DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 2021

Administrator
Ecumen North Branch
5379 -383rd Street
North Branch, MN 55056

RE: CCN: 245370
Cycle Start Date: February 12, 2021

Dear Administrator:

On March 30, 2021, CMS notified you remedies were being imposed. On July 13, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 12, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 14, 2021 be discontinued as of July 12, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 14, 2021. This does not apply to or affect any previously imposed NATCEP loss. The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

June 4, 2021

Administrator
Ecumen North Branch
5379 -383rd Street
North Branch, MN 55056

RE: CCN: 245370
Cycle Start Date: February 12, 2021

Dear Administrator:

On March 30, 2021, the Centers for Medicare & Medicaid Services (CMS) informed you that they were imposing enforcement remedies.

On May 19, 2021, the Minnesota Department of Health completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 14, 2021 remains in effect.

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 14, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 14, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 14, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Ecumen North Branch will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 14, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 12, 2021 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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	245370	A. BUILDING _____ B. WING _____	R 05/19/2021

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

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{F 000}	INITIAL COMMENTS On 5/17/21, through 5/19/21, an onsite revisit was conducted to follow up on deficiencies related to a health comparative Federal Monitoring Survey conducted by the Centers for Medicare & Medicaid Services exited 3/16/21. The facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	{F 686}		7/12/21

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

Electronically Signed | 06/14/2021

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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{F 686}	Continued From page 1 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Pressure injury stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. R28's Admission Record printed 5/20/21, indicated R28's diagnoses included Alzheimer's disease with late onset, dementia without	{F 686}	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? " The nurse for R28 was educated on timely skin assessments and repositioning. The CNA for R28 was educated on timely repositioning. The CNA for R194 was educated on timely repositioning. Neither R28 or R194 have not suffered any adverse events since identifying deficient practice.. All CNA□s and nursing staff will be educated on timely skin and Braden assessments, timely repositioning, and daily CNA skin check charting and the need to document refusals of care. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? " Reviewed all residents and weekly skin assessment completed. Reviewed all residents who need repositioning that they have been assessed for repositioning needs. Residents that are identified at moderate or high risk on the Braden scale (14 or lower) will have a clinical review of the care plan. Skin assessments will be reviewed for compliance with policy. CNA care sheet review and observations will be used to ensure compliance with care plan in regard to residents□	

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{F 686}	Continued From page 2 behavioral disturbance, history of venous thrombosis and embolism (blood clots), and postural kyphosis (curvature of the spine). R28's quarterly MDS dated 4/14/21, indicated R28 had no unhealed pressure ulcers, had a pressure reducing device for chair and for bed, had a moderately impaired cognitive status for daily decisions with short term and long term memory deficits, and had not refusals of care during the assessment period. R28's MDS further indicated R28 required extensive assist with bed mobility, transfers, toilet use and personal hygiene, was always incontinent of urine and frequently incontinent of bowel. R28's CAA for pressure ulcer/injury dated 8/17/20, indicated R28's skin was clean, dry and intact, and did not present any pressure-related concerns. R28's CAA indicated staff attempted to observe her skin daily during cares and weekly skin checks were attempted by a licensed nurse, but at that time R28 frequently refused to allow staff to see her skin. R28's CAA indicated R28 had a pressure reducing mattress on her bed and a pressure reducing cushion in her wheelchair, and staff assisted her to offload and reposition. R28's care plan initiated 7/24/20, indicated R28 was able to make occasional to frequent movements of extremities, but required staff assist of one to two staff with off-loading (providing full relief from pressure in the same area) and repositioning, and directed staff to off-load and reposition every 2 hours and as needed. R28's care plan further identified R28 as having the potential for the development of pressure ulcers, and R28 had a history of pressure-related redness to the coccyx (tailbone).	{F 686}	repositioning plans. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? " All nurses and CNA□s will be educated regarding interventions for moderate and high risk residents as identified by braden scale and the importance of following the care plan in regard to repositioning. " Audits will be conducted using an audit tool to review: o Braden scale and weekly skin assessments complete in compliance with policy. o Residents are repositioned in a timely manner per care plan o Daily CNA charting on skin check is complete. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " Weekly review of completion and compliance of audits. Audits to be conducted on all shifts: Repositioning Two times per week for one month Skin Assessments Two times per week for one month Education will be provided to specific staff members as needed and audits will be reviewed for understanding of processes. Identified concerns will be corrected immediately, documented education will be provided, and audit findings will be submitted to the facility□s QAPI for further monitoring, recommendations, or follow	

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{F 686}	Continued From page 3 R28's care plan indicated R28 was unable to completely off-load independently and required the assistance of one staff and directed staff to off-load and reposition R28 every 2 hours and as needed. R28's care plan further indicated R28 preferred to lay on her back and directed staff to encourage and assist R28 with repositioning and off-loading from side to side as able. R28 was to have an alternating air mattress on her bed, a pressure reducing device in her wheelchair, heels elevated off the bed with pillows or use blue heel protectors. Staff were directed to monitor, document and report any changes in R28's skin status. R28's weekly Skin Assessment dated 4/29/21, indicated R28 had a blanchable redness (skin turns white when pressed, and color returns when pressure relieved, so no evidence of long term skin damage), on her coccyx and sacrum (large wedge shaped vertebra at the base of the spine). Documentation further indicated R28 had a redness on her coccyx that was slow to blanch. R28's Braden Scale for Predicting Pressure Sore Risk dated 5/5/21, indicated R28 was at high risk for developing pressure ulcers. R28's weekly Skin Assessment dated 5/6/21, contained the same documentation regarding redness that was slow to blanch on R28's coccyx, and blanchable redness on her coccyx and sacrum. R28's progress notes dated 5/12/21, indicated staff was unable to complete R28's weekly skin assessment. R28's medical record lacked a weekly skin	{F 686}	up. Audits will continue until resolved by the QAPI committee. The administrator will be responsible for obtaining and substantiating substantial compliance.	

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{F 686}	Continued From page 4	{F 686}		

assessment during the week of 5/13/21.

R28's progress notes dated 5/15/21, at 2:24 p.m. indicated an open area was identified on R28's coccyx, and was described as a "small closed dry skin flapped/open area 0.7 x 0.3 mm on the coccyx." R28's progress note indicated a dressing and bacitracin (antibiotic ointment) was applied and an intervention to encourage more repositioning every 2 hours was initiated.

R28's progress notes dated 5/16/21, at 4:01 a.m. indicated R28's coccyx was cleaned, skin prep applied and dressing applied to R28's coccyx for preventative pressure injury.

R28's Braden Scale for Predicting Pressure Sore Risk dated 5/17/21, indicated R28 was at moderate risk for pressure ulcer development.

R28's progress notes dated 5/17/21, at 10:56 indicated R28's open pressure ulcer was closed, fragile, and a non-blanching redness, measuring 0.4 cm x 0.2 cm. R28's coccyx was covered with a dressing to protect it as the area was bony and R28 was thin. R28 was identified as being at risk for impaired skin integrity and pressure, and was on hospice. R28's progress note indicated R28 had heel protectors in place, had an air mattress on her bed, and was to be off-loaded side to side with pillows as able.

R28's weekly Skin Assessment dated 5/20/21, indicated R28 had a one centimeter (cm) open area on her coccyx.

On 5/17/21, at 3:27 p.m. registered nurse (RN)-D administered acetaminophen to R28 for pain, and R28 stated she had back pain and when RN-D

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{F 686}	Continued From page 5	{F 686}		

asked R28 to clarify the location of her pain, R28 stated the pain in her butt was very bad. RN-D stated R28 had an open area on her bottom and she needed to look at it. R28 had been incontinent of a large amount of loose bowel movement (BM). RN-D stated R28's dressing had been changed approximately 2 hours prior and remained intact, so did not need to be changed at this time.

On 5/19/21, at 8:52 a.m. licensed practical nurse (LPN)-A stated she found R28's pressure ulcer on 5/15/21, and it was just tiny, and knew they needed to do something right away. LPN-A stated it was almost gone now, but felt R28's pressure ulcer developed because she refused to be repositioned on her side due to her back pain. LPN-A stated they had been working on managing R28's pain for her.

On 5/19/21, at 9:03 a.m. RN-B changed the dressing and assessed R28's pressure ulcer. RN-B stated R28's coccyx area had been partially open on the edge for a very short time and was no longer open. RN-B stated R28's pressure ulcer was a healing Stage 2 pressure ulcer, but if it had been found right now, it would be a Stage 1. RN-B stated R28's pressure injury had measured 0.5 cm x 0.3 cm the previous day, but did not measure the area at this time. R28's tissue around the pressure injury was a blanchable pink. RN-B cleansed the pressure area, applied a dressing, and positioned R28 on her right side.

On 5/19/21, at 11:20 a.m. the DON verified there was no documentation of refusals of repositioning for R28 between 5/7/21, and 5/18/21.

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{F 686}	Continued From page 6 On 5/19/21, at 2:18 p.m. RN-B stated R28's pressure injury developed during the weekend due to her variable intake, advanced age, and related to not wanting to get off her back. RN-B stated they were trying to encourage her to be repositioned more, while positioning her for comfort. RN-B stated R28 had an air mattress, heel protectors or heels elevated off the mattress. RN-B stated skin assessments should be done weekly with the resident's shower or bath day. RN-B verified R28's skin assessment hadn't been done during the week of 5/13/21, and her last skin assessment was on 5/6/21. RN-B verified R28's open area could have been potentially identified before it opened if a skin assessment had been done that week. On 5/19/21, at 3:52 p.m. RN-C stated nurses must look at each resident's skin every bath day. RN-C verified when wound rounds were done, the nurse was looking only at the wound and not at all the resident's skin. On 5/19/21, at 3:52 p.m. the DON verified the skin assessment was to have a professional set of eyes looking at it and identifying areas of concern. The facility policy Prevention of Pressure Injuries revised 4/20, directed nursing to do a weekly pressure injury risk assessment and with any changes in condition. In addition, staff were directed to inspect the skin on a daily basis with personal cares or activities of daily living for pressure points and signs of developing pressure injuries.	{F 686}		

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

(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 686}	Continued From page 7	{F 686}		

Based on observation, interview, and document review, the facility failed to provide timely repositioning to prevent the development of pressure ulcers for 1 of 3 residents (R194) reviewed for pressure ulcers. In addition, the facility failed to ensure weekly skin assessments were completed to readily identify new skin impairments for 1 of 3 residents (R28) reviewed for pressure ulcers.

