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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: U7EI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00844

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245471**
2.STATE VENDOR OR MEDICAID NO.
(L2) **048540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN SCENIC SHORES**
(L4) **402 - 13TH AVENUE**
(L5) **TWO HARBORS, MN** (L6) **55616**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2011**

6. DATE OF SURVEY **03/20/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Chris Campbell, Unit Supervisor 03/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 04/02/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245471	A. Building B. Wing	3/20/2015

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **03/13/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **03/17/2015**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **03/17/2015**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **03/13/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/12/2015**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **03/17/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	CC/mm	03/26/2015	13922	03/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/5/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245471	A. Building B. Wing 01 - MAIN BUILDING	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	03/17/2015	ID Prefix Reg. # NFPA 101 LSC K0072	03/17/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	03/26/2015	03005	03/23/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/3/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: U7EI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00844

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245471**

2.STATE VENDOR OR MEDICAID NO.
(L2) **048540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN SCENIC SHORES**
(L4) **402 - 13TH AVENUE**
(L5) **TWO HARBORS, MN** (L6) **55616**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2011**

6. DATE OF SURVEY **02/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Terri Ament, HFE NEII 03/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/19/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 03/24/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	RECEIVED MAR 04 2015 MN Dept of Health Duluth F156 1. Corrective Action: A. Resident 61 has discharged 2. Corrective Action as it applies to Other Residents: A. Starting 3/3/15 will issue SNFABN along with the notice of Medicare Non-Coverage to every resident who has been decided that Medicare coverage will end, and on every resident who are anticipated to discharge at least 48 hours in advance. B. The MDS Coordinator completed a training session on 3/10/15 to instruct staff members on giving the two Medicare Denial letters together. C. The MDS Coordinator completed a training session on 2/11/15 and all documentation pertaining to Medicare coverage will be documented in the progress notes under the Medicare/Insurance tab. Also included in this training session was a section on the importance of documenting Patient Initiated Discharges, cancelled or delayed discharges. Documentation will include	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	OK 3/5/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve Bankmer — TITLE: Executive Director — (X6) DATE: 3/4/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

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F 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a	F 156	discharge plan and plan of continued stay. 3. Date of Completion: 3/13/15 4. Reoccurrence will be Prevented by: A. Staff education provided on 3/10/15 B. Random audits will be conducted two times weekly for two weeks, then weekly for one month and monthly for one quarter. Findings will be reported to the QAPI team for review and discussion. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI 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.	

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F 156	Continued From page 2 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide two day notice prior to discharge from Medicare services for 1 of 3 residents (R61) reviewed for liability notices. Findings include: R61 was discharged from Medicare Part A services on 11/7/14, according to the Notice of Non-Coverage. R61 signed the Notice of Non-Coverage on 11/7/14. On 2/4/14, the director of nursing was interviewed, and verified there was no evidence the facility provided R61 with the two day notice prior to discharge from Medicare services.	F 156		

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F 156	Continued From page 3 The facility policy and procedure on Medicare Non-Coverage Notification/Demand Bill/Benefit Exhaust Claims dated 10/07 directed a generic notice will be delivered to the resident within 24 hours of advising them their coverage will end.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe self-administration of medications (SAM) for 1 of 1 residents (R64) observed to self-administer a nebulizer treatment. Findings include: R64's Admission Record identified diagnoses that included late effects of cerebrovascular disease (disease of the blood vessels supplying the brain) and asthma. R64's admission Minimum Data Set (MDS) dated 11/27/14, indicated R64 had moderate cognitive impairment. The physician's orders dated 11/21/14, directed Albuterol Sulfate Nebulization solution (an inhaled medication used to treat wheezing and chest tightness) every four hours as needed for wheezing. On 2/4/15, at 12:50 a.m. R64 was observed sitting in her wheelchair by the nurse's desk. The trained medication aide (TMA)-B checked R64's	F 176	F176 1. Corrective Action: A. Resident 64 has been re-assessed for the ability to Self-Administer Medications (SAM) 2. Corrective Action as it applies to Other Residents: A. The policy and Procedure for SAM has been reviewed and revised as appropriate. The SAM policy will be reviewed with all nursing staff at the All Staff Meeting which will be held on 3/10/15. B. All other residents will be evaluated for their ability to SAM and new assessments will be completed as necessary. Care plans will be updated to reflect the resident's ability to SAM as appropriate. 3. Date of Completion: 3/17/15 4. Reoccurrence will be Prevented by: A. DON or designee will complete random audits daily for two weeks,	

