completed 03/17/2015
	483.10(b)(5) - (10), 48			483.10(n)		-			483.15(q)(1)		<u> </u>
		Correction Completed				Correction Completed					Correction Completed
ID Prefix	F0281	03/13/2015	ID Prefix	F0356		03/12/2015		ID Prefix	F0364		03/17/2015
Reg. # LSC	483.20(k)(3)(i)	<u> </u>	Reg. # LSC	483.30(e)		-		Reg. # LSC	483.35(d)(1)-(2)		- -
		Correction				Correction					Correction
ID Prefix		Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #			Reg. #			-					_
LSC		 	LSC			-		LSC			- -
ID D (Correction Completed	ID Due fire			Correction Completed		ID Des fee			Correction Completed
ID Prefix						=					=
Reg. # LSC		<u> </u>	Reg. # LSC					Reg. # LSC			_ _
		Correction Completed				Correction Completed					Correction Completed
ID Prefix		<u> </u>	ID Prefix			<u>.</u>		ID Prefix			_
Reg. # LSC		_	Reg. # LSC			-		Reg. # LSC			= -
Reviewed E	By Review	ed By	Date:	Signature	e of Sui	veyor:	,		D	ate:	
State Agen	cy CC/1	nm	03/26/20	15		1392	22			03/2	0/2015
Reviewed E	By Review	ed By	Date:	Signature	e of Sui	rveyor:			D	ate:	
Followup t	to Survey Completed 2/5/2015	on:							Summary of the Facility?	/ES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245471	(Y2) Multiple Const A. Building B. Wing	IN BUILDING	(Y3) Date of Revisit 3/23/2015
Name of Facility		Street Address, City, State, Zip Code	
ECUMEN SCENIC SHORES		402 - 13TH AVENUE TWO HARBORS, MN 55616	

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date (Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 03/17/2015	ID Prefix		Correction Completed 03/17/2015	ID Prefix		Correction Completed
•	NFPA 101			NFPA 101		Reg. #		
LSC	K0029		LSC	K0072		LSC _		
Reg. #			Reg. #		Correction Completed	Reg. #		Correction Completed
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed	Reg. #		Correction Completed
Reg. #			Reg. #		Correction Completed			Correction Completed
Reg. #			Reg. #			D "		
Reviewed E	By Revie	wed By	Date:	Signature of Sur	veyor:		Date:	
State Agen	cy PS	/mm	03/26/201	_	0300)5	03/23	3/2015
Reviewed E	By Revie	wed By	Date:	Signature of Sur	veyor:		Date:	
Followup t	o Survey Complete 2/3/2015	d on:		Check for any Uncor Uncorrected Defic				NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: U7EI

020499

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

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AG	ENCY		Facility ID: 00844
1. MEDICARE/MEDICAID PROVIDER N (L1) 245471 2.STATE VENDOR OR MEDICAID NO. (L2) 048540300	NO.	3. NAME AND ADI (L3) ECUMEN SO (L4) 402 - 13TH A (L5) TWO HARB	CENIC SHORES VENUE		(L6)	55616	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 01/01/2011		7. PROVIDER/SUF 01 Hospital 02 SNF/NF/Dual	PPLIER CATEGOR 05 HHA 06 PRTF	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 02/05 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	45 (L18) 45 (L17)	X B. Not in Com	ce With quirements Based On: cceptable POC	n	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	Following Requirements:	etor
14. LTC CERTIFIED BED BREAKDOWN	T				15. FACILITY MI	EETS		
18 SNF 18/19 SNF 45	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	VEY AGENCY API	PROVAL	Date:
Terri Ament, HFE N	NEII		03/06/2015	(L19)) Mark Neeth, Enforcement Specialist 03/19/2015 (L20)			
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY			PLIANCE WITH O	CIVIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF	A-1513)
22 ODIODIAL DATE					<u> </u>			
22. ORIGINAL DATE OF PARTICIPATION 05/01/1987	23. LTC AGREEMI BEGINNING I		4. LTC AGREEM ENDING DAT		26. TERMINAT VOLUNTARY 01-Merger, Closu	00	<u>INVOLUN</u>	(L30) TARY feet Health/Safety
(L24)	(L41)		(L25)			W/ Reimbursemer	nt 06-Fail to M	leet Agreement
25. LTC EXTENSION DATE:	A. Suspension of		(L44)		03-Risk of Involui 04-Other Reason f	-	OTHER 07-Provider 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	, ,					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	00320		(L31)	Posted (03/24/2015	Co.	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DA	TE				
	(L32)			(L33)	DETERMINA	TION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0174

April 13, 2015

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

Dear Mr. Baukner:

Recently you received a CMS form 2567, as a result of a standard survey completed on February 5, 2015. Language has since been changed in deficiency cited at F250. Specifically, we removed the word, "harm" referenced in this deficiency.

Enclosed you will find a revised copy.

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

Sincerely,

Mark Meath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2439

February 20, 2015

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

RE: Project Number S5471025

Dear Mr. Baukner:

On February 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 17, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 17, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 5, 2015 (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 August 5, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