Findings include:

R194 's Admission Record printed 5/20/21, indicated R194's diagnoses included dementia, hemiparesis and hemiplegia (weakness and paralysis on one side of the body), and paralytic syndrome affecting both sides following a stroke.

R194's significant change Minimum Data Set (MDS) dated 5/14/21, indicated R194 had mildly impaired cognition. The MDS indicated R194 required extensive assistance of two staff for bed mobility and repositioning, and required the use of mechanical lift (Hoyer lift) for all transfers. R194's MDS further indicated R194 had a Foley catheter and was always incontinent of bowel. R194's MDS indicated R194 was at risk for developing newly acquired pressure ulcers.

R194's Care Area Assessment (CAA) for pressure ulcers dated 3/3/21, indicated R194 was at risk for the development of pressure ulcers related to bed mobility status and bowel incontinence.

R194's care plan initiated 4/23/18, indicated R194 had a potential for pressure ulcer development and impaired skin integrity related to pain, contractures, weakness, and impaired mobility.

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	245370	A. BUILDING _____ B. WING _____	R 05/19/2021

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ECUMEN NORTH BRANCH	**5379 -383RD STREET NORTH BRANCH, MN 55056**

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{F 686}	Continued From page 8	{F 686}		

The care plan also indicated R194 was at risk for moisture associated skin damage (MASD) and he was dependent on staff for cares. R194's care plan interventions directed staff to turn/reposition every two hours, or more often as needed when in bed and wheelchair (w/c).

R194's nursing assistant care guide sheet printed 5/18/21, indicated R194 was incontinent of bowel, required total assistance with toileting, and directed staff to reposition alternating side to side every two hours.

On 5/18/21, at 8:42 a.m. R194 was continuously observed sitting in w/c in the dining. At 9:56 a.m. nursing assistant (NA)-A was observed transporting R194 via w/c from the dining room to her room. NA-A positioned R194 in her w/c in a reclining position and exited R194's room. NA-A did not reposition R194. At 9:51 a.m. R194 was interviewed and stated she had been in her w/c since her morning cares were provided, and staff frequently left her in her w/c for long periods of time. R194 further stated that being left in her w/c caused pain to her buttock region.

At 11:04 a.m. NA-A was interviewed. NA-A stated R194 should be repositioned every two hours. NA-A stated R194 had not been repositioned since morning cares were completed at approximately 6:45 a.m. NA-A stated she was aware that R194 required repositioning every two hours, but she had not provided the cares per R194's care guide. NA-A stated repositioning was important to prevent skin breakdown.

At 11:23 a.m. (2 hours and 41 minutes since continuous observations started) NA-A and NA-B transferred R194 from her w/c and into her bed.

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{F 686}	Continued From page 9 NA-A placed a pillow under R194's left back and stated she would go get a nurse to inspect R194's buttocks. NA-A placed R194's call light next to her and stated they would be right back. At 11:28 a.m. licensed practical nurse (LPN)-A entered R194's nurse. LPN-A stated R194 required repositioning every two hours due to her inability to reposition herself. At 11:36 a.m. registered nurse (RN)-A entered R194's room. RN-A stated staff were to be repositioning residents per the resident's individual care plan to prevent new or worsening skin breakdown. RN-A verified R194 was at risk for developing new pressure ulcers. RN-A completed a skin assessment on R194. R194 was noted to have slow blanchable redness to both left and right buttocks, with no open areas noted to the area. On 5/19/21, at 3:50 p.m. the director of nursing (DON) was interviewed and stated she expected residents to be repositioned timely per their care plan. The DON stated she would not consider reclining a resident in their w/c as offloading or repositioning. The DON stated repositioning requires getting the resident off the bony prominences. The DON stated residents repositioning needs are based off the RN assessments completed at the time of admission and with their quarterly assessments. The DON stated timely repositioning needed to be completed to prevent pressure ulcers from developing or an already acquired pressure ulcers from worsening. The DON stated all staff had received recent training related to repositioning.	{F 686}		

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{F 686}	Continued From page 10 The facility policy Repositioning revised date 5/13, directed the purpose of developing an individualized care plan for repositioning is to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. The policy indicated repositioning is critical for a resident who is immobile or dependent upon staff for repositioning.	{F 686}		
{F 812} SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff wore hair coverings in the kitchen to prevent physical contamination of food. This practice had the potential to affect all 38 residents who received	{F 812}	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Staff member DA-A was educated on	7/12/21

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{F 812}	Continued From page 11 food from the kitchen. On 5/19/21, at 7:10 a.m. a sign on the kitchen door indicated hairnets were required to enter. On 5/19/21, at 7:22 a.m. dietary aid (DA)-A was observed exiting the kitchen without hair covering. DA-A was holding a breakfast plate. DA-A was observed entering into the dining room and proceeded to serve an unidentified male resident his breakfast plate. At 7:24 a.m. DA-A stated the box where hairnets were kept was empty, and she had not gone to get more from the storage room. DA-A further stated she should have had a hairnet on prior to entering the kitchen at the start of her shift at 7:00 a.m. DA-A was observed going into the storage room and donned a hairnet. On 5/19/21, at 2:47 p.m. dietary manager (DM)-A stated all dietary staff, as well as facility staff, had recent education to always wearing hairnets when in the kitchen and pantry areas. DM-A further stated his expectation was that anyone entering the kitchen area were required to wear hairnets to prevent any hair from coming into the food to prevent contamination. DM-A verified all dietary staff were aware of where to find hairnets The facility policy Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices Uniform Guidelines dated 10/2017, directed hairnets or caps and /or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens.	{F 812}	wearing hairnets and a corrective action was given to DA-A for violating Hairnet policy. Director of Culinary and Environmental Services immediately filled hairnets at all locations. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? All staff will be re-educated on wearing a hairnet in the kitchen per policy. Immediate corrective action will be conducted if staff are observed not wearing a hair net. New signage stating No entrance into kitchens or pantry□s without a hairnet on and also a phone number of who to call if all hairnets have been used. We will move all hairnet wall racks outside of the kitchen and pantries and install them on the walls just before entrance for easy access and donning prior to entering. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Dining Director and Dining Supervisor or designee will conduct 5 random audits a week using an audit tool from 6/7/2021 to 7/2/21. If all audits pass during this time	

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{F 812}	Continued From page 12	{F 812}	then 2 random monthly audits will be conducted from 7/5/21-9/30/21. Audits will be discussed and monitored by all team members during monthly QAPI meetings. Should any audits result in a failure, this cycle shall start over starting with 7 random audits per week for 2 weeks, 2 random weekly audits for 2 months, and 4 random monthly audits for 3 months until all audits have passed and staff can prove understanding/compliance of the hair net policy.	
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	{F 880}		7/12/21

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{F 880}	Continued From page 13 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	{F 880}		

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{F 880}	Continued From page 14 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene was performed during incontinent cares for 1 of 1 residents (R28) observed during incontinent cares. Findings include: R28's Admission Record printed 5/20/21, indicated R28's diagnoses included Alzheimer's disease with late onset, dementia without behavioral disturbance, and postural kyphosis (curvature of the spine). R28's quarterly Minimum Data Set (MDS) dated 4/14/21, indicated R28 had a moderately impaired cognitive status for daily decisions with short term and long term memory deficits, and had not refusals of care during the assessment period. R28's MDS further indicated R28 required extensive assist with bed mobility, transfers, toilet use and personal hygiene, was always incontinent of urine and frequently incontinent of bowel. R28's care plan initiated 7/24/20, indicated R28 was frequently incontinent of bowel and bladder, and required staff assistance for bed mobility, transfers, personal hygiene, and toilet use. R28's care plan directed staff to check and change R28 every two hours and as needed when in bed and one staff to perform personal hygiene. On 5/17/21, at 3:27 p.m. registered nurse (RN)-D administered acetaminophen to R28 for pain, and	{F 880}	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? R28 did not suffer any adverse effects from the deficient practice. The CNA and RN for R28 was educated on 5/19/2021 by the nurse manager on proper hand hygiene between glove changes during peri care and cleaning appropriate surfaces. All staff providing peri-care will be provided education on hand hygiene with glove use during peri-care, and handling linen and contaminated surfaces. How will the facility identify other residents having the potential to be affected by the same deficient practice? UTI□s and wound infections were reviewed from the last 60 days and validated that peri-care and hand hygiene weren□t contributing factors. All staff who participate in peri care will have education, return demonstration, and monitored with audits by Director of Nursing/designee on hand hygiene between glove changes during peri care. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Hand hygiene and linen handling P&P were reviewed and revised versions were used to educate staff and audit practice. Hand sanitizer stations were placed in appropriate resident rooms on June 4th, 2021. Director of Nursing/designee has	

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{F 880}	Continued From page 15 R28 stated the pain in her butt was very bad. RN-D stated R28 had an open area on her bottom, and she needed to look at it. R28 had been incontinent of a large amount of loose bowel movement (BM). Nursing assistant (NA)-C entered R28's room to assist RN-D. NA-D washed her hands and donned gloves. R28 turned toward her left, NA-C wiped up R28's perineum and buttocks with cleansing wipes, removed her soiled gloves, and without performing hand hygiene, donned clean gloves. RN-D removed her gloves, left the room, returned, washed her hands. NA-C prepared to change the draw sheet under R28, and picked up the bag of wipes to the top of the bed, removed R28's soiled brief from under her, and placed it in a garbage bag on R28's tray table. NA-C cleaned R28's buttocks with a washcloth, and put the washcloth into the plastic bag on R28's tray table. NA-C continued cleaning R28's bottom, dabbed R28's bottom with a dry towel, and wiped a small amount of BM off of the bottom sheet. RN-D and NA-C put on a new bottom sheet. A clean brief was placed under R28. RN-D placed the soiled sheet in the garbage can, removed her gloves and washed her hands. NA-C removed her soiled gloves and washed her hands, then donned clean gloves. RN-D and NA-C positioned R28 on her left side with pillows. RN-D and NA-C put garbage and soiled linens in the garbage bags on the tray table and the garbage can, and RN-D removed the bags from the room. NA-C moved R2's water mug, remote control for the TV, glasses and Kleenex box on the tray table where the bag of soiled brief and linens had been. On 5/17/21, at 3:50 p.m. NA-C verified she should have done hand hygiene between glove changes, should have sanitized R28's tray table	{F 880}	reeducated nursing staff on appropriate hand hygiene between glove changes during peri care and linen handling. Audits will be conducted each shift every day for one week then decrease based upon compliance. Audits will continue until resolved by the QAPI committee with 100% compliance. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Hands-on education provided on hand hygiene with glove use in peri care. Identified concerns will be corrected immediately, documented education will be provided, and audit findings will be submitted to the facility□s QAPI for further monitoring, recommendations, or follow up. Audits will be conducted each shift every day for one week then decrease based upon compliance. Audits will continue until resolved by the QAPI committee with 100% compliance. The administrator will be responsible for obtaining and substantiating substantial compliance.	