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F 176	Continued From page 4 oxygen saturation level, and announced to R64 that it was 88%. TMA-B asked R64 if she was having a hard time breathing, and R64 replied "a little." TMA-B stated she would help R64 lay down, and get her a nebulizer treatment. TMA-B brought R64 to her room and R64 was transferred into bed by a nursing assistant. At 12:56 p.m. TMA-B brought the nebulizer treatment to R64, started the treatment and left the room. R64 was left alone in the room to SAM. At 1:08 p.m. R64 continued to self-administer the nebulizer treatment. On 2/4/15, at 1:10 p.m. TMA-B was interviewed and asked if R64 had a physician's order to self-administer the nebulizer treatment. TMA-B stated she did not know if there was an order, but if a resident is able to hold a nebulizer treatment, she lets them self-administer it. On 2/4/15, at 2:00 p.m. the director of nursing was interviewed and stated a resident must have an assessment and a physician's order to self administer a nebulizer treatment. The DON verified R64 had not been assessed and did not have a physician's order to safely self-administer medications. The facility policy and procedure on Self-Administration of Medications dated 12/12, directed residents in the facility who wish to self-administer medications may do so, if it is determined they are capable of doing so.	F 176	then weekly for one month, then monthly for one quarter.. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI 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.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250		

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F 250	Continued From page 5 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically related social services for 1 of 1 residents (R52) with self-identified issues that included end-stage disease, separation from young children, lack of adjustment to the facility, and lack of discharge planning. This resulted in actual harm to R52. Findings include: R52 was 44 years old, and according to the Admission Record was admitted to the facility on 12/30/14. He had multiple diagnoses including end stage congestive heart failure (CHF), hypotension (low blood pressure), mild cognitive impairment, depression, diabetes, morbid obesity, and cardiomyopathy (a disease of the heart muscle). On 1/2/15, R52 was placed on hospice (end of life) services for the end-stage CHF and hypoventilation syndrome (a condition in some obese people in which poor breathing leads to lower oxygen and higher carbon dioxide levels in the blood). R52's admission Minimum Data Set (MDS) dated 1/5/15, identified R52 had moderate cognitive impairment, and mood indicators of verbal behaviors towards others 1-3 days/week that did not interfere with his cares or impact other 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	F 250	F250 1. Corrective Action: A. Resident 52 has been re-assessed and his care plan has been updated. Hospice aand the facility staff continue to collaborate on the residents care. He continues to have frequent family involvement including visits with his children 2. Corrective Action as it applies to Other Residents: A. The Social Service policy has been reviewed and revised as appropriate. B. The Social Service Director has received additional training related to expectations of the role. C. All residents have been assessed for their Medically Related Social Service needs and their care plans were reviewed and updated as appropriate. 3. Date of Completion: 3/17/15 4. Reoccurrence will be Prevented by: A. DON or designee will complete random audits daily for two weeks, then weekly for one month, then monthly for one quarter.	

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F 250	Continued From page 6 with ambulation and toileting; independent and required set up assistance with eating and personal hygiene; required supervision with bed mobility and bathing; and assistance of one staff for transfers, dressing and locomotion on and off the unit. R52's Care Area Assessment (CAA) dated 1/12/15, indicated he had a potential problem with his psychosocial well-being due to having a difficult time with accepting his illness. The CAA further identified R52 was making friends at the facility, he was not a threat to himself or others, and he was at risk for social isolation related to his diagnoses and his age. R52's care plan dated 1/5/15, indicated R52 had a terminal prognosis related to CHF. R52's goals included he would be free from depression and anxiety, and his dignity and autonomy would be maintained at the highest level. R52's interventions included to assess his coping strategies and respect his wishes, encourage him to express his feelings and listen with non-judgmental acceptance and compassion, and work cooperatively with the hospice team to ensure his spiritual, emotional, intellectual, physical and social needs were met. The hospice social worker (SW)-B visited with R52 twice. On 1/8/15, the hospice SW-B documented R52's concern of social service assessment, prepare his children, and action taken was social service assessment, prepare for good sleep and talk of his children. On 1/26/15, the hospice SW-B met with R52, and documented R52's concerns of life review. Action taken was working through guilt, regret, wanting to be a full-time father.	F 250	5. The Correction will be Monitored by: A. DON or designee. B. The QAPI 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.	