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

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5471s15

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245471 B. WING 02/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **402 - 13TH AVENUE ECUMEN SCENIC SHORES** TWO HARBORS, MN 55616 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG F 000 **INITIAL COMMENTS** F 000 THE FACILITY PLAN OF CORRECTION (POC) F156 WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S 1. Corrective Action: ACCEPTANCE. YOUR SIGNATURE AT THE A. Resident 61 has discharged BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS 2. Corrective Action as it applies to VERIFICATION OF COMPLIANCE. Other Residents: UPON RECEIPT OF AN ACCEPTABLE POC, AN A. Starting 3/3/15 will issue ONSITE REVISIT OF YOUR FACILITY MAY BE SNFABN along with the notice CONDUCTED TO VALIDATE THAT of Medicare Non-Coverage to SUBSTANTIAL COMPLIANCE WITH THE every resident who has been REGULATIONS HAS BEEN ATTAINED IN decided that Medicare coverage ACCORDANCE WITH YOUR VERIFICATION. will end, and on every resident F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF F 156 who are anticipated to discharge RIGHTS, RULES, SERVICES, CHARGES SS=D at least 48 hours in advance. B. The MDS Coordinator The facility must inform the resident both orally and in writing in a language that the resident completed a training session on understands of his or her rights and all rules and 3/10/15 to instruct staff regulations governing resident conduct and members on giving the two responsibilities during the stay in the facility. The Medicare Denial letters facility must also provide the resident with the together. notice (if any) of the State developed under C. The MDS Coordinator §1919(e)(6) of the Act. Such notification must be completed a training session on made prior to or upon admission and during the 2/11/15 and all documentation resident's stay. Receipt of such information, and pertaining to Medicare coverage any amendments to it, must be acknowledged in writing. will be documented in the progress notes under the The facility must inform each resident who is Medicare/Insurance tab. Also entitled to Medicaid benefits, in writing, at the time included in this training session of admission to the nursing facility or, when the was a section on the importance resident becomes eligible for Medicaid of the of documenting Patient Initiated items and services that are included in nursing Discharges, cancelled or facility services under the State plan and for delayed discharges. which the resident may not be charged; those Documentation will include 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245471	B. WING	a		02/05/2015	
	PROVIDER OR SUPPLIER SCENIC SHORES			4	TREET ADDRESS, CITY, STATE, ZIP CODE 02 - 13TH AVENUE WO HARBORS, MN 55616	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	other items and ser and for which the re the amount of charginform each resider the items and service (i) (A) and (B) of this The facility must infat the time of admiss the resident's stay, facility and of chargincluding any chargunder Medicare or the facility must fur legal rights which in A description of the funds, under paragraph A description of the for establishing eligithe right to request 1924(c) which deternon-exempt resource institutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid eligitation of the form of the	vices that the facility offers esident may be charged, and ges for those services; and it when changes are made to ces specified in paragraphs (5) is section. Form each resident before, or esion, and periodically during of services available in the est for those services, est for services not covered by the facility's per diem rate. Inish a written description of cludes: Inish a written description of c	F -	156	discharge plan and plan of continued stay. 3. Date of Completion: 3/13/15 4. Reoccurrence will be Prevent A. Staff education provided 3/10/15 B. Random audits will be conducted two times were two weeks, then weekly month and monthly for of quarter. Findings will be reported to the QAPI tear review and discussion. 5. The Correction will be Monit by: A. DON or designee. B. The QAPI Committee we review the audit results of monthly basis and provide further direction, as need QAPI team will determine the audits may be discontinued.	ted by: on ekly for for one one m for tored ill on a de led. The	

		& MEDICAID SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
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NAME OF F	PROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP CODE		39,20.0
ECUMEN	I SCENIC SHORES				402 - 13TH AVENUE TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 156	agency concerning misappropriation of facility, and non-cordirectives requirement of facility must infiname, specialty, an physician responsibility must provide information, applicants for admininformation about he Medicare and Medicare	State survey and certification resident abuse, neglect, and resident property in the advance	F	156			
	by: Based on interview facility failed to providischarge from Med residents (R61) revisionings include: R61 was discharged services on 11/7/14	and document review, the ride two day notice prior to dicare services for 1 of 3 lewed for liability notices. If the form Medicare Part A according to the Notice of 1/7/14.					
	the facility provided	tor of nursing was rified there was no evidence R61 with the two day notice om Medicare services.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/20/2015 APPROVED
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•		245471	B. WING		· .	02/0	05/2015
	PROVIDER OR SUPPLIER			402 - 137	ADDRESS, CITY, STATE, ZIP CODE ITH AVENUE ARBORS, MN 55616	, OZ/	50/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176 SS=D	Non-Coverage Noti Exhaust Claims dat notice will be delive hours of advising the 483.10(n) RESIDEN DRUGS IF DEEME An individual reside the interdisciplinary §483.20(d)(2)(ii), has practice is safe. This REQUIREMEN by: Based on observative, the facility faself-administration of 1 residents (R64) of the nebulizer treatment. Findings include: R64's Admission Resincluded late effects (disease of the bloom and asthma. R64's a (MDS) dated 11/27/moderate cognitive orders dated 11/21/Nebulization solution to treat wheezing ar hours as needed for On 2/4/15, at 12:50	and procedure on Medicare fication/Demand Bill/Benefit ed 10/07 directed a generic red to the resident within 24 em their coverage will end. IT SELF-ADMINISTER D SAFE Int may self-administer drugs if team, as defined by a determined that this IT is not met as evidenced from the served to ensure safe of medications (SAM) for 1 of the served to self-administer a served to self-administer a decord identified diagnoses that of cerebrovascular disease divessels supplying the brain admission Minimum Data Set 14, indicated R64 had impairment. The physician's 14, directed Albuterol Sulfate in (an inhaled medication used ad chest tightness) every four wheezing. a.m. R64 was observed	F 1	F1 1. 2.	Corrective Action: A. Resident 64 has been reassessed for the ability to Administer Medications Corrective Action as it applied Other Residents: A. The policy and Procedur SAM has been reviewed revised as appropriate. The SAM policy will be reviewed with all nursing staff at the Staff Meeting which will held on 3/10/15. B. All other residents will be evaluated for their ability. SAM and new assessme be completed as necessary Care plans will be update reflect the resident's abity. SAM as appropriate. Date of Completion: 3/17/15. Reoccurrence will be Prevent.	es to re for and The ewed the All I be oe y to nts will ry. red to lity to	
	sitting in her wheelc	hair by the nurse's desk. The kide (TMA)-B checked R64's			A. DON or designee will corrandom audits daily for two	mplete	