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{F 880}	Continued From page 16 where the bag of soiled incontinent brief and wipes had been. On 5/17/21, at 4:50 p.m. the director of nursing (DON) verified staff should wash hands or sanitize hands between glove changes during incontinent cares. The facility policy Handwashing/Hand Hygiene reviewed 8/19, directed all staff were to follow handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The facility policy directed staff to use an alcohol-based hand rub containing 62% alcohol or wash with soap and water and after removing gloves.	{F 880}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UNI6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00066

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/21//2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **67** (L18)
13.Total Certified Beds **67** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 07/26/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/26/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/12/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 2021

CMS Certification Number (CCN): 245370

Administrator
Ecumen North Branch
5379 -383rd Street
North Branch, MN 55056

Dear Administrator:

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 July 12, 2021 the above facility is certified for:

67 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 skilled nursing facility beds

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 2021

Administrator
Ecumen North Branch
5379 -383rd Street
North Branch, MN 55056

RE: CCN: 245370
Cycle Start Date: February 12, 2021

Dear Administrator:

On March 30, 2021, CMS notified you remedies were being imposed. On July 13, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 12, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 14, 2021 be discontinued as of July 12, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 14, 2021. This does not apply to or affect any previously imposed NATCEP loss.
The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UNI6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00066

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/12/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **67** (L18)
13.Total Certified Beds **67** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sativa Bushey, FNE - NE II 03/23/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/08/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 8, 2021

Administrator
Ecumen North Branch
5379 -383rd Street
North Branch, MN 55056

RE: CCN: 245370
Cycle Start Date: February 12, 2021

Dear Administrator:

On February 12, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 12, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by August 12, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245370	A. BUILDING _____ B. WING _____	C 02/12/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 2/8/21, through 2/12/21, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 2/8/21, through 2/12/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5370056C and H5370057C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F 550		4/16/21

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

Electronically Signed | 03/18/2021

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
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F 550	Continued From page 1	F 550		

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conceal a urinary drainage bag from public view for 1 of 3 residents (R194) reviewed for dignity. Findings include: R194's Admission Record printed on 2/11/21, indicated R194's diagnoses included Alzheimer's disease with late onset, dementia without behavioral disturbances, benign prostatic hyperplasia with lower urinary tract symptoms (age-associated prostate gland enlargement that can cause urination difficulty), obstructive and reflux uropathy (urine cannot flow through the ureter, bladder, or urethra due to some type of obstruction), artificial openings of urinary tract (a surgical procedure that creates an opening of the urinary system), and neuromuscular dysfunction of bladder (a bladder which is flaccid or spastic which can cause incontinence, frequency, urgency, and retention). R194's quarterly Minimum Data Set (MDS) dated 12/9/20, indicated R194 was totally dependent on staff for toilet use, and he had an ostomy (type of urinary catheter surgically inserted through the abdomen). R194's Medication Review Report dated 2/11/21, identified R194 had an order for a urinary catheter. R194's care plan reviewed 1/7/21, identified R194 had a supra-pubic catheter (type of urinary catheter surgically inserted through the abdomen). R194's care plan directed staff to	F 550	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? A. All residents affected by this deficient practice were provided catheter bag covers, or current one was applied. The care sheets and care plans were audited to ensure compliance of this practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? A. All residents with catheters have had chart audits to confirm that care plan and care sheets reflect the use of catheter bag coverings and catheter care to ensure compliance. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? A. CNA Shift checklists will be updated to include applying the drainage bag cover and documenting catheter care. B. Audits will be performed on Days and evening shifts daily for 2 weeks, 3 times per week for 2 weeks, and weekly x 4 weeks to ensure completion of the application of the drainage bag cover per care plan. C. All nursing staff will attend one of the mandatory educational meetings	

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F 550	Continued From page 3 check tubing for kinks, patency and ensure it was covered each shift. On 2/8/21, at approximately 5:30 p.m. R194 was seated in the dining room for the evening meal. His urinary drainage bag was hanging under his chair without a privacy cover. On 2/9/21, at 8:42 a.m. R194 was seated in the dining room, his urinary drainage bag did not have a privacy cover. At 11:01 a.m. R194 remained in the dining room, his urinary drainage bag did lacked a privacy cover. On 2/10/21, at 10:10 a.m. registered nurse (RN)-A was interviewed. RN-A verified urinary drainage bags should have privacy covers. On 2/11/21, at 5:10 p.m. the director of nursing (DON) was interviewed. The DON verified urinary drainage bags should be covered for privacy and dignity. The facility policy Quality of Life - Dignity revised 8/09, directed each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy further directed staff shall promote dignity and assist residents as needed by: Helping the resident to keep urinary catheter bags covered.	F 550	regarding catheter care and resident dignity on March 24, 2021 and March 25, 2021. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. A. DON, ADON, or designee will monitor this process weekly for compliance through audits and staff education understanding. B. Routine audits and competencies will continue to be performed annually. C. QAPI committee will monitor audit results for compliance monthly, and determine if additional auditing/education will need to be completed.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		4/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 4 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure walls were in good repair to create a home-like environment for	F 584	1. How corrective action will be accomplished for those residents found to have been affected by the deficient	

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ECUMEN NORTH BRANCH	**5379 -383RD STREET NORTH BRANCH, MN 55056**

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F 584	Continued From page 5 1 of 1 residents (R17) reviewed for room environment. Findings include: R17's Admission Record printed 2/11/21, indicated R17's diagnoses included Alzheimer's disease with late onset, and dementia without behavioral disturbance, R17's admission Minimum Data Set (MDS) dated 12/8/20, indicated R17 was able to understand and be understood. On 2/10/21, at 7:56 a.m. the wall in R17's room was observed to be damaged. The area was approximately two feet by three feet about the height of a chair back. The wall had gray areas were the paint appeared to be scratched off and white areas where the dry wall appeared to be showing. Nursing assistant (NA)-D stated she was not sure how long the damage had been present. At 10:50 a.m. registered nurse (RN)-A was in the room. RN-A stated she did not know if a work request for repair of the wall had been filled out. On 2/11/21, at 9:53 a.m. R17 was interviewed. R17 stated she had noticed the wall was scratched and damaged. R17 stated the damage to the wall was present when she moved in. She stated someone came in and looked at it but it hadn't been fixed yet. R17 stated it didn't look very nice. -at 10:21 a.m. RN-A verified the wall had extensive damage, and again stated she was not sure if a repair ticket had been filled out. -at 10:44 a.m. the environmental services director (ESD)-A was interviewed. ESD-A stated he was	F 584	practice? The residents room that was identified for having the damaged walls was repaired on 02/11/2021. The wall was repaired with spackling and then and any other areas of the wall have been touched up with paint. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Because all residents' rooms are painted and have drywall, all residents have the potential to be affected by the deficient practice. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? An initial 100% audit of all residents rooms will be completed by 3/19/2021 with any damages noted to be repaired immediately. Random audits of 10 rooms weekly will be conducted by the Director of Culinary and Environmental Services or designee for 6 weeks and any repairs will be documented into TELS which is our online work order program. Education will be provided to housekeeping and maintenance staff by 3/22/2021 on how to properly report any damages within a residents room. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. TELS task has been created to be completed bi-weely by the EVS Director or designee to ensure all damage repairs reported were addressed and completed in a timely manner. A TELS task has	

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	245370	A. BUILDING _____ B. WING _____	C 02/12/2021

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F 584	Continued From page 6 unsure if he had a work order for repair. -at 10:56 a.m. ESD-A verified there was not a repair ticket for R17's wall. -at 5:10 p.m. the director of nursing (DON) was interviewed. The DON verified damaged walls were not home-like, and a repair request should have been made.	F 584	been created that the EVS Director or designee inspects all residents rooms on a monthly basis for 3 months to ensure all residents rooms are in good living conditions and results of audits will be brought to the QAPI committee for review.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585		4/16/21

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F 585	Continued From page 7 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and	F 585		

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F 585	Continued From page 8 as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written letter of resolution for grievances, were provided to 2 of 2 residents (R26, R21) reviewed for grievances. Findings include: R26's Admission Record dated 2/11/21, indicated R21's diagnoses included anxiety disorder and major depressive disorder. R26's annual Minimum Data Set (MDS) dated 1/13/21, indicated R26 was cognitively intact, was able to clearly verbalize her needs, understood	F 585	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Social Worker to go back 6 months and fill out a written letter of resolution of grievances for residents R26 and R21. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? The facility has identified that all residents have the potential to be affected by this deficient practice. The monthly audits will minimize or eliminate the potential risk by	