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F 250	Continued From page 7 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	F 250		

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F 250	Continued From page 8 facility was providing to help him through this time, SW-A stated "I don't know" and said she could go talk with him today and set up a meeting with him and his family. SW-A verified she was not meeting with R52 to assist him with addressing his concerns. On 2/11/15, at 12:37 p.m. the hospice registered nurse (RN)-H was interviewed, and stated she would expect hospice and the facility to collaborate care. RN-H further stated hospice's main focus is on end of life issues, and she would expect the facility to meet R52's other needs. RN-H further stated hospice was another piece of support, an addition to what the facility should already be providing. The Collaboration at End of Life between the hospice agency and the facility indicated hospice in the long term care facility was designed to optimize end-of-life services in the facility. The collaboration divided tasks between the hospice and facility social workers. The facility social worker was expected to identify psychosocial issues and initiate interventions and notify hospice with specific patient/family needs.	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the need for use of a nebulizer treatment prior to	F 281	F281 1. Corrective Action: A. Resident 64 has been re-assessed for the ability to SAM. The care plans have been updated. 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 medication. 2. Corrective Action as it applies to Other Residents: A. The policy and procedure for SAM has been reviewed and revised as appropriate.	

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F 281	Continued From page 9 administration for 1 of 1 residents (R64) observed with a nebulizer treatment. Findings include: R64's Admission Record identified diagnoses that included asthma. R64's admission Minimum Data Set (MDS) dated 11/27/14, indicated R64 had moderate cognitive impairment. The physician's orders dated 11/21/14, directed Albuterol Sulfate Nebulization solution (an inhaled medication used to treat wheezing and chest tightness) every four hours as needed (PRN) for wheezing. On 2/4/15, at 12:50 a.m. R64 was observed sitting in her wheelchair by the nurse's desk. Trained medication aide (TMA)-B checked R64's oxygen saturation level, and announced to R64 that it was 88%. TMA-B asked R64 if she was having a hard time breathing, and R64 replied "a little." TMA-B stated she would help R64 lay down, and get her a nebulizer treatment. TMA-B brought R64 to her room and R64 was transferred into bed by a nursing assistant. At 12:56 p.m. TMA-B brought the nebulizer treatment to R64 and provided the treatment. It is outside the TMA's scope of practice to administer PRN medications without obtaining an assessment/permission of a licensed nurse. On 2/04/15, at 1:10 p.m TMA-B was interviewed and was asked if she had a licensed nurse assess R64 prior to the administration of the nebulizer. TMA-B she did not, she knew R64 was having problems breathing, and the licensed nurses "trusted" her to give PRN medications. On 2/4/15, at 2:00 p.m. the director of nursing was interviewed and stated she would expect the	F 281	B. TMA's were educated on 3/10/15 related to licensed nurses needing to evaluate the resident prior to administration of a PRN medication. C. All other residents will be evaluated for their ability to SAM and new assessments will be completed as necessary. Care plans will be updated to reflect the patient's ability to SAM as appropriate. Nurses will evaluate residents prior to the TMA administering a PRN medication. 3. Date of Completion: 3/13/15 4. Reoccurrence will be Prevented by: A. DON or designee will complete random audits daily for two weeks, then weekly for one month, then monthly for one quarter. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI 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.	

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F 281	Continued From page 10 TMA to ask a licensed staff to do an assessment prior to administering a nebulizer treatment.	F 281		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 356	F356 1. Corrective Action: A. The nursing hours are now posted and updated as changes occur throughout the day. 2. Corrective Action as it applies to Other Residents: A. Nursing staff responsible for posting the schedule have been educated on the need to post staff hours and keep the document updated. The education occurred on 3/10/15 3. Date of Completion: 3/12/15 4. Reoccurrence will be Prevented by: A. Staff education provided on 3/10/15 B. Administrator or designee will complete random audits will be conducted two times weekly for two weeks, then weekly for one month and monthly for one quarter 5. The Correction will be Monitored by: A. Administrator or designee. B. The QAPI 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.	