		AND HUMAN SERVICES				FORM.	APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
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ECHMEN	SCENIC SHORES			1	102 - 13TH AVENUE		
LOOME	OCENIC SHORES			7	TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 176	oxygen saturation let that it was 88%. TM having a hard time I little." TMA-B stated down, and get her a brought R64 to her transferred into bed 12:56 p.m. TMA-B treatment to R64, state the room. R64 was At 1:08 p.m. R64 conebulizer treatment. On 2/4/15, at 1:10 p and asked if R64 haself-administer their stated she did not k if a resident is able to she lets them self-at On 2/4/15, at 2:00 p was interviewed and an assessment and administer a nebuliz verified R64 had not have a physician's comedications. The facility policy and Self-Administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SOCIAL is self-administer med determined they are 483.15(g)(1) PROVIRELATED SO	evel, and announced to R64 IA-B asked R64 if she was breathing, and R64 replied "a she would help R64 lay nebulizer treatment. TMA-B room and R64 was by a nursing assistant. At brought the nebulizer treatment and left left alone in the room to SAM. Intinued to self-administer the same and a physician's order to nebulizer treatment. TMA-B now if there was an order, but to hold a nebulizer treatment, dminister it. Im. the director of nursing a stated a resident must have a physician's order to self ter treatment. The DON to been assessed and did not order to safely self-administer and procedure on the facility who wish to ications may do so, if it is capable of doing so. SION OF MEDICALLY SERVICE	F 1		then weekly for one month, the monthly for one quarter 5. The Correction will be Monitor by: A. DON or designee. B. The QAPI Committee will review the audit results on monthly basis and provide further direction, as needed QAPI team will determine the audits may be discontinuous.	ored l n a e ed. The	
		vide medically-related social					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/20/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245471 B. WING 02/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE **ECUMEN SCENIC SHORES** TWO HARBORS, MN 55616 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 250 Continued From page 5 F 250 practicable physical, mental, and psychosocial well-being of each resident. F250 1. Corrective Action: A. Resident 52 has been reassessed and his care plan has This REQUIREMENT is not met as evidenced been updated. Hospice aand the Based on observation, interview and document facility staff continue to review, the facility failed to provide medically collaborate on the residents related social services for 1 of 1 residents (R52) care. He continues to have with self-identified issues that included end-stage frequent family involvement disease, separation from young children, lack of including visits with his adjustment to the facility, and lack of discharge children planning. This resulted in actual harm to R52. 2. Corrective Action as it applies to Findings include: Other Residents: A. The Social Service policy has R52 was 44 years old, and according to the Admission Record was admitted to the facility on been reviewed and revised as 12/30/14. He had multiple diagnoses including appropriate. end stage congestive heart failure (CHF), B. The Social Service Director has hypotension (low blood pressure), mild cognitive received additional training impairment, depression, diabetes, morbid obesity, related to expectations of the and cardiomyopathy (a disease of the heart muscle). On 1/2/15, R52 was placed on hospice C. All residents have been assessed (end of life) services for the end-stage CHF and for their Medically Related hypoventilation syndrome (a condition in some obese people in which poor breathing leads to Social Service needs and their lower oxygen and higher carbon dioxide levels in care plans were reviewed and the blood). updated as appropriate.

R52's admission Minimum Data Set (MDS) dated

behaviors towards others 1-3 days/week that did

residents or staff. The MDS also identified R52

had behaviors of rejection of care 1-3 days/week. The MDS further identified R52 was independent

1/5/15, identified R52 had moderate cognitive impairment, and mood indicators of verbal

not interfere with his cares or impact other

3. Date of Completion: 3/17/15

monthly for one quarter.

4. Reoccurrence will be Prevented by:

A. DON or designee will complete

random audits daily for two weeks.

then weekly for one month, then

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/20/2015 APPROVED 0938-0391
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NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	, ,,,,	30/2010
ECUMEN	SCENIC SHORES				2 - 13TH AVENUE VO HARBORS, MN 55616		
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	with ambulation and required set up ass personal hygiene; remobility and bathing for transfers, dressi the unit. R52's Care Area As 1/12/15, indicated his psychosocial we difficult time with act further identified R5 facility, he was not a and he was at risk fis diagnoses and his diagnoses and his diagnoses and respectively, and his digmaintained at the his interventions include strategies and respecto express his feeling non-judgmental account and work cooperatively ensure his spiritual, physical and social and the mospice social of R52 twice. On 1/8/1 documented R52's cooperatively assessment, prepartaken was social segood sleep and talk the hospice SW-B in documented R52's countered R52's	d toileting; independent and istance with eating and equired supervision with bed g; and assistance of one staffing and locomotion on and off sessment (CAA) dated e had a potential problem with ell-being due to having a cepting his illness. The CAA 2 was making friends at the a threat to himself or others, or social isolation related to his age. ed 1/5/15, indicated R52 had a related to CHF. R52's goals e free from depression and hity and autonomy would be ghest level. R52's ed to assess his coping ect his wishes, encourage him gs and listen with eptance and compassion, wely with the hospice team to emotional, intellectual, needs were met. worker (SW)-B visited with 5, the hospice SW-B concern of social service e his children, and action rvice assessment, prepare for of his children. On 1/26/15,	F 2	250	5. The Correction will be Moniby: A. DON or designee. B. The QAPI Committee we review the audit results of monthly basis and proving further direction, as need QAPI team will determine the audits may be discorted.	ill on a de led. The ne wher	

to be a full-time father.

PRINTED: 02/20/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245471 B. WING 02/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **402 - 13TH AVENUE ECUMEN SCENIC SHORES** TWO HARBORS, MN 55616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 250 Continued From page 7 F 250 On 2/5/15, at 8:30 a.m. R52 was interviewed and stated he would like to go home to his sister's house. She was currently taking care of his three children. Although he hadn't spoken with his sister about it, he was sure he could go there. R52 stated he didn't feel he needed to be at the facility, but no staff had talked with him about alternative placement. R52 continued to state that he was only 45 years old and everyone else residing in the facility was so old. He felt he could do so much more on his own. R52 expressed a desire to be with his children and how much he missed them. R52 stated he wanted to be more involved in raising his children. R52 stated he was unsure about his life expectancy. He didn't feel sick, but did voice an understanding of how ill he is. R52 indicated he had been compliant with his diet and his fluid intake, and just wanted to be there for his children. R52 teared up when speaking about his children and his life expectancy. R52 stated nobody from the facility had spoken with him about these issues. On 2/5/15, at 10:33 a.m. the social worker (SW)-A was asked if she had a plan and had met with R52 about his concerns. SW-A stated R52 was receiving hospice services, and the family's plan was that he would remain at the facility. SW-A stated R52's plan would be to graduate from hospice, and move in with his sister, but his

sister is unable to care for him. When asked if she met with R52 to discuss his concerns, SW-A stated "not really, he's gone a lot during the day." SW-A further stated he went to his sister's to visit and have dad time. SW-A further stated R52 was extremely afraid for his children and what would happen to them after he died, and it was tearing him up inside. When asked what services the

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F281

F 281

1. Corrective Action:

updated.

medication.

Other Residents:

2. Corrective Action as it applies to

A. The policy and procedure for SAM has been reviewed and

A. Resident 64 has been re-

The care plans have been

B. The TMA's have been educated

on the need to notify a licensed

nurse and request evaluation for the need to administer a PRN

assessed for the ability to SAM.

by:

F 281

SS=D

and facility social workers. The facility social

worker was expected to identify psychosocial

483.20(k)(3)(i) SERVICES PROVIDED MEET

The services provided or arranged by the facility

must meet professional standards of quality.