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F 585	Continued From page 9 others, and did not display signs or symptoms of delirium, psychosis, behaviors or rejection of care. R26 required extensive assistance with bed mobility, dressing, and personal hygiene. R26 filed the following Resident Concern Reports, or grievances: -5/15/20, R26 was missing her rings, though did not feel they were stolen. After an investigation, R26 was informed the facility was unable to find them. The documentation lacked evidence a written letter of resolution was provided to R26. -10/7/20, R26 was missing three sweatshirts. After the initial investigation, R26 was informed the facility was unable to locate her sweatshirts. R26's sweatshirts were found at a later date. The documentation lacked evidence a written letter of resolution was provided to R26. -10/30/20, R26 had concerns about food being cold and wanted more options, needed more heat in her room, and nursing staff needed more help. Each department addressed her concerns, but the documentation lacked evidence a written letter of resolution was provided to R26. -1/20/21, R26 had concerns about staffing at night and stated it had affected her baths and showers. R26 stated she had not received a bath, and stated staff did not seem to have time when her baths were scheduled. It was determined R26 had had an extra bath during that time frame. The documentation lacked evidence a written letter of resolution was provided to R26. On 2/8/21, at 6:23 p.m. R26 was interviewed and	F 585	quickly identifying any lapse in process. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Policy will be changed to reflect written notices given to all who have grievances. Monthly audits will minimize or eliminate the potential risk by quickly identifying any lapse in process. QAPI will be involved to ensure that they are completed by reviewing the audit documentation. Grievance form will be changed to reflect the need for ensuring that the person who voiced the grievance received a written letter of resolution. The Administrator will be able to ensure that this was completed prior to signing off on the grievance as a copy of the letter will be attached to the grievance form. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. QAPI Action Plan will reflect new policy and monthly audits to continue for 6 months and to ensure this continues. QAPI team to determine when audits can be stopped after 6 months time based on compliance.	

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stated she had lost her rings, and felt they were lost in the sheets. R26 stated the facility had done what they could to look for them, but was hoping her son would move the furniture to look for them underneath. R26 stated she had not received a letter of resolution for any of her grievances from the facility.

R21's Admission Record dated 2/11/21, indicated R21's diagnoses included major depressive disorder.

R21's annual MDS dated 12/29/20, indicated R21 was cognitively intact, was able to clearly verbalize her needs, and understood others. R21's MDS further indicated R21 had no signs or symptoms of delirium, psychosis, behaviors, rejection of care, and was independent or independent with supervision with activities of daily living.

Over the previous 6 months, R21 had filed the following Resident Concern Reports, or grievances:

-8/24/20, R21 expressed concerns her care conference was missed, rugs needed to be washed, she would like more to do, and would like 1:1 visits. Each appropriate department met with R21 and worked to resolve R21's concerns. The documentation lacked evidence a written letter of resolution was provided to R21.

-10/1/20, a housekeeper broke R21's vase and picture frame. The facility addressed R21's concerns, but documentation lacked evidence a written letter of resolution was provided to R21.

-12/18/20, R21 was missing a special pillowcase.

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The facility searched for it, but was unable to find it. The documentation lacked evidence a written letter of resolution was provided to R21.

On 2/8/21, at 6:53 p.m. R21 stated she has had ongoing concerns about the food she is served for her special diet needs. R21 stated she has talked with the dietary manager and social worker several times, and they provide her with some options, but had not liked their resolutions. R26 also stated she had missed a care conference. R21 verified she had not received a written letter of resolution.

On 2/10/21, at 1:33 p.m. the social services director (SS)-A stated they investigate the concern, and verbal resolutions were provided. SS-A verified written letters of resolution for concerns, or grievances, were not provided.

On 2/10/21, at 2:00 p.m. the dietary manager (DM)-A stated he had worked with R21 several times and had provided several options and attempts to resolve R21's concerns. DM-A stated he continued to try to find a resolution.

On 2/11/21, at 12:07 p.m. SS-A stated R21's concerns had slowed down since the ombudsman became involved in September. SS-A stated it had been a long process to try to find a resolution to R21's concerns. SS-A verified R21 had not received any written letters of resolution, only verbal responses.

On 2/11/21, at 5:15 pm. the administrator was interviewed and verified it was not the facility's practice to provide a written letter of resolution for concerns or grievances.

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F 585	Continued From page 12 The facility policy Filing Grievances/Complaints revised 11/10, directed the administrator or designee would make oral reports of findings of the investigation and actions taken within 5 days of the filing of the grievance or complaint to the person filing the grievance or complaint. The policy lacked directives to provide a written letter of resolution to the complainant.	F 585		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed and oral cares were completed for 4 of 4 residents (R10, R17, R194, and R26) who required assistance with hygiene, and were reviewed for activities of daily living. In addition, the facility failed to ensure bathing was completed for 1 of 2 residents (R26) reviewed with bathing concerns. Findings include: R10's Admission Record dated 4/16/20, indicated R10's diagnoses included Parkinson's disease, liver failure, diabetes, and muscle weakness. R10's quarterly Minimum Data Set (MDS) dated 11/27/20, indicated R10 had intact cognition, and required supervision with hygiene.	F 677	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? A. Audits have been completed to ensure that care plans and care sheets reflect shaving and oral care. How will the facility identify other residents having the potential to be affected by the same deficient practice? A. All residents dependent on staff for set up, supervision, or completion of shaving and oral care have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? A. Audits for compliance of shaving and oral care will be completed for nursing staff daily on days and evening for 2 weeks, 3 times per week for 2 weeks, and	4/16/21

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F 677	Continued From page 13 R10's care plan revised 8/24/20, identified R10 had a self-care deficit which required R10 to have her facial hair removed every Wednesday and Saturday, during showers. On 2/8/21, at 6:22 p.m. R10 was observed to have several long white chin hairs which were approximately 1 centimeter (cm.) long. R10 stated she did not like having chin hairs, and preferred to have her chin hairs cut with scissors. On 2/10/21, at 9:38 a.m. R10 was observed to have several white chin hairs approximately 1 cm long. On 2/11/21, at 8:15 a.m. R10 was observed to have several white chin hairs approximately 1 cm. long. During interview, R10 stated she received a shower the night before, but staff was in a hurry and didn't trim her chin hairs. On 2/11/21, at 8:26 a.m. nursing assistant (NA)-A verified R10 had facial hair. NA-A stated the overnight shift assisted R10 get ready for the day earlier that morning. On 2/11/21, at 8:38 a.m. registered nurse (RN)-A stated R10 wanted her chin hairs trimmed with a scissor. RN-A stated staff should trim R10's facial hairs when they noticed them. RN-A verified R10's care plan directed facial hair needed be groomed on shower days, which was the night before, but there was no documentation that verified the shower. On 2/11/21, at 8:47 a.m. the director of nursing (DON) stated staff should offer or assist residents with activities of daily living (ADLs). The DON stated if a resident refused. the nurse needed to	F 677	weekly x 4 weeks to ensure B. CNA shift checklists have been revised to identify staff assistance/completion for resident shaving and oral care for dependent residents. C. Documentation of completion of these tasks will be audited in the documentation section of point of care weekly. D. Nursing and therapy staff will be required to attend a mandatory educational meeting regarding oral cares and shaving on March 24, 2021 and March 25, 2021. E. Razors or shaving devices or oral care devices will be provided to each resident either by family members, social services, or facility order to tailor the type of shaving device or oral care device that would best fit the residents needs. Need for replacement items will be discussed at the quarterly care conference and as needed. F. Routine audits and competency testing for compliance and understanding will continue annually and as needed. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. A. DON, ADON, or designee will review audits weekly to ensure compliance and education is being met. B. Results of audits and compliance with the correction plan will be discussed weekly at an IDT meeting. C. QAPI committee will review audit and compliance results monthly. QAPI committee to determine if an extension of	

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F 677	Continued From page 14 be notified. The facility policy Shaving the Resident revised 10/10, directed the purpose of the procedure is to promote cleanliness and to provide skin care. The policy further directed the following information should be recorded in the resident's medical record: date and time that the procedure was performed. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure and if the resident refused the treatment, the reason(s) why and the interventions taken. R17's Admission Record printed 2/11/21, indicated R17's diagnoses included Alzheimer's disease with late onset. R17's admission MDS dated 12/8/20, indicated R17 required extensive assistance with bed mobility, transfers, dressing, personal hygiene, and toilet use. In addition R17's MDS indicated she was severely cognitively impaired. R17's Care Area Assessment (CAA) for ADLs dated 12/15/20, indicated she was weak and required increased assistance to complete ADLs. Staff were directed to anticipate her needs and assist with completion of ADLs. R17's care plan dated 1/11/21, indicated R17 had an ADL self-care deficit. R17's care plan directed staff to set R17 up for oral cares and grooming.	F 677	the audits is needed or if the audits can complete.	

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On 2/10/21, at 7:49 a.m. R17's morning cares were observed with NA-D. NA-D assisted R17 with washing up, brushed her hair, then brought R17 out of her room. R17 was not brought to the sink and/or set up for oral care.

The facility's Documentation Survey Report printed on 2/11/21, for 1/1/21, through 2/11/21, indicated R17 was to have oral care twice a day. R17 had one refusal documented, 35 times she accepted oral care, and 48 times she was not offered oral care.

On 2/11/21, at 9:53 a.m. R17 was interviewed. R17 stated she had not had the opportunity to brush her teeth yet. She stated it was bothering her. R17's documentation indicated she had received oral care at 1:27 p.m. on 2/11/21.

- at 10:21 a.m. RN-A was interviewed. RN-A verified R17 should be set up for oral care. RN-A stated it might not be getting done, because staff were rushing to get everyone up for the day, and ready for breakfast.

R194's Admission Record printed on 2/11/21, indicated R194's diagnoses included Alzheimer's disease with late onset, and hemiplegia and hemiparesis (muscle weakness or partial paralysis one side of the body) following cerebral infarction (stroke) affecting right dominant side, and contracture of right hand.

R194's quarterly MDS dated 12/9/20, indicated R194 was totally dependent on staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. R194's MDS further indicated he was severely cognitively impaired.