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F 356	Continued From page 11 Based on observation, interview and document review, the facility did not ensure the nurse staff posting was posted daily. This had the potential to affect all 41 residents residing in the facility. Findings include: On 2/2/15, at 6:15 p.m. during the initial tour, the Hours Report of Nursing Staff Directly Responsible for Resident Care (nurse staff posting) was observed to have the most current date of 1/29/15. There were three nurse staff postings behind the 1/29/15 posting dated 1/26/15, 1/27/15, and 1/28/15. On 2/2/15, at 6:25 p.m. registered nurse (RN)-C verified the most current nurse staff posting was dated 1/29/15. On 2/5/15, at 11:15 a.m. the director of nursing (DON) verified the nurse staff posting for 2/2/15, was 1/29/15. The DON stated the nurses working the weekend were suppose to post the current nurse staff posting each day and the front desk staff person posted the nurse staff posting during the week.	F 356		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food served at	F 364	F364 1. Corrective Action: A. Food is now being temperature checked to assure that food is being served within the temperature guidelines. 2. Corrective Action as it applies to Other Residents: A. Staff members have been educated on the need to serve food in accordance with safe food handling guidelines. Staff education occurred on 3/10/15.	

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F 364	Continued From page 12 meals was appetizing and served at the proper temperature for 4 of 4 residents (R7, R63, R52, and R2) who complained of food quality. Findings include: During an interview on 2/3/15, at 12:58 p.m. R7 stated the food was too cool at meals. R7 ate in the main dining room. During an interview on 2/3/15, at 8:49 a.m. R63 stated the food was a little cool at meals. R63 ate in the unit dining area. During an interview on 2/3/15, at 8:47 a.m. R52 stated the food wasn't very good and is institutional. R52 ate in the dining area or in his room. During an interview on 2/3/15, at 10:00 a.m. R2 stated the food at meals was too cold sometimes. R2 ate in the main dining room. During an observation on 2/4/15, at 8:47 a.m. R63 was heard to tell a staff member who was interviewing residents regarding food quality, that the food was a bit too cool. During an observation on 2/4/15, at 12:07 p.m., a cart with individual meal trays had been delivered to the main dining room. Each entree had an insulated cover on it. The cart had a clear plastic cover over it. The plates were taken off the trays and served to each resident, and the cover was removed. R7, R52, and R2 ate their meal in the main dining room and were able to eat independently. The last meal from the cart was served 5 minutes after the cover was removed and 19 minutes after the cart had been delivered.	F 364	3. Date of Completion: 3/17/15 4. Reoccurrence will be Prevented by: A. CDM or designee will complete random audits daily for two weeks, then weekly for one month, then monthly for one quarter. 5. The Correction will be Monitored by: A. CDM or designee. B. The QAPI 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.	

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F 364	Continued From page 13 On 2/4/15, at 12:30 p.m. a meal cart with individual trays was delivered to the east dining area. Meals were served off the trays to residents seated in the dining area, and then individual trays were carried and served to residents who ate in their rooms. At 12:38 p.m. the last tray was delivered at 12:38 p.m. At 12:39 p.m., 9 minutes after the delivery of the cart, the cover was removed and the temperatures were checked on a test tray by dietary aide (DA)-B. The temperature of the ravioli was 110 degrees Fahrenheit, the mixed vegetables were 95 degrees Fahrenheit, and the milk was 40 degrees. The surveyor tasted the the food and found the ravioli to be luke warm, the vegetables to be cool, and the milk to be cold. On 2/4/15, after the lunch meal, the dietary manager (DM) verified that the temperatures of the food served at lunch were cool and needed to be addressed. The DM further verified the staff should have kept the food covered until they were able to assist the residents with their meal. The facility policy and procedure for Taking Accurate Temperatures was dated 2010, and usedf to record food temperatures. It directed staff to take temperatures periodically to ensure hot foods stay above 135 degrees Fahrenheit and cold foods stay below 41 degrees Fahrenheit during the portioning, transporting and serving process. The facility Food Temperatures Sample Form dated 2010, used to record food temperatures indicated hot foods should be at least 135 degrees Fahrenheit through the end of the trayline.	F 364		

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F 364	Continued From page 14 The facility policy and procedure for Dining and Food Service was dated 2010. The procedure indicated the food service manager would perform meal rounds routinely to determine if the meals are attractive and nutritious and meet the needs of the individual. The food service manager would observe meals for preferences, portion sizes, temperature, flavor, variety and meal passes for accuracy, and would report concerns to the administrator, director of nursing, registered dietitian and/or dietetic technician registered or other necessary staff. The facility policy and procedure for Dining Atmosphere dated 2010, directed that hot food must be hot and cold food must be cold (as acceptable to the individual being served).	F 364		

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F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156		3/13/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/04/2015

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other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a

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complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide two day notice prior to discharge from Medicare services for 1 of 3 residents (R61) reviewed for liability notices.