This REQUIREMENT is not met as evidenced

Based on observation, interview and document

review, the facility failed to assess the need for

use of a nebulizer treatment prior to

issues and initiate interventions and notify hospice with specific patient/family needs.

PROFESSIONAL STANDARDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER N SCENIC SHORES			STREET ADDRESS, CITY, STAT 402 - 13TH AVENUE TWO HARBORS, MN 556		<u> </u>	05/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN	OF CORRECTION ACTION SHOULD E TO THE APPROPRI	BE	(X5) COMPLETION DATE
F 281	Findings include: R64's Admission Reincluded asthma. R Set (MDS) dated 11 moderate cognitive orders dated 11/21/Nebulization solution to treat wheezing an hours as needed (FO) on 2/4/15, at 12:50 sitting in her wheeled Trained medication oxygen saturation lethat it was 88%. The having a hard time little." TMA-B stated down, and get her abrought R64 to her transferred into bed 12:56 p.m. TMA-B to treatment to R64 aroutside the TMA's sepron medications wassessment/permis On 2/04/15, at 1:10 and was asked if shassess R64 prior to nebulizer. TMA-B shaving problems brourses "trusted" her	ecord identified diagnoses that 64's admission Minimum Data /27/14, indicated R64 had impairment. The physician's 14, directed Albuterol Sulfate in (an inhaled medication used and chest tightness) every four PRN) for wheezing. a.m. R64 was observed chair by the nurse's desk. aide (TMA)-B checked R64's evel, and announced to R64 IA-B asked R64 if she was breathing, and R64 replied "a I she would help R64 lay a nebulizer treatment. TMA-B room and R64 was by a nursing assistant. At brought the nebulizer and provided the treatment. It is acope of practice to administer	F 2	B. TMA's were 3/10/15 related nurses needing resident prior of a PRN me. C. All other resident and new be completed plans will be the patient's appropriate. evaluate resident TMA administ medication. 3. Date of Completion 4. Reoccurrence with A. DON or design random audits date then weekly for one of the completion of the completio	ed to licensed ag to evaluate to administrate dication. It dents will be their ability to wassessments as necessary. It is necessary to graded to reflability to SAM Nurses will dents prior to the stering a PRN and a PRN and a PRN are will compare will compare will compare will compare will stering to the prevented one month, the quarter.	will Care lect I as he lete eks, en red	

PRINTED: 02/20/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245471 B. WING 02/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE **ECUMEN SCENIC SHORES** TWO HARBORS, MN 55616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) F 281 Continued From page 10 F 281 TMA to ask a licensed staff to do an assessment prior to administering a nebulizer treatment. F356 483.30(e) POSTED NURSE STAFFING F 356 F 356 **INFORMATION** SS=C 1. Corrective Action: A. The nursing hours are now The facility must post the following information on posted and updated as changes a daily basis: o Facility name. occur throughout the day. o The current date. 2. Corrective Action as it applies to o The total number and the actual hours worked Other Residents: by the following categories of licensed and A. Nursing staff responsible for unlicensed nursing staff directly responsible for posting the schedule have been resident care per shift: educated on the need to post - Registered nurses. staff hours and keep the - Licensed practical nurses or licensed document updated. The vocational nurses (as defined under State law). education occurred on 3/10/15 Certified nurse aides. o Resident census. 3. Date of Completion: 3/12/15 The facility must post the nurse staffing data 4. Reoccurrence will be Prevented by: specified above on a daily basis at the beginning A. Staff education provided on of each shift. Data must be posted as follows: 3/10/15 o Clear and readable format. B. Administrator or designee will o In a prominent place readily accessible to complete random audits will be residents and visitors. conducted two times weekly for two weeks, then weekly for one The facility must, upon oral or written request, month and monthly for one make nurse staffing data available to the public for review at a cost not to exceed the community quarter

by:

standard.

The facility must maintain the posted daily nurse

staffing data for a minimum of 18 months, or as

This REQUIREMENT is not met as evidenced

required by State law, whichever is greater.

by:

5. The Correction will be Monitored

A. Administrator or designee.

B. The OAPI Committee will

review the audit results on a monthly basis and provide further direction, as needed. The

QAPI team will determine when

the audits may be discontinued.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245471	B. WING			02/0	05/2015
	PROVIDER OR SUPPLIER			40	REET ADDRESS, CITY, STATE, ZIP CODE 12 - 13TH AVENUE NO HARBORS, MN 55616	1 02/0	30,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 356	review, the facility of posting was posted	ge 11 ion, interview and document lid not ensure the nurse staff daily. This had the potential to its residing in the facility.	F3	356			
	Hours Report of Nu Responsible for Re posting) was obser date of 1/29/15. Th	sident Care (nurse staff ved to have the most current ere were three nurse staff e 1/29/15 posting dated	·				
F 364 SS=E	verified the most cu dated 1/29/15. On 2 director of nursing posting for 2/2/15, with the nurses working post the current nur the front desk staff posting during the with 483.35(d)(1)-(2) NU	JTRITIVE VALUE/APPEAR,	F3	364	F364 1. Corrective Action: A. Food is now being temp	•	
	food prepared by m value, flavor, and a palatable, attractive	ves and the facility provides nethods that conserve nutritive ppearance; and food that is e, and at the proper			checked to assure that f being served within the temperature guidelines.		
	by: Based on observa	NT is not met as evidenced tion, interview, and document ailed to ensure food served at			 2. Corrective Action as it appropriate Other Residents: A. Staff members have be educated on the need to food in accordance with food handling guideline education occurred on 	en serve h safe es. Staff	

AND PLAN OF CORRE		IDENTIFICATION NUMBER:	1 ' '	ING	ETRUCTION	COMI	PLETED
		245471	B. WING			02/0	05/2015
NAME OF PROVIDER				402 - 137	ADDRESS, CITY, STATE, ZIP CODE TH AVENUE ARBORS, MN 55616		
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
meals temper and R2 Finding During stated the ma During stated in the u During stated instituti room. During stated R2 ate During R63 wa intervie the foo During cart wit to the rinsulate cover of	ature for 4 of 1 who composes include: an interview the food was in interview the food was init dining an an interview the food was onal. R52 at an interview the food at rin the main an observation and observation observation of the food at rin in the main an observation observation of the food at rin in the main an observation observation of the food at rindividual and observation obse	ing and served at the proper of 4 residents (R7, R63, R52, plained of food quality. If on 2/3/15, at 12:58 p.m. R7 is too cool at meals. R7 ate in om. If on 2/3/15, at 8:49 a.m. R63 is a little cool at meals. R63 at rea. If on 2/3/15, at 8:47 a.m. R52 is to very good and is ate in the dining area or in his in the dining area or in his dining room. If on 2/3/15, at 8:47 a.m. R2 meals was too cold sometimes dining room. Ition on 2/4/15, at 8:47 a.m. tell a staff member who was ints regarding food quality, that	e		Date of Completion: 3/17/1 Reoccurrence will be Preve A. CDM or designee will corandom audits daily for two then weekly for one month, monthly for one quarter.	nted by: omplete weeks, then nitored will on a ide eded. The	