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R194's care plan reviewed 1/7/21, identified R194 had an ADL self-care performance deficit. Staff were directed to assist with upper and lower body washing, oral cares, and grooming. It was noted he would decline shaving frequently, but staff were to offer shaving daily.

On 2/9/21, at 10:43 a.m. R194 stated he didn't get his teeth brushed yet today. R194 was observed with orange and red stains around his mouth and lips. R194 stated he had orange and cranberry juice with breakfast. R194 had white stubble on his cheeks, chin, and neck. R194 stated he preferred to be clean shaven.

On 2/10/21, at 7:29 a.m. R194's morning cares were observed. NA-D cleansed R194's lower body and dressed R194, combed his hair, and then brought him to the dining room. R194 was not offered oral care, shaving, or hand and face washing.

R194's Documentation Survey Report printed on 2/11/21, for 1/1/21, through 2/11/21, indicated R194 was to be offered oral care twice a day. There were 11 times R194 accepted oral care, 25 times he refused oral care, 1 not applicable, and 46 times he was not offered oral care.

On 2/10/21, at 1:41 p.m. NA-D was interviewed. NA-D verified she did not offer oral care or shaving stating, "He won't let anyone do it."

On 2/11/21, at 10:10 a.m. RN-A was interviewed. RN-A verified oral care should be offered even if the staff think the resident will refuse. RN-A was aware that R194 prefers to be clean shaven, but would often refuse. RN-A stated staff should be

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F 677	Continued From page 17 trying at least weekly to shave him. -at 5:10 p.m. the DON was interviewed. The DON verified staff need to offer/try to get residents to perform oral care and shaving, even if they think the resident will refuse. The facility policy Teeth, Brushing dated 10/10, indicated the purpose of oral care is to clean and freshen the resident's mouth, to prevent infection of the mouth, to maintain the teeth and gums in a healthy condition, to stimulate the gums, and to remove food particles from between the teeth. The policy directed staff to document the time a.m. or p.m., to document refusals, the reason, and the intervention take. The policy further indicated staff were to report to the supervisor if the resident refuses the procedure. R26's Admission Record dated 2/11/21, indicated R26's diagnoses included paraplegia, and muscle weakness. R26's annual MDS dated 1/13/21, indicated R26 was cognitively intact, and required extensive assistance with bed mobility, dressing, and personal hygiene, required physical help in part of bathing activity, and had limited functional ROM of both lower extremities. R26's care plan for ADLs initiated 2/23/20, indicated R26 had an ADL self-care performance deficit, preferred a bath twice weekly on	F 677		

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Wednesday and Saturday evenings, and required extensive assistance by one staff for bathing. R26's care plan directed staff to provide a sponge bath when a full bath or shower could not be tolerated.

R26's undated caresheet directed staff to give R26 a tub bath on Wednesday and Saturday evening shifts.

R26's Documentation Survey Report of tasks for January 2021, indicated R26 received a shower on 1/2/21, 1/16/21, and 1/20/21. R26's report indicated no baths were provided 6 of the 9 scheduled bath days for January 2021.

R26's Documentation Survey Report of tasks for February 2021, indicated R26 had not received either of the 2 scheduled baths or showers between 2/1/20 and 2/9/20, so had not received a bath or shower since 1/20/21.

On 2/8/21, at 6:18 p.m. R26 stated the staff was so short staffed, they couldn't always do her baths or showers. R26 stated she had complained about that. R26 stated she had only one bed bath while quarantined for 24 days, and there was only one staff that knew how to give a proper bed bath. R26 stated she preferred to sit in the bathtub. R26 stated there was only one nursing assistant (NA) on in the evening.

On 2/10/21, at 9:46 a.m. NA-C stated she was unable to complete all cares due to staffing levels. NA-C stated there was usually only one NA on for the afternoon shift on that unit, so some things would most likely not get done.

On 2/10/21, at 3:00 p.m. RN-C stated she works

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F 677	Continued From page 19 as an NA some shifts, and stated they could not always get showers done due to staffing. On 2/11/21, at 10:17 a.m. RN-B stated staff communicate to the nurses if they were unable to get baths done. RN-B verified R26 was to receive a regular bath or shower twice weekly, but it had not been documented as being done the previous couple of weeks.	F 677		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure functional maintenance programs were implemented as directed by the care plan for 5 of 5 residents (R194, R2, R15, R26, and R24).	F 688	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? A. All residents affected by this deficient practice have received chart audits and	4/16/21

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F 688	Continued From page 20 Findings include: R194's Admission Record printed on 2/11/21, indicated R194's diagnoses included Alzheimer's disease with late onset, and hemiplegia and hemiparesis (muscle weakness or partial paralysis one side of the body) following cerebral infarction (stroke) affecting right dominant side, and contracture of right hand. R194's quarterly Minimum Data Set (MDS) dated 12/9/20, indicated R194 had an impairment of one upper extremity, and had not received restorative nursing care programs for range of motion (ROM) or splinting. R194's care plan reviewed 1/7/21, directed a functional maintenance program (FMP) that included complete gentle prolonged stretch of fingers into extension, note do not force. Staff were directed to cue resident to relax fingers and open hand. After ROM apply blue foam roll in palm of his hand. On 9/7/20, occupational therapy (OT) notes indicated R194 was placed on an FMP. The goal was for nursing staff to follow the FMP, resident will report decreased pain in right hand to moderate in order to perform passive ROM (PROM), and reduce contracture related skin breakdown. R194's nursing assistant care sheets directed complete gentle prolonged stretch of fingers into extension, do not force. Cue patient to relax fingers and open hand. Splint placed to hand on a.m. cares off at bedtime. Apply washcloth or pillow case to wick moisture. Document in progress notes. Please place hand splint daily.	F 688	FMP (Functional Maintenance Program) review to ensure the plan of care and care sheets contained the FMP. How will the facility identify other residents having the potential to be affected by the same deficient practice? A. All residents who have FMPs have the risk of being affected by this deficient practice. Chart reviews of these residents have been performed to ensure that the FMP was present on the plan of care and care sheets. B. All residents who have FMPs have been audited to ensure that the FMP plan is posted in the residents rooms if stated in care plan. C. All residents who have FMPs that require equipment (such as splints, AFOs, weights, etc) have been audited to ensure that the equipment is present and accessible in their rooms. D. Therapy staff will be included in audits and reviews of FMPs/Restorative programs. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? A. Nursing and therapy staff will be required to attend a mandatory educational meeting for better understanding of the purpose of FMPs, ROM, PROM, adaptive equipment, frequencies, and documentation of performance on March 24, 2021 and March 25, 2021. B. Routine staff compliance/understanding audits and competency testing for compliance and	

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F 688	Continued From page 21 Documentation Survey Report printed on 2/11/21, for 1/1/21, through 2/11/21, indicated R194 was to have ROM and splint documented twice a day. The documention indicated R194 was not offered ROM or splint 58 times, refused 29 times, and documented as not applicable 6 times. On 2/10/21, at 7:29 a.m. R194's morning cares were observed. R194 was dressed, and transferred into his wheelchair. Nursing assistant (NA)-D combed R194's hair. There was no offer of of oral care, shaving, face and hand washing, or PROM and splint placement. R194's hand splint was visible on his dresser, but was not placed on his right hand. R194 was wheeled to the dining room. -at 10:10 a.m. registered nurse (RN)-A was interviewed. RN-A stated it was difficult to get R194 to cooperate with PROM and wearing his split. RN-A stated, "He just won't wear it, won't do the stretching." RN-A stated it bothered R194 to wear the splint, and it "might possibly be a time factor for staff to attempt." -12:58 p.m. R194 was seated in the dining room, there was no splint on his right hand. -1:41 p.m. NA-D was interviewed and stated she followed the care sheets for knowing how to care for residents. On 2/11/21, at 10:05 a.m. R194 was in his room. There was no splint on his right hand. R194 stated he stated he couldn't open his right hand, but that was "usual." -at 12:43 NA-D was interviewed. NA-D stated she had never seen R194 wear his splint, so that was	F 688	understanding will continue annually. C. Audits on the nursing staff completion of FMPs will be completed daily for 2 weeks, 3 times per week for 2 weeks, and weekly x 4 weeks to ensure compliance has been met. D. Therapy services to audit FMPs quarterly and as needed for resident compliance and changes, equipment replacement, and/or new techniques to institute. How the facility will monitor it□s corrective actions to ensure that the deficient practice is being corrected and will not recur. A. DON, ADON, and/or designee will monitor audits weekly for compliance for 8 weeks. B. Audits will be discussed weekly with the IDT at leadership meetings each Wednesday until compliance is achieved. C. QAPI committee to review compliance monthly and determine completion or extension of audit period.	

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why she didn't try to put it on. NA-D stated if they do try to put it on, he cries out and resists.

-at 1:19 p.m. occupational therapist (OT)-C was interviewed. OT-C stated R194 did not like to wear the splint related to pain. OT-C stated R194 could be verbally and physically abusive. OT-C stated when staff was able to get R194's hand open, it was odorous.

-at 2:01 p.m. NA-E and NA-F were interviewed. Both NA-E and NA-F stated they no longer try to perform PROM or put R194's splint on his right hand. They stated they report his refusal to the nurse.

-at 5:10 p.m. the director of nursing (DON) was interviewed. The DON stated it was her expectation that staff would follow the care plan and perform PROM and the use of splints.

R2's Face Sheet printed 2/11/21, indicated diagnosis that included Parkinson's disease.

R2's quarterly Minimum Data Set (MDS) dated 11/4/20, indicated R2 had moderate cognitive impairment.

R2's care plan dated/revised 2/11/21, indicated

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R2 needed one or two persons to assist him with walking. R2's plan of care included ambulation to and from all meals, and to other activities with a step walker.

R2's Plan of Care Response History was reviewed and indicated R2's ambulation was not conducted at all on the following dates: January 19, 22, 23, 29, 30, 31, and February 1, 2, 4, 6, 7, or 9. Ambulation was reported as "not applicable" on 1/16/21, and 1/17/21. R2 refused to ambulate on 1/26/21.