Findings include:

R61 was discharged from Medicare Part A services on 11/7/14, according to the Notice of Non-Coverage. R61 signed the Notice of Non-Coverage on 11/7/14.

On 2/4/14, the director of nursing was interviewed, and verified there was no evidence the facility provided R61 with the two day notice prior to discharge from Medicare services.

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F 156	Continued From page 3 The facility policy and procedure on Medicare Non-Coverage Notification/Demand Bill/Benefit Exhaust Claims dated 10/07 directed a generic notice will be delivered to the resident within 24 hours of advising them their coverage will end.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe self-administration of medications (SAM) for 1 of 1 residents (R64) observed to self-administer a nebulizer treatment. Findings include: R64's Admission Record identified diagnoses that included late effects of cerebrovascular disease (disease of the blood vessels supplying the brain) and asthma. R64's admission Minimum Data Set (MDS) dated 11/27/14, indicated R64 had moderate cognitive impairment. The physician's orders dated 11/21/14, directed Albuterol Sulfate Nebulization solution (an inhaled medication used to treat wheezing and chest tightness) every four hours as needed for wheezing. On 2/4/15, at 12:50 a.m. R64 was observed sitting in her wheelchair by the nurse's desk. The trained medication aide (TMA)-B checked R64's	F 176		3/17/15

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F 176	Continued From page 4 oxygen saturation level, and announced to R64 that it was 88%. TMA-B asked R64 if she was having a hard time breathing, and R64 replied "a little." TMA-B stated she would help R64 lay down, and get her a nebulizer treatment. TMA-B brought R64 to her room and R64 was transferred into bed by a nursing assistant. At 12:56 p.m. TMA-B brought the nebulizer treatment to R64, started the treatment and left the room. R64 was left alone in the room to SAM. At 1:08 p.m. R64 continued to self-administer the nebulizer treatment. On 2/4/15, at 1:10 p.m. TMA-B was interviewed and asked if R64 had a physician's order to self-administer the nebulizer treatment. TMA-B stated she did not know if there was an order, but if a resident is able to hold a nebulizer treatment, she lets them self-administer it. On 2/4/15, at 2:00 p.m. the director of nursing was interviewed and stated a resident must have an assessment and a physician's order to self administer a nebulizer treatment. The DON verified R64 had not been assessed and did not have a physician's order to safely self-administer medications. The facility policy and procedure on Self-Administration of Medications dated 12/12, directed residents in the facility who wish to self-administer medications may do so, if it is determined they are capable of doing so.	F 176		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250		3/17/15

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practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide medically related social services for 1 of 1 residents (R52) with self-identified issues that included end-stage disease, separation from young children, lack of adjustment to the facility, and lack of discharge planning.

Findings include:

R52 was 44 years old, and according to the Admission Record was admitted to the facility on 12/30/14. He had multiple diagnoses including end stage congestive heart failure (CHF), hypotension (low blood pressure), mild cognitive impairment, depression, diabetes, morbid obesity, and cardiomyopathy (a disease of the heart muscle). On 1/2/15, R52 was placed on hospice (end of life) services for the end-stage CHF and hypoventilation syndrome (a condition in some obese people in which poor breathing leads to lower oxygen and higher carbon dioxide levels in the blood).

R52's admission Minimum Data Set (MDS) dated 1/5/15, identified R52 had moderate cognitive impairment, and mood indicators of verbal behaviors towards others 1-3 days/week that did not interfere with his cares or impact other 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

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with ambulation and toileting; independent and required set up assistance with eating and personal hygiene; required supervision with bed mobility and bathing; and assistance of one staff for transfers, dressing and locomotion on and off the unit.

R52's Care Area Assessment (CAA) dated 1/12/15, indicated he had a potential problem with his psychosocial well-being due to having a difficult time with accepting his illness. The CAA further identified R52 was making friends at the facility, he was not a threat to himself or others, and he was at risk for social isolation related to his diagnoses and his age.

R52's care plan dated 1/5/15, indicated R52 had a terminal prognosis related to CHF. R52's goals included he would be free from depression and anxiety, and his dignity and autonomy would be maintained at the highest level. R52's interventions included to assess his coping strategies and respect his wishes, encourage him to express his feelings and listen with non-judgmental acceptance and compassion, and work cooperatively with the hospice team to ensure his spiritual, emotional, intellectual, physical and social needs were met.