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 02/20/2015 M APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DA	TE SURVEY
		245471	B. WING	ì		02	2/05/2015
	PROVIDER OR SUPPLIER I SCENIC SHORES				STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 364	Continued From pa	ge 13	F	364	·		
	individual trays was area. Meals were seresidents seated in individual trays were residents who ate in the last tray was dep.m., 9 minutes after cover was removed checked on a test to the temperature of Fahrenheit, the mix degrees Fahrenheit degrees. The surve	p.m. a meal cart with delivered to the east dining served off the trays to the dining area, and then e carried and served to a their rooms. At 12:38 p.m. livered at 12:38 p.m. At 12:39 or the delivery of the cart, the and the temperatures were ray by dietary aide (DA)-B. the ravioli was 110 degrees ed vegetables were 95 and the milk was 40 beyor tasted the the food and the luke warm, the vegetables milk to be cold.					
	manager (DM) verif the food served at la be addressed. The should have kept th	lunch meal, the dietary ied that the temperatures of unch were cool and needed to DM further verified the staff e food covered until they were sidents with their meal.					
	Accurate Temperatused to record food staff to take temperatus hot foods stay above cold foods stay belo	nd procedure for Taking ures was dated 2010, and it temperatures. It directed atures periodically to ensure e 135 degrees Fahrenheit and w 41 degrees Fahrenheit g, transporting and serving					
	dated 2010, used to indicated hot foods	mperatures Sample Form record food temperatures should be at least 135 through the end of the					

trayline.

	RS FOR MEDICARE	& MEDICAID SERVICES			0	FORI	M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY MPLETED
		245471	B. WING	i		02)/0E/201E
	PROVIDER OR SUPPLIER SCENIC SHORES		•	4	STREET ADDRESS, CITY, STATE, ZIP CODE 102 - 13TH AVENUE TWO HARBORS, MN 55616	02	2/05/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Food Service was dindicated the food seperform meal round meals are attractive needs of the individual manager would obseportion sizes, tempermeal passes for acconcerns to the admiregistered dietitian a registered or other in the facility policy an Atmosphere dated 2 must be hot and color	nd procedure for Dining and ated 2010. The procedure ervice manager would s routinely to determine if the and nutritious and meet the ual. The food service erve meals for preferences, erature, flavor, variety and euracy, and would report hinistrator, director of nursing, and/or dietetic technician	F3	364			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/20/2015

PRINTED: 04/13/2015 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245471	B. WING _			02/	05/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616		1 02	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
	INITIAL COMMENTS THE FACILITY PLAN WILL SERVE AS YOU COMPLIANCE UPON ACCEPTANCE. YOU BOTTOM OF THE FI CMS-2567 FORM WI VERIFICATION OF COMPLIANT OF CONDUCTED TO VA SUBSTANTIAL COM REGULATIONS HAS ACCORDANCE WITH 483.10(b)(5) - (10), 4. RIGHTS, RULES, SE The facility must informand in writing in a lan understands of his or regulations governing responsibilities during facility must also provinotice (if any) of the S §1919(e)(6) of the Acmade prior to or upor resident's stay. Rece any amendments to it writing. The facility must infor	N OF CORRECTION (POC) UR ALLEGATION OF N THE DEPARTMENT'S IR SIGNATURE AT THE RST PAGE OF THE ILL BE USED AS COMPLIANCE. AN ACCEPTABLE POC, AN TYOUR FACILITY MAY BE ALIDATE THAT PLIANCE WITH THE BEEN ATTAINED IN H YOUR VERIFICATION. 83.10(b)(1) NOTICE OF	F	CROSS-REFERENCED TO THE A			
	of admission to the no resident becomes eliq items and services th facility services under which the resident ma	ursing facility or, when the gible for Medicaid of the at are included in nursing r the State plan and for ay not be charged; those					
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.

03/04/2015

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245471	B. WING		02/05/2015
	ROVIDER OR SUPPLIER SCENIC SHORES		STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616		,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 156	other items and servand for which the re the amount of charge inform each residenthe items and service (i)(A) and (B) of this. The facility must inform the time of admission the resident's stay, of facility and of charge including any charge under Medicare or but the facility must further facility faci	vices that the facility offers sident may be charged, and es for those services; and the when changes are made to es specified in paragraphs (5) section. Form each resident before, or sion, and periodically during of services available in the est for those services, est for services not covered by the facility's per diem rate. Inish a written description of cludes: Imanner of protecting personal each (c) of this section; Irrequirements and procedures bility for Medicaid, including an assessment under section mines the extent of a couple's est at the time of a dattributes to the community eshare of resources which a davailable for payment the institutionalized spouse's or her process of spending	F 156		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245471	B. WING		02/05/2015
	ROVIDER OR SUPPLIER SCENIC SHORES		STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616		,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 156	agency concerning r misappropriation of facility, and non-con directives requirement. The facility must info name, specialty, and physician responsible. The facility must pro- written information, a applicants for admis information about he Medicare and Medic	tate survey and certification resident abuse, neglect, and resident property in the apliance with the advance ents. Form each resident of the d way of contacting the lee for his or her care. In the survey and certification residents and resident abuse.	F 15	6	
	by: Based on interview facility failed to provide discharge from Med residents (R61) review Findings include: R61 was discharged services on 11/7/14, Non-Coverage. R61 Non-Coverage on 17 On 2/4/14, the direct interviewed, and verthe facility provided				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245471	B. WING			02/	05/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 402 - 13TH AVENUE TWO HARBORS, MN 55616	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 156 F 176	Non-Coverage Notific Exhaust Claims dated notice will be delivered	I procedure on Medicare cation/Demand Bill/Benefit d 10/07 directed a generic d to the resident within 24 m their coverage will end.		156 176			3/17/15
SS=D	DRUGS IF DEEMED An individual resident the interdisciplinary to §483.20(d)(2)(ii), has practice is safe.	may self-administer drugs if eam, as defined by					
	by: Based on observatio review, the facility fail self-administration of 1 residents (R64) obs nebulizer treatment.	is not met as evidenced n, interview and document ed to ensure safe medications (SAM) for 1 of served to self-administer a					
	included late effects of (disease of the blood and asthma. R64's ac (MDS) dated 11/27/14 moderate cognitive in orders dated 11/21/14 Nebulization solution to treat wheezing and hours as needed for volume of the company of the compa	npairment. The physician's 4, directed Albuterol Sulfate (an inhaled medication used I chest tightness) every four					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED	
		245471	B. WING _			02/	05/2015
	ROVIDER OR SUPPLIER SCENIC SHORES			STREET ADDRESS, CITY, 402 - 13TH AVENUE TWO HARBORS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 176	that it was 88%. TMA having a hard time brilittle." TMA-B stated shown, and get her a rebrought R64 to her rotransferred into bed be 12:56 p.m. TMA-B brotreatment to R64, statthe room. R64 was le At 1:08 p.m. R64 connebulizer treatment. On 2/4/15, at 1:10 p.r. and asked if R64 had self-administer the nestated she did not know if a resident is able to she lets them self-administer and a administer a nebulize verified R64 had not be	el, and announced to R64 -B asked R64 if she was eathing, and R64 replied "a she would help R64 lay nebulizer treatment. TMA-B om and R64 was y a nursing assistant. At bought the nebulizer rted the treatment and left ft alone in the room to SAM. tinued to self-administer the n. TMA-B was interviewed a physician's order to bulizer treatment. TMA-B bow if there was an order, but hold a nebulizer treatment, minister it. n. the director of nursing stated a resident must have physician's order to self	F	76			
F 250 SS=D	directed residents in t self-administer medic determined they are of 483.15(g)(1) PROVIS RELATED SOCIAL S	Medications dated 12/12, he facility who wish to ations may do so, if it is capable of doing so. HON OF MEDICALLY ERVICE	F2	50			3/17/15