R15's Face Sheet printed 2/11/21, included diagnoses of cerebral infarction (stroke) with right sided hemiplegia, and contractures of right foot and ankle.

R15's quarterly MDS dated 12/10/20, indicated R15 was cognitively intact.

R15's FMP dated 5/3/19, indicated staff was to perform right lower extremity PROM exercises twice a day, and massage right foot, ankle, twice a day.

R15's treatment record for January 2021, listed prescribed restorative therapies to be done every shift. Therapies included the following restorative cares: dorsiflexion, inversion and eversion, plantar flexion, hip abduction, adduction, hip rotation, flexion/extension left lower extremity (LLE). Active range of motion LLE, PROM right lower extremity (RLE). Gentle massage/stroking to RLE while times when doing PROM. Directions on closet door. For the month of January, 62 opportunities to perform these interventions existed. Interventions were performed 37 times.

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On 2/09/21, at 1:59 p.m. R15 was interviewed and stated she was able to do her exercises without assistance most of the time. This included moving her arms while using one pound weights and changing position in bed. R15 stated she could not move her right leg without assistance.

On 2/10/21, at 7:35 a.m. NA-B stated PROM was not done on R15's right side. NA-B stated, "She is paralyzed on that side. You don't do range of motion on the paralyzed side. There is no point." When asked for clarification NA-B stated, "The paralyzed side does not receive passive range of motion because that side is paralyzed."

On 2/11/21, at 10:40 a.m. R15 stated staff offered to help with exercises "only once or twice a week, if that. They are too busy."

On 2/11/21, at 11:05 a.m. certified occupational therapy assistant (COTA)-C stated R15 had been taught various exercise regimes to help increase her mobility and decrease pain. PROM and massage was prescribed to decrease right leg and foot pain, and R15 needed assistance with massage and PROM. COTA-C stated upper body strengthening exercises were prescribed to increase her mobility and stamina. COTA-C stated R15 had hand weights and has done exercises independently while in bed.

On 2/11/21, at 4:15 p.m. the DON stated PROM should be performed as care planned.

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R26's Admission Record printed 2/11/21, indicated R26's diagnoses included paraplegia, chronic pain, and muscle weakness.

R26's annual MDS dated 1/13/21, indicated R26 was cognitively intact, and had limited ROM to both of her lower extremities. R26's MDS indicated R26 did not participate in a restorative program during the assessment period.

R26's care plan initiated 2/23/20, identified R26 had limited physical mobility. R26's goal was to remain free from complications related to immobility which included contractures, formation of blood clots, and skin breakdown. R26's interventions included an FMP and active ROM, and strengthening exercises of her upper extremities which included completing two sets, 10 repetitions each, three times weekly. R26's care plan further directed R26 was to have ROM completed with a.m. and p.m. care daily.

R26's undated caresheet, directed staff to provide R26's FMP three times weekly, according to Tasks in the electronic medical record (EMR). The caresheet further directed staff to provide bilateral lower extremity passive ROM, twice daily, according to the posted pictures.

R26's FMP dated 11/5/20, directed staff to perform bilateral lower extremity passive ROM,

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twice daily, to maintain bilateral lower extremity ROM. R26's program indicated R26 was able to perform upper extremity and neck ROM independently. Exercises were posted on the door for staff and resident to refer to.

R26's physical therapy progress and discharge summary dated 11/18/20, indicated R26 was able to complete a home exercise program for upper extremities independently. R26 required assistance with her lower extremity FMP. Discharge instructions included a FMP for a ROM program.

R26's January 2021, Documentation Survey Report directed R26 was to have a functional ROM program of 2 sets, of 10 repetitions, completed three times a week on the afternoon/evening shift. R26's report indicated R26's ROM program was documented as completed once on 1/20/21. The report further directed staff to perform bilateral lower extremity passive ROM (performed by staff), twice daily, and ensure R26 was performing upper extremity and neck ROM independently on day shift and afternoon/evening shift. R26's report indicated R26's ROM programs were completed 7 of 62 opportunities, and potentially offered 15 of 62 possible opportunities.

R26's February 2021, Documentation Survey Report directed R26 was to have a functional ROM program of 2 sets, of 10 repetitions, completed three times a week on the afternoon/evening shift. R26's report indicated R26's ROM program was documented as completed once on 2/5/21, between 2/1/21 and 2/10/21. The report further directed staff to perform bilateral lower extremity passive ROM,

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twice daily, and ensure R26 was performing upper extremity and neck ROM independently on day shift and afternoon/evening shift. R26's report indicated R26's ROM programs were completed 1 of 19 opportunities, and potentially offered 5 of 19 possible opportunities through 2/10/21.

On 2/8/21, at 6:40 p.m. R26 stated she was supposed to get exercises for her legs, but no one did them. R26 stated she was unable remember the last time her exercises were done. R26 pointed towards exercises which were posted on her bathroom door.

R24's Admission Record dated 2/11/21, indicated R24's diagnoses included left hip pain, osteoarthritis (inflammation of one or more joints), chronic pain, history of a stroke, and spinal stenosis (condition where spinal column narrows and compresses the spinal cord).

R24's quarterly MDS dated 1/7/21, indicated R24 was cognitively intact, and did not participate in a restorative program.

R24's care plan initiated 5/13/20, directed staff to ambulate R24 in her room, bed-to-door and back, twice daily. Staff were also permitted to walk with R24 in the hallway.

R24's undated caresheet, directed staff to ambulate R24 in her room, from bed-to-door and back, twice daily. The caresheet also indicated staff could walk R24 in the hallway with a wheelchair following. R24's caresheet further directed staff to document, under the Tasks section of the EMR, every time R24 walked.

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R24's Therapist Progress & Discharge Summary dated 5/15/20, indicated R24 was able to walk 20 feet safely with a front wheeled walker, and contact guard assist, on even surfaces. A home exercise program for ambulation and lower extremity strengthening was initiated.

R24's FMP dated 5/20/20, directed staff to ambulate R24 in her room twice daily, from bed-to-door and back, with a walker and assist of one. Additional comments on R24's FMP indicated R24 was slow and needed extra time. R24 could also walk in the hallway as distance increased.

R24's FMP dated 7/15/20, directed R24 was to ambulate twice daily with staff and a 4-wheeled walker.

R24's Documentation Survey Report for December 2020, indicated R24 walked in her room, from bed-to-door and back, or hallway, 5 of 62 opportunities. R24's refused 14 times; was documented not completed/not applicable/not available 5 of 62 opportunities; and, was blank 38 times. R24 walked either in her room, or hallway, an additional 5 times.

R24's Documentation Survey Report for January 2020, indicated R24 walked in her room, from bed-to-door and back, or hallway, 4 of 62 opportunities; R24's refused 7 times; was documented as not applicable/not available 3 times; and, was blank 47 times. R24 walked either in her room, or hallway, an additional 6 times.

R24's Documentation Survey Report for February 2020, indicated R24 walked in her room, from

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bed-to-door and back, or hallway, 0 of 20 opportunities between 2/1/20, and 2/10/20. R24's refused 2 times; was documented as not applicable/not available 1 time; and was blank 17 shifts. R24 walked either in her room, or hallway, 1 time.

R24's Treatment Administration Record (TAR) for December 2020, indicated R24 had ambulated 9 of 33 possible shifts. R24's TAR indicated R24's ambulation was on hold from 12/17/20, afternoon shift through the end of the month.

R24's TAR for January 2021, indicated R24 had not ambulated, and her ambulation was on hold from 1/1/21 through 1/28/21, p.m. shift. Though R24's Documentation Survey Report indicated R24 had ambulated during the time it was on hold.

R24'S TAR for February 2021, indicated R24 ambulated 2 of 20 opportunities.

On 2/8/21, at 5:15 p.m. R24 stated she was on a walking program, but wasn't getting walked during Coronavirus 2019. R24 stated she walked sometimes now, but it was now harder to walk since she wasn't previously walked.

On 2/10/21, at approximately 8:45 a.m. R24 was observed walking in the hallway using a 4-wheeled walker and a wheelchair followed. One staff assisted her.

On 2/10/21, at 9:46 a.m. NA-C stated restorative programs were not getting done. NA-C stated R26's ROM was most likely not getting done, as it was to be done on the afternoon/evening shift, and there was only one NA scheduled for all

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residents during that shift. NA-C stated R26's ROM took a long time to do, and staff did not have time. NA-C stated she was surprised R24 walked that morning, and it had been so long since she had seen R24 walk.

On 2/10/21, at 3:00 p.m. RN-C stated staff was not able to do all the restorative programs due to being short-handed. RN-C stated R26's restorative program does not always get done, but staff tried to do part of the program, when able.

On 2/11/21, at 10:17 a.m. RN-B stated R26 had ROM programs, and was to do the upper extremity exercises herself. RN-B stated NA's had not documented restorative programs recently and felt it was a lack of documentation. RN-B stated the nurse also assured the ROM was getting done and documented it on the TAR, or the nurse was doing the restorative program. RN-B stated NA's had not reported they were not able to get them done.

On 2/11/21, at 2:39 p.m. LPN-A and RN-D stated therapy gave them a restorative programs and they entered them into the TAR. LPN-A and RN-D stated the NA's told them if a resident refused restorative cares, and then they would re-approach the resident. Both LPN-A and RN-B stated if a NA did not say anything to them, they would assume the restorative program was done, and they documented it as being done in the TAR.

On 2/11/21, at 4:32 p.m. the DON stated documentation was not up to par, and when a resident refused, they were to encourage and find alternatives.