The hospice social worker (SW)-B visited with R52 twice. On 1/8/15, the hospice SW-B documented R52's concern of social service assessment, prepare his children, and action taken was social service assessment, prepare for good sleep and talk of his children. On 1/26/15, the hospice SW-B met with R52, and documented R52's concerns of life review. Action taken was working through guilt, regret, wanting to be a full-time father.

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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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F 250	Continued From page 8 facility was providing to help him through this time, SW-A stated "I don't know" and said she could go talk with him today and set up a meeting with him and his family. SW-A verified she was not meeting with R52 to assist him with addressing his concerns. On 2/11/15, at 12:37 p.m. the hospice registered nurse (RN)-H was interviewed, and stated she would expect hospice and the facility to collaborate care. RN-H further stated hospice's main focus is on end of life issues, and she would expect the facility to meet R52's other needs. RN-H further stated hospice was another piece of support, an addition to what the facility should already be providing. The Collaboration at End of Life between the hospice agency and the facility indicated hospice in the long term care facility was designed to optimize end-of-life services in the facility. The collaboration divided tasks between the hospice and facility social workers. The facility social worker was expected to identify psychosocial issues and initiate interventions and notify hospice with specific patient/family needs.	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the need for use of a nebulizer treatment prior to	F 281		3/13/15

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administration for 1 of 1 residents (R64) observed with a nebulizer treatment.

Findings include:

R64's Admission Record identified diagnoses that included asthma. R64's admission Minimum Data Set (MDS) dated 11/27/14, indicated R64 had moderate cognitive impairment. The physician's orders dated 11/21/14, directed Albuterol Sulfate Nebulization solution (an inhaled medication used to treat wheezing and chest tightness) every four hours as needed (PRN) for wheezing.

On 2/4/15, at 12:50 a.m. R64 was observed sitting in her wheelchair by the nurse's desk. Trained medication aide (TMA)-B checked R64's oxygen saturation level, and announced to R64 that it was 88%. TMA-B asked R64 if she was having a hard time breathing, and R64 replied "a little." TMA-B stated she would help R64 lay down, and get her a nebulizer treatment. TMA-B brought R64 to her room and R64 was transferred into bed by a nursing assistant. At 12:56 p.m. TMA-B brought the nebulizer treatment to R64 and provided the treatment. It is outside the TMA's scope of practice to administer PRN medications without obtaining an assessment/permission of a licensed nurse.

On 2/04/15, at 1:10 p.m TMA-B was interviewed and was asked if she had a licensed nurse assess R64 prior to the administration of the nebulizer. TMA-B she did not, she knew R64 was having problems breathing, and the licensed nurses "trusted" her to give PRN medications.

On 2/4/15, at 2:00 p.m. the director of nursing was interviewed and stated she would expect the

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	245471	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 10 TMA to ask a licensed staff to do an assessment prior to administering a nebulizer treatment.	F 281		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 356		3/12/15

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F 356	Continued From page 11 Based on observation, interview and document review, the facility did not ensure the nurse staff posting was posted daily. This had the potential to affect all 41 residents residing in the facility. Findings include: On 2/2/15, at 6:15 p.m. during the initial tour, the Hours Report of Nursing Staff Directly Responsible for Resident Care (nurse staff posting) was observed to have the most current date of 1/29/15. There were three nurse staff postings behind the 1/29/15 posting dated 1/26/15, 1/27/15, and 1/28/15. On 2/2/15, at 6:25 p.m. registered nurse (RN)-C verified the most current nurse staff posting was dated 1/29/15. On 2/5/15, at 11:15 a.m. the director of nursing (DON) verified the nurse staff posting for 2/2/15, was 1/29/15. The DON stated the nurses working the weekend were suppose to post the current nurse staff posting each day and the front desk staff person posted the nurse staff posting during the week.	F 356		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food served at	F 364		3/17/15

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F 364	Continued From page 12	F 364		

meals was appetizing and served at the proper temperature for 4 of 4 residents (R7, R63, R52, and R2) who complained of food quality.

Findings include:

During an interview on 2/3/15, at 12:58 p.m. R7 stated the food was too cool at meals. R7 ate in the main dining room.

During an interview on 2/3/15, at 8:49 a.m. R63 stated the food was a little cool at meals. R63 ate in the unit dining area.

During an interview on 2/3/15, at 8:47 a.m. R52 stated the food wasn't very good and is institutional. R52 ate in the dining area or in his room.