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY ETED
		245471	B. WING _		02/0	5/2015
	ROVIDER OR SUPPLIER SCENIC SHORES		,	STREET ADDRESS, CITY, STATE, ZIP C 402 - 13TH AVENUE TWO HARBORS, MN 55616	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 250	Continued From pag practicable physical, well-being of each re	mental, and psychosocial	F 2	250		
	by: Based on observation review, the facility farelated social service with self-identified is disease, separation	T is not met as evidenced on, interview and document iled to provide medically es for 1 of 1 residents (R52) sues that included end-stage from young children, lack of cility, and lack of discharge				
	Findings include:					
	Admission Record w 12/30/14. He had mu end stage congestive hypotension (low blood impairment, depress and cardiomyopathy muscle). On 1/2/15, (end of life) services hypoventilation synd obese people in whice	d, and according to the ras admitted to the facility on altiple diagnoses including to heart failure (CHF), and pressure), mild cognitive ion, diabetes, morbid obesity, (a disease of the heart R52 was placed on hospice for the end-stage CHF and rome (a condition in some ch poor breathing leads to gher carbon dioxide levels in				
	1/5/15, identified R5. impairment, and mode behaviors towards on the interfere with his residents or staff. The had behaviors of rejections of rejections and the interference with his residents.	nimum Data Set (MDS) dated 2 had moderate cognitive od indicators of verbal thers 1-3 days/week that did cares or impact other the MDS also identified R52 ection of care 1-3 days/week. Intified R52 was independent				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245471	B. WING		02/05/2015
	ROVIDER OR SUPPLIER SCENIC SHORES		4	TREET ADDRESS, CITY, STATE, ZIP CODE 02 - 13TH AVENUE WO HARBORS, MN 55616	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 250	required set up ass personal hygiene; r mobility and bathing for transfers, dressi the unit. R52's Care Area As 1/12/15, indicated his psychosocial we difficult time with activity facility, he was not and he was at risk finis diagnoses and his diagnoses and his diagnoses and respiculated he would a terminal prognosi included he would anxiety, and his digmaintained at the hinterventions includ strategies and respito express his feelir non-judgmental accand work cooperativensure his spiritual, physical and social The hospice social R52 twice. On 1/8/1 documented R52's assessment, prepartaken was social segood sleep and talk the hospice SW-B r documented R52's	d toileting; independent and istance with eating and equired supervision with bed g; and assistance of one staffing and locomotion on and off assessment (CAA) dated he had a potential problem with ell-being due to having a scepting his illness. The CAA is was making friends at the athreat to himself or others, for social isolation related to his age. Med 1/5/15, indicated R52 had as related to CHF. R52's goals be free from depression and nity and autonomy would be highest level. R52's ed to assess his coping ect his wishes, encourage him had an interest and compassion, wely with the hospice team to emotional, intellectual, needs were met. Morker (SW)-B visited with 15, the hospice SW-B concern of social service re his children, and action envice assessment, prepare for a of his children. On 1/26/15,	F 250		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245471	B. WING		02/05/2015	
	ROVIDER OR SUPPLIER SCENIC SHORES		4	STREET ADDRESS, CITY, STATE, ZIP CODE 102 - 13TH AVENUE TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 250	Continued From pa	ge 7	F 250			
	stated he would like house. She was cu children. Although his sister about it, he wild R52 stated he didn' facility, but no staff alternative placement he was only 45 year residing in the facility do so much more of desire to be with his missed them. R52 sinvolved in raising hunsure about his lift sick, but did voice a sis. R52 indicated he diet and his fluid into there for his children speaking about his expectancy. R52 st	a.m. R52 was interviewed and a to go home to his sister's rrently taking care of his three he hadn't spoken with his as sure he could go there. It feel he needed to be at the had talked with him about ent. R52 continued to state that are old and everyone else ty was so old. He felt he could an his own. R52 expressed a schildren and how much he estated he wanted to be more his children. R52 stated he was a expectancy. He didn't feel an understanding of how ill he had been compliant with his ake, and just wanted to be n. R52 teared up when children and his life ated nobody from the facility in about these issues.				
	(SW)-A was asked with R52 about his was receiving hosp plan was that he wo SW-A stated R52's from hospice, and r sister is unable to chapter stated "not really, he SW-A further stated and have dad time. extremely afraid for happen to them after stated with the stated and have the stated after the stated and have dad time.	a.m. the social worker if she had a plan and had met concerns. SW-A stated R52 ice services, and the family's ould remain at the facility. plan would be to graduate move in with his sister, but his are for him. When asked if o discuss his concerns, SW-A e's gone a lot during the day." If he went to his sister's to visit SW-A further stated R52 was his children and what would er he died, and it was tearing n asked what services the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245471	B. WING _			02/05/2015	
	ROVIDER OR SUPPLIER SCENIC SHORES			STREET ADDRESS, CITY, STATE, 402 - 13TH AVENUE TWO HARBORS, MN 55616	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 250	time, SW-A stated "I could go talk with him with him and his famil not meeting with R52 addressing his conce On 2/11/15, at 12:37 nurse (RN)-H was into would expect hospice collaborate care. RN-main focus is on end expect the facility to mRN-H further stated him.	to help him through this don't know" and said she today and set up a meeting ly. SW-A verified she was to assist him with rns. p.m. the hospice registered erviewed, and stated she	F.	250			
F 281 SS=D	hospice agency and to in the long term care optimize end-of-life secollaboration divided and facility social worker was expected issues and initiate into hospice with specific 483.20(k)(3)(i) SERV PROFESSIONAL STATE The services provided must meet profession This REQUIREMENT by: Based on observation	patient/family needs. ICES PROVIDED MEET ANDARDS d or arranged by the facility hal standards of quality. is not met as evidenced n, interview and document ed to assess the need for	F:	281		3/13/15	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245471	B. WING		02/05/2015		