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F 688	Continued From page 31 The facility policy Range of Motion Exercises, revised 10/10, directed staff to ensure the resident had an order, check the resident's care plan for special needs, and how to perform range of motion. The facility policy and procedure directed staff what to document in the resident's medical record regarding the ROM exercises performed, and directed staff to notify the supervisor if the resident refused ROM. The facility policy Rehabilitative Nursing Care, revised 7/13, directed the rehabilitative nursing care program is to assist each resident to achieve and maintain their optimal level of self-care and independence, and was to be performed daily for those residents who required the service.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		4/16/21

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F 690	Continued From page 32 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure catheter drainage bags and tubing were kept off the floor for 2 of 3 residents (R17, R194) reviewed for catheters or urinary tract infections. Findings include: R17's Admission Record printed 2/11/21, indicated R17's diagnoses included Alzheimer's disease with late onset, and retention of urine. R17's admission Minimum Data Set (MDS) dated 12/8/20, indicated R17 was severely cognitively impaired. In addition, R17's MDS indicated she had an indwelling catheter, and required extensive assistance of one with toilet use. R17's care plan reviewed on 1/11/21, lacked identification of catheter care.	F 690	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? A. The residents with catheters who have been identified have received audits to confirm that the care plan and care sheets reflect catheter use, proper placement of bag in relation to bladder, and documentation of completed catheter care. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who have catheters are at risk due to this deficient practice. A. Audits will be performed to ensure compliance for catheter care, placement in relation to the bladder, and appropriate placement of the bag. B. Review of infection control monitoring	

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F 690	Continued From page 33 On 2/8/21, at 6:17 p.m. R17 was observed seated in her room. R17's urinary drainage bag was resting on the floor. On 2/10/21, at 7:13 a.m. R17's catheter drainage bag was observed resting on the floor. R194's Admission Record printed on 2/11/21, indicated R194's diagnoses included Alzheimer's disease with late onset, benign prostatic hyperplasia with lower urinary tract symptoms (age-associated prostate gland enlargement that can cause urination difficulty), obstructive and reflux uropathy (urine cannot flow through the ureter, bladder, or urethra due to some type of obstruction), artificial openings of urinary tract (a surgical procedure that creates an opening of the urinary system), and neuromuscular dysfunction of bladder (a bladder which is flaccid or spastic which can cause incontinence, frequency, urgency, and retention). R194's Medication Review Report dated 2/11/21, identified R194 had an order for a urinary catheter. R194's care plan reviewed 1/7/21, identified R194 had a supra-pubic catheter (type of urinary catheter surgically inserted through the abdomen). R194's care plan directed staff to check tubing for kinks, patency and ensure it was covered each shift. On 2/8/21, at approximately 5:30 p.m. R194 was seated in the dining room waiting for the evening meal. R194's catheter drainage bag was observed resting on the floor. On 2/11/21, at 10:10 a.m. registered nurse	F 690	of CAUTI (Catheter Associated Urinary Tract Infections) to identify those residents with catheters who have had a hx of UTI. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? A. Residents who have catheters will be audited for compliance regarding cares and placement, and documentation of catheter care daily for 2 weeks, 3 times per week for 2 weeks, and weekly x 4 weeks to ensure B. All nursing staff will be required to attend an educational meeting regarding catheter care, placement, and infection control practices relating to catheter use on March 24, 2021 or March 25, 2021. C. Routine audits and competency testing for compliance and understanding will continue annually for catheter care. D. CNA shift checklists will be updated to reflect completion of this care area and documentation or completed cares. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. A. DON, ADON, and/or designee will monitor compliance weekly through audit and chart review. B. Administration will be updated on the audit results and compliance of catheter care at IDT weekly meetings. C. QAPI committee will discuss audit findings and compliance monthly to determine if compliance has been met, and if the audit period would need extension.	

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F 690	Continued From page 34 (RN)-A was interviewed. RN-A verified urinary drainage bags should not touch the floor. -at 5:10 p.m. the director of nursing (DON) was interviewed. The DON verified urinary drainage bags should not touch the floor. The facility policy Catheter Care, Urinary dated 9/14, directed staff to be sure the catheter tubing and drainage bag are kept off the floor.	F 690	D. QAPI committee will continue to review CAUTI quarterly to ensure compliance and detect trends. E. Annual infection control mandatory meetings and routine competencies relating to catheter care/placement will continue to ensure staff skills remain compliant.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the oxygen humidifier was changed in a timely manner for 1 of 1 residents (R31) reviewed for respiratory care. Findings include: R32's Admission Record printed on 2/11/21, indicated diagnoses which included chronic diastolic heart failure (a condition in which the heart does not pump blood as well as it should often causing shortness of breath), and dependence on supplemental oxygen.	F 695	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? A. Supplies were changed and labeled for appropriate frequency of weekly change. The identified resident□s orders and tasks were reviewed to ensure they were appropriate. Oxygen supplies (tubing and the humidifier bottle) were audited for an appropriate date of change out. How will the facility identify other residents having the potential to be affected by the same deficient practice?	4/16/21

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F 695	Continued From page 35 R32's admission Minimum Data Set (MDS) dated 1/11/21, indicated R32 was severely cognitively impaired, and was using oxygen therapy. R32's care plan initiated 1/26/21, indicated R32 had altered respiratory status related to history of COVID-19, and pneumonia. The care plan directed staff to use oxygen via nasal cannula with liter flow per physician orders. R32's Medication Review Report dated 2/11/21, indicated R32 was on oxygen 2 liters per nasal cannula continuous. The order included change oxygen tubing weekly every night shift on Tuesday. On 2/8/21, at approximately 4:30 p.m. R32 was lying on his bed wearing nasal cannula. R32's oxygen was set at 2 liters. The oxygen humidifier was dated 1/20/21. On 2/10/21, at 9:00 a.m. R32 was seated in his chair. R32 was not wearing oxygen, the oxygen cannula was off and tucked under his pillow. R32 stated they had changed all of his tubing "today." The oxygen humidifier was dated 1/20/21. On 2/11/21, at 10:32 a.m. registered nurse (RN)-A was interviewed. RN-A stated oxygen tubing, including the humidifier bottle, should be changed weekly. RN-A verified a humidifier bottle dated 1/20/21, was out of date, and should have been changed. -at 5:10 p.m. the director of nursing (DON) was interviewed. The DON verified oxygen tubing and humidifier bottles should be changed weekly. The facility policy Oxygen Administration dated	F 695	A. All residents who use oxygen who could be affected by this deficient practice. B. Residents have received a chart order audit and care sheet audit to ensure that this task is communicated to the staff. C. NOC shift unit checklists were reviewed to ensure that this task is listed as an assigned task on the NOC shift. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? A. Nurses and CNAs from all shifts will attend one of the mandatory educational meetings regarding oxygen supply change out on March 24, 2021 or March 25, 2021. B. Residents (current residents, those with a change of status, and new admissions) who receive oxygen will continue to be identified on the CNA care sheets and in the resident chart/care plan. C. Nurse managers, ADON, and DON will complete a weekly audit to ensure that this task has been completed appropriately. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. A. DON, ADON, or designated assignee will review audits weekly and complete education with staff who have not completed this task appropriately. B. Review of audits during monthly QAPI to ensure compliance has been met. C. QAPI Committee will determine if	

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F 695	Continued From page 36 10/10, lacked indication of frequency of replacing oxygen tubing and humidifier.	F 695	corrective auditing should continue following the 8 week initial period.	
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient staff was available in order to meet the needs of the residents.	F 725	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?	4/16/21

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F 725	Continued From page 37 Findings include: See F677: The facility failed to ensure facial hair was removed and oral cares were completed for 4 of 4 residents (R10, R17, R194, and R26) who required assistance with hygiene, and were reviewed for activities of daily living. In addition, the facility failed to ensure bathing was completed for 1 of 2 residents (R26) reviewed with bathing concerns. See F688: The facility failed to ensure functional maintenance programs were implemented as directed by the care plan for 5 of 5 residents (R194, R2, R15, R26, and R24). On 2/8/21, at approximately 3:00 p.m. R39 was interviewed. R39 was asked about care at the facility, and stated things were, "Not too good." R39 stated service was slow, there was not enough help, and how long he waited for help depended on the day. On 2/8/21, at 5:15 p.m. R24 was interviewed. R24 stated she was on a walking program, but wasn't getting walked consistently. R24 stated she walked sometimes, but it was now harder to walk. -at 6:18 p.m. R26 was interviewed and stated sometimes the facility was so short staffed she did not always get her showers or baths done. R26 stated she had complained to the facility about that. R26 stated she was in her room on quarantine for 24 days, and only got one bed bath during that time. R26 said there was only one staff on during the evening today. R26 also	F 725	a. Five Agency Aides contracted and started the week of 3/1/21 specifically for PMs and NOC shifts to assist in completing the ADLs and functional maintenance programs for those residents identified in the 2567. b. Continued efforts for recruiting staff are ongoing. c. Audits already being completed for noted deficiencies regarding adequate and timely assistance with activities of daily living and restorative nursing services. See plan of corrections for tags F677 and F688 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? . All residents have been identified to potentially be affected by the deficient practice. Audits have been implemented to identify dependent residents with the same care needs. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? . Addendum H in the facility assessment was updated to show staffing levels that will comply with Ecumen□s policy. a. Continued collaboration with centralized scheduling to fill open shifts utilizing current team members and potential agency staff. b. Added incentives have been implemented to recruit and retain staff. c. Prioritization of resident care needs over other tasks as needed. 4. How the facility will monitor its corrective actions to ensure that the	

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F 725	Continued From page 38 stated she had not gotten her leg exercises done as she was supposed to, and she could not remember the last time staff had helped her to get them done. -at 7:17 p.m. R21 was interviewed and stated she did not always get her showers completed due to not having enough staff, and said there was only one staff on duty in the evenings. R21 stated sometimes she has to wait up to an hour when she puts on her call light, and there are times she is in the bathroom during those times, and needs staff assistance. On 2/9/21, at 9:40 a.m. R4 was interviewed and stated she had to wait a long time for staff to answer her call light. She was unsure of how long. Staff Concerns: On 2/10/21, at 10:10 a.m. nursing assistant (NA)-C was interviewed. NA-C stated resident cares were not being done, because there have not been enough staff. NA-C stated residents who were scheduled to be repositioned every two to three hours had not been repositioned on time. NA-C stated R2 had not been walked because they don't have time. NA-C stated residents were not being toileted or checked and changed on time, and skin breakdown had become more of a problem. NA-C stated baths and showers were not being done according to resident care plans. NA-C stated residents have complained that their care is not being done, and they have to wait long to have their call light answered. NA-C stated there were 16 open positions as of 2/10/21. -at 1:47 p.m. NA-D was interviewed. NA-D stated	F 725	deficient practice is being corrected and will not recur. . Monitoring of daily staffing levels will be implemented to ensure that all levels are running below recommended per Addendum H that all efforts are made to recruit staff to come in and fill any empty shifts. Weekly audits using the audit tool will be conducted by the Executive Director or designee to ensure the POC is being followed. Monthly review for 3 months during QAPI will be conducted to ensure the POC is being followed. a. Audits already being completed for noted deficiencies regarding adequate and timely assistance with activities of daily living and restorative nursing services.	