During an interview on 2/3/15, at 10:00 a.m. R2 stated the food at meals was too cold sometimes. R2 ate in the main dining room.

During an observation on 2/4/15, at 8:47 a.m. R63 was heard to tell a staff member who was interviewing residents regarding food quality, that the food was a bit too cool.

During an observation on 2/4/15, at 12:07 p.m., a cart with individual meal trays had been delivered to the main dining room. Each entree had an insulated cover on it. The cart had a clear plastic cover over it. The plates were taken off the trays and served to each resident, and the cover was removed. R7, R52, and R2 ate their meal in the main dining room and were able to eat independently. The last meal from the cart was served 5 minutes after the cover was removed and 19 minutes after the cart had been delivered.

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F 364	Continued From page 13 On 2/4/15, at 12:30 p.m. a meal cart with individual trays was delivered to the east dining area. Meals were served off the trays to residents seated in the dining area, and then individual trays were carried and served to residents who ate in their rooms. At 12:38 p.m. the last tray was delivered at 12:38 p.m. At 12:39 p.m., 9 minutes after the delivery of the cart, the cover was removed and the temperatures were checked on a test tray by dietary aide (DA)-B. The temperature of the ravioli was 110 degrees Fahrenheit, the mixed vegetables were 95 degrees Fahrenheit, and the milk was 40 degrees. The surveyor tasted the the food and found the ravioli to be luke warm, the vegetables to be cool, and the milk to be cold. On 2/4/15, after the lunch meal, the dietary manager (DM) verified that the temperatures of the food served at lunch were cool and needed to be addressed. The DM further verified the staff should have kept the food covered until they were able to assist the residents with their meal. The facility policy and procedure for Taking Accurate Temperatures was dated 2010, and usedf to record food temperatures. It directed staff to take temperatures periodically to ensure hot foods stay above 135 degrees Fahrenheit and cold foods stay below 41 degrees Fahrenheit during the portioning, transporting and serving process. The facility Food Temperatures Sample Form dated 2010, used to record food temperatures indicated hot foods should be at least 135 degrees Fahrenheit through the end of the trayline.	F 364		

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F 364	Continued From page 14 The facility policy and procedure for Dining and Food Service was dated 2010. The procedure indicated the food service manager would perform meal rounds routinely to determine if the meals are attractive and nutritious and meet the needs of the individual. The food service manager would observe meals for preferences, portion sizes, temperature, flavor, variety and meal passes for accuracy, and would report concerns to the administrator, director of nursing, registered dietitian and/or dietetic technician registered or other necessary staff. The facility policy and procedure for Dining Atmosphere dated 2010, directed that hot food must be hot and cold food must be cold (as acceptable to the individual being served).	F 364		

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5471024
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/03/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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.whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date.	K 000	POC ok 3-6-15 RECEIVED MAR - 5 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 3-17-15

EXIT: 2-5-15

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

Executive Director — 3/4/15

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

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K 000	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Ecumen Scenic Shores was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Ecumen Scenic Shores is a 1-story building with a small partial basement. The building was constructed in 1979, with a kitchen addition, in 2001. An assisted living building is connected and properly fire separated. Therefore, the facility was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 45 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029		

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K 029	Continued From page 2 extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect all occupants in the event of a fire in the laundry room. Findings include: During facility tour between 8:30-10:30AM, on 2-3-15 observation revealed that 2 of 2 doors between the laundry room and the exit corridor would not fully close and latch. It appears to be an air balancing problem. This deficient practice was verified by the Maintenance Director (MJ) at the time of the inspection.	K 029	K029 1. Corrective Action: A. Adjustments have been made to laundry room doors so they close and latch properly 2. Date of Completion: 3/17/15 3. The Correction will be Monitored by: A. EVS or designee. B. EVS or designee will conduct a random audit on doors on a monthly basis and make necessary adjustments as needed.	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072		

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K 072	Continued From page 3 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of the patients in an emergency situation. Findings include: On facility tour between 8:30-10:30AM, on 2-3-15, observation revealed that several items are being stored in the exit corridor outside of the laundry 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.	K 072	K072 1. Corrective Action: A. Hallway has been cleared of obstacles and signage placed to assist with compliance. 2. Date of Completion: 3/17/15 3. The Correction will be Monitored by: A. EVS or designee. B. EVS or designee will monitor hallway on a weekly basis for compliance.	