	ROVIDER OR SUPPLIER SCENIC SHORES		4	STREET ADDRESS, CITY, STATE, ZIP CODE 102 - 13TH AVENUE FWO HARBORS, MN 55616	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 281	Findings include: R64's Admission Reincluded asthma. R Set (MDS) dated 11 moderate cognitive orders dated 11/21/ Nebulization solution to treat wheezing an hours as needed (F) On 2/4/15, at 12:50 sitting in her wheeld Trained medication oxygen saturation let that it was 88%. The having a hard time little." TMA-B stated down, and get her abrought R64 to her transferred into bed 12:56 p.m. TMA-B I treatment to R64 are outside the TMA's sepron PRN medications was assessment/permis On 2/04/15, at 1:10 and was asked if shassess R64 prior to nebulizer. TMA-B shaving problems brurses "trusted" her On 2/4/15, at 2:00 p.	of 1 residents (R64) observed atment. ecord identified diagnoses that 64's admission Minimum Data 1/27/14, indicated R64 had impairment. The physician's 14, directed Albuterol Sulfate on (an inhaled medication used not chest tightness) every four PRN) for wheezing. a.m. R64 was observed chair by the nurse's desk. aide (TMA)-B checked R64's evel, and announced to R64 IA-B asked R64 if she was breathing, and R64 replied "a dishe would help R64 lay a nebulizer treatment. TMA-B room and R64 was 1 by a nursing assistant. At prought the nebulizer and provided the treatment. It is ecope of practice to administer	F 281				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245471	B. WING			02/05/2015	
	ROVIDER OR SUPPLIER SCENIC SHORES		•	40	TREET ADDRESS, CITY, STATE, ZIP CODE D2 - 13TH AVENUE WO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281 F 356 SS=C		d staff to do an assessment a nebulizer treatment.		281 356			3/12/15
	a daily basis: o Facility name. o The current date. o The total number at by the following cated unlicensed nursing st resident care per shif - Registered nurs - Licensed practic	aff directly responsible for t: es. al nurses or licensed defined under State law).					
	specified above on a of each shift. Data m o Clear and readable o In a prominent plac residents and visitors. The facility must, upo make nurse staffing of for review at a cost no standard.	e readily accessible to					
	staffing data for a mir required by State law	nimum of 18 months, or as , whichever is greater.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	1 ' '	(X3) DATE SURVEY COMPLETED	
		245471	B. WING _		02	2/05/2015	
NAME OF PROVIDER OR SUPPLIER ECUMEN SCENIC SHORES				STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 356 F 364 SS=E	Based on observation review, the facility did posting was posted of affect all 41 residents. Findings include: On 2/2/15, at 6:15 p. Hours Report of Nurs Responsible for Resiposting) was observed date of 1/29/15. The postings behind the 1/26/15, 1/27/15, and On 2/2/15, at 6:25 p. verified the most curriculated 1/29/15. On 2/2 director of nursing (D posting for 2/2/15, was the nurses working the post the current nurs the front desk staff proposting during the we 483.35(d)(1)-(2) NUT PALATABLE/PREFE Each resident receive food prepared by me value, flavor, and appalatable, attractive, temperature. This REQUIREMENT by:	on, interview and document of not ensure the nurse staff daily. This had the potential to be residing in the facility. In during the initial tour, the sing Staff Directly dent Care (nurse staff end to have the most current rewere three nurse staff 1/29/15 posting dated 1/28/15. In registered nurse (RN)-C rent nurse staff posting was 5/15, at 11:15 a.m. the 1/29/15. The DON stated he weekend were suppose to be staff posting each day and the end of the nurse staff end weekend were suppose to be staff posting each day and the son posted the nurse staff end erson posted the	F3			3/17/15	
	Based on observation	on, interview, and document led to ensure food served at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245471 B. WING			02/05/2015		
NAME OF PROVIDER OR SUPPLIER ECUMEN SCENIC SHORES			•	40	TREET ADDRESS, CITY, STATE, ZIP CODE 02 - 13TH AVENUE WO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROVIDENCE)			(X5) COMPLETION DATE
F 364	temperature for 4 of 4 and R2) who complaid Findings include: During an interview of stated the food was to the main dining room. During an interview of stated the food was a in the unit dining area. During an interview of stated the food wasn's institutional. R52 at a room. During an interview of stated the food at mere R2 at a in the main directly and the main directly and served to the main dining room insulated cover on it. Cover over it. The plasm of the main dining room independently. The last served 5 minutes after the food was a feet of the main dining room and independently. The last served 5 minutes after the food was a feet of the main dining room and independently. The last served 5 minutes after the food was a feet of the main dining room and independently. The last served 5 minutes after the food was a feet of the fe	and served at the proper residents (R7, R63, R52, ned of food quality. In 2/3/15, at 12:58 p.m. R7 too cool at meals. R7 ate in 2/3/15, at 8:49 a.m. R63 ate in the dining area or in his a staff member who was a regarding food quality, that cool. In on 2/4/15, at 12:07 p.m., a teal trays had been delivered on. Each entree had an The cart had a clear plastic ates were taken off the trays esident, and the cover was and R2 ate their meal in the	F	364			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		245471	B. WING _			02/05/2015
	ROVIDER OR SUPPLIER SCENIC SHORES			STREET ADDRESS, CITY, STATE, ZIP C 402 - 13TH AVENUE TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 364	area. Meals were seresidents seated in the individual trays were residents who ate in the last tray was delip.m., 9 minutes after cover was removed checked on a test tray the temperature of the fahrenheit, the mixed degrees Fahrenheit, degrees. The surver found the ravioli to be to be cool, and the manager (DM) verifies the food served at lube addressed. The should have kept the able to assist the resident of the facility policy and Accurate Temperaturused to record food staff to take temperaturused foods stay above cold foods stay above cold foods stay below during the portioning process. The facility Food Teredated 2010, used to	o.m. a meal cart with delivered to the east dining erved off the trays to the dining area, and then carried and served to their rooms. At 12:38 p.m. vered at 12:38 p.m. At 12:39 the delivery of the cart, the and the temperatures were ay by dietary aide (DA)-B. the ravioli was 110 degrees and the milk was 40 yor tasted the the food and the luke warm, the vegetables hilk to be cold. Sunch meal, the dietary the dietary the dietary end that the temperatures of the staff to food covered until they were sidents with their meal. In procedure for Taking the staff the food and the milk was dated 2010, and the temperatures. It directed the temperatures. It directed the staff the food solvers and the food solvers	F	364		
		should be at least 135 through the end of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		(X3) DATE SURVEY COMPLETED			
		245471	B. WING _			02	/05/2015
	ROVIDER OR SUPPLIER SCENIC SHORES			402 - 1	T ADDRESS, CITY, STATE, ZIP CODE 3TH AVENUE HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 364	Food Service was da indicated the food se perform meal rounds meals are attractive a needs of the individual manager would obse portion sizes, temper meal passes for accuroncerns to the admit registered dietitian ar registered or other new temper meal passes for accuroncerns to the admit registered or other new temperature or other new temperature for the facility policy and atmosphere dated 20 must be hot and cold	d procedure for Dining and ated 2010. The procedure rvice manager would routinely to determine if the and nutritious and meet the al. The food service arve meals for preferences, rature, flavor, variety and aracy, and would report inistrator, director of nursing, and/or dietetic technician	F	364			

PRINTED: 02/20/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 245471 02/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **402 - 13TH AVENUE ECUMEN SCENIC SHORES** TWO HARBORS, MN 55616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1 POC ok 18 3-6-15 K 000 l **INITIAL COMMENTS** K 000 **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES K TAGS TO:** Health Care Fire Inspections State Fire Marshal Division 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By E-Mail to: marian.whitnev@state,mn.us THE PLAN OF CORRECTION FOR FACH MAR - 52015 DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: IN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. LABORATORY DIRECTOR'S OB PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE brecher

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 regulate to continued program participation.

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING				(X3) DATE SURVEY COMPLETED	
	245471			ì		02	02/03/2015	
	PROVIDER OR SUPPLIER N SCENIC SHORES			۱ ،	STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616	I	, 53, 25.3	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE	
K 000	3. The name and/or responsible for corr		K	000				
8	A Life Safety Code S Minnesota Departm time of this survey E found not in substar requirements for pa Medicare/Medicaid a 483.70(a), Life Safe edition of National F	Survey was conducted by the ent of Public Safety. At the Ecumen Scenic Shores was nital compliance with the ricipation in at 42 CFR, Subpart ty from Fire, and the 2000 ire Protection Association 11, Life Safety Code (LSC),						
	a small partial baser constructed in 1979, 2001. An assisted li	ores is a 1-story building with ment. The building was with a kitchen addition, in lying building is connected parated. Therefore, the facility he building.	ŧ					
	facility has a comple smoke detection in s that is monitored for notification. The facil	fire sprinkler protected. The te fire alarm system with spaces open to the corridor, automatic fire department lity has a licensed capacity of ensus of 41 at the time of the			T2 #11			
K 029 SS=E	NOT MET as eviden NFPA 101 LIFE SAF One hour fire rated of	t2 CFR Subpart 483.70(a) is ced by: ETY CODE STANDARD construction (with ¾ hour n approved automatic fire	K 0	29			-	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
245471			B. WING		02/	02/03/2015	
	PROVIDER OR SUPPLIER N SCENIC SHORES			STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETION DATE	
K 029	and/or 19.3.5.4 prot the approved autom option is used, the a other spaces by sm doors. Doors are so field-applied protect	m in accordance with 8.4.1 rects hazardous areas. When ratic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or ive plates that do not exceed cottom of the door are	ΚO	1. Corrective Action: A. Adjustments have bee laundry room doors so close and latch proper	they ly		
	Based on observati hazardous areas are accordance with NF 19.3.2.1. This defici	not met as evidenced by: on and interview, the e not maintained in PA 101-2000, Section ent practice could affect all ent of a fire in the laundry		 3. The Correction will be Moby: A. EVS or designee. B. EVS or designee will random audit on doors monthly basis and mal necessary adjustments needed. 	conduct a on a	÷	
	2-3-15 observation r between the laundry	etween 8:30-10:30AM, on evealed that 2 of 2 doors room and the exit corridor and latch. It appears to be olem.					
K 072 SS=F	inspection. NFPA 101 LIFE SAF	er (MJ) at the time of the ETY CODE STANDARD	K 07	72			
	of all obstructions or use in the case of fire	continuously maintained free impediments to full instant e or other emergency. No ons, or other objects obstruct				-	

PRINTED: 02/20/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 245471 02/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **402 - 13TH AVENUE ECUMEN SCENIC SHORES** TWO HARBORS, MN 55616 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 072 Continued From page 3 K 072 exits, access to, egress from, or visibility of exits. 7.1.10 K072 1. Corrective Action: A. Hallway has been cleared of This STANDARD is not met as evidenced by: obstacles and signage placed to Based on observation, the facility has egress assist with compliance. corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the 2. Date of Completion: 3/17/15 convenient and effective removal of the patients in an emergency situation. 3. The Correction will be Monitored by: Findings include: A. EVS or designee. On facility tour between 8:30-10:30AM, on 2-3-15, B. EVS or designee will monitor observation revealed that several items are being hallway on a weekly basis for stored in the exit corridor outside of the laundry compliance. room reducing the corridor width to less than 8 feet. This storage included old resident furniture, and a mattress. This deficient practice was verified by the Maintenance Director (MJ) and the time of discovery.