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they used to have four NAs for their wing, now typically have two NAs. NA-D stated "the personal things" don't get done for the residents anymore. NA-D stated "today" with the nurse manager and medication nurse helping them, they were able to get all of the residents repositioned and checked and changed timely. NA-D stated she often has to stay overtime to complete documentation.

- at 2:00 p.m. NA-E was interviewed. NA-E stated staffing on the day shift is best, but the afternoon and night shifts are "struggling." NA-E stated on most day shifts they can get all residents checked and changed and repositioned as ordered, but today they would not have been able to accomplish this if the nurse manager and medication nurse wouldn't have helped them.

-at 2:20 p.m. NA-B was interviewed. NA-B stated due to poor staffing, they have had to rush residents with cares. NA-B stated sometimes the cares are not completed such as baths, showers, shaving, and walks with residents. NA-B stated residents have long waits after putting on the call light.

-at 2:24 p.m. NA-G was interviewed. NA-G stated "tonight" she is the only NA for 14 residents. Two residents require turning every three hours, the rest are on an every two hour turning schedule. Two residents will need to be transferred in/out of bed using a mechanical lift which requires two staff. NA-G stated the medication nurse's main job was to pass medications, but she would help as she is able. NA-G stated three residents need to be assisted with eating, another needs to be coaxed to eat, one resident doesn't eat but is lonely, and he likes her to sit and visit with him. NA-G stated all she can give him for visiting is 10

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minutes. NA-G stated she has two baths tonight which will likely not get done, so will need to do bed baths instead. NA-G stated she would not be able to turn and check and change the residents timely. NA-G stated there was another NA floating between all three units who may be available to help.

-at 2: 44 p.m. registered nurse (RN)-E was interviewed. RN-E stated she would be working with another RN caring for 12 residents. RN-E stated baths and showers don't always get done for the residents.

-at 2:55 p.m. NA-H was interviewed. NA-H stated, "Last night was rough." NA-H stated she would not have gotten through the evening meal without the help of physical therapy (PT) staff who stayed through the evening meal. NA-H stated she had two bath/showers to give last night, but was not able to get them done. NA-H stated she had three bath/showers tonight, and would likely not get them done.

On 2/11/21, at 10:40 a.m. RN-A was interviewed. RN-A stated she had "no control" over the staffing. RN-A stated "sometimes" staff let her know when they can't complete all of the resident cares. RN-A stated she couldn't say how often this occurred over the past month. RN-A stated "maybe" staff have quit coming to tell her about not being able to get their work done.

-at 11:05 a.m. a certified occupational therapy aide (COTA)-C was interviewed. COTA-C stated occupational (OT) and PT staff design restorative therapy programs for residents. Once a program was designed, instruction sheets were created and placed in resident rooms. The NA's assist

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	245370	A. BUILDING _____ B. WING _____	C 02/12/2021

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

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F 725	Continued From page 41	F 725		

residents in performing restorative therapy exercises. COTA-C stated restorative therapy was not being consistently done, and residents have not been assisted with ambulation or exercise programs. COTA-C stated PT and OT staff have tried to help nursing staff with basic cares when staffing is deficient. COTA-C stated, "I try to help with feeding and basic cares when I can. It is frustrating to see staffing so inadequate. It is frustrating to see the residents not receiving restorative care."

-at 4:32 p.m. the director of nursing (DON) and the administrator were interviewed. The administrator stated ideal staffing for all three houses would be six NAs on the day shift, six NAs on evenings, and three NAs on nights. The administrator stated ideally there would be one RN for each unit on the day shift and evening shift, and two RNs for the night shift. The administrator stated there was always a nurse on call. The DON stated staffing had been "hard" so day nurses will stay through the evening meal to help with the meal, and also help with any admissions, deaths, and evening cares. The DON stated when they were short staffed, staff have to re-prioritize the work. The administrator stated they closed one unit related to insufficient staff, and identified they are in a staffing crisis. The administrator stated prior to the COVID-19 outbreak they had ebbs and flows with staffing, but they have lost staff related to COVID-19 and fear. When asked specifically about restorative programs, ambulation and range of motion programs, the DON stated that it was not up to standard, and when residents refused, the staff often moved on, as there was not time to go back and re-approach.

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F 725	Continued From page 42	F 725		

The daily staff posting for 2/8/21, for a census of 44 was as follows:

Night: RN 2, NA 1
Day: RN 3, RN managers 2, NA 5
Evening: RN 3, LPN 1, NA 2

2/9/21, posted staffing;

Night: RN 2, NA 2
Day: RN 3, RN lead 1, RN managers 2, NA 6
Evening: RN 3, LPN 1, NA 3

2/10/21, posted staffing;

Night: LPN 2, NA 2
Day: RN 3, RN lead 1, RN managers 3, NA 6
Evening: RN 4, NA 3

The Centers for Medicare and Medicaid (CMS) form 672 indicated the facility had eight residents dependent on staff for bathing, and 36 residents who required the assistance of two for bathing.
Twelve residents were dependent on staff for toilet use, and 30 residents who required the assistance of two staff for toilet use.
Three residents were dependent on staff for assistance with eating, and eight residents who required some assitance with eating.
Ten residents had unplanned significant weight loss/gain.
Nine residents had pressure ulcers, and of that number only one had a pressure ulcer on admission. Twenty-five residents were receiving preventative skin care.

The Facility Assessment reviewed 2/11/21, indicated the facility's staffing was based on case mix and 2018 Resource Utilization Group scores.

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F 725	Continued From page 43 The facility assessment addendum H was a staffing guideline current as of 2018. The guideline had a staffing pattern for a census 67-49. On 2/10/21, at 9:46 a.m. NA-C stated staffing had been bad. NA-C stated she was unable to complete all cares due to staffing levels. NA-C stated there was usually only one NA on for the afternoon shift on that unit, so some things would most likely not get done. NA-C stated R26's range of motion (ROM) was most likely not getting done, as it was to be done on the afternoon/evening shift, and there was only one NA scheduled during that shift, and it took a long time to do R26's ROM. NA-C stated staff did not have time to do the ROM. NA-C stated she was surprised to see R24 walked that morning, and said it had been so long since she had seen her walk. On 2/10/21, at 3:00 p.m. RN-C stated she worked as an NA some shifts, usually four to five of her seven scheduled shifts per pay period, due to being short-staffed. RN-C stated staff were not able to do all the restorative programs and get showers or baths done, due to being short-handed. RN-C stated they have gotten a small bonus for overtime, but were losing staff.	F 725		

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F 725	Continued From page 44 RN-C stated they were unable to get repositioning done within the time frames. RN-C stated they tried to get the dependent residents done first. RN-C stated she does not have time to complete her document every shift, and gets behind. RN-C stated she would stay over and get her documentation done when working as a nurse. RN-C stated when working as a nurse, she helps the NA's out, but then gets behind with her responsibilities. RN-C stated she tried to do some of R26's ROM program, though is unable to complete it all. RN-C stated therapy staff will sometimes stay over and help them out on the afternoon shift, too. RN-C stated they try to get it all done the best they can for the residents. On 2/11/21, at 10:17 a.m. RN-B stated staff were supposed to communicate to the nurses if they were unable to get baths done. RN-B verified R26 was to receive a regular bath or shower twice weekly, but it had not been documented as being done the past two weeks. RN-B stated the NAs had not documented restorative programs recently, but felt it was due to a lack of documentation rather than not doing the restorative program. RN-B stated the NA's had not reported they were not able to get them done.	F 725		

Electronically delivered
March 8, 2021

Administrator
Ecumen North Branch
5379 -383rd Street
North Branch, MN 55056

Re: State Nursing Home Licensing Orders
Event ID: UNI611

Dear Administrator:

The above facility was surveyed on February 8, 2021 through February 12, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00066	A. BUILDING: _____ B. WING _____	C 02/12/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/8/21, through 2/12/21, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been	2 000		

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2 000	Continued From page 1 assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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2 270	Continued From page 2	2 270		
2 270	MN Rule 4658.0090 Use of Oxygen A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the oxygen humidifier was changed in a timely manner for 1 of 1 residents (R31) reviewed for respiratory care. Findings include: R32's Admission Record printed on 2/11/21, indicated diagnoses which included chronic diastolic heart failure (a condition in which the heart does not pump blood as well as it should often causing shortness of breath), and dependence on supplemental oxygen. R32's admission Minimum Data Set (MDS) dated 1/11/21, indicated R32 was severely cognitively impaired, and was using oxygen therapy. R32's care plan initiated 1/26/21, indicated R32 had altered respiratory status related to history of COVID-19, and pneumonia. The care plan directed staff to use oxygen via nasal cannula with liter flow per physician orders. R32's Medication Review Report dated 2/11/21, indicated R32 was on oxygen 2 liters per nasal cannula continuous. The order included change oxygen tubing weekly every night shift on Tuesday. On 2/8/21, at approximately 4:30 p.m. R32 was	2 270	corrected	4/16/21

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2 270	Continued From page 3 lying on his bed wearing nasal cannula. R32's oxygen was set at 2 liters. The oxygen humidifier was dated 1/20/21. On 2/10/21, at 9:00 a.m. R32 was seated in his chair. R32 was not wearing oxygen, the oxygen cannula was off and tucked under his pillow. R32 stated they had changed all of his tubing "today." The oxygen humidifier was dated 1/20/21. On 2/11/21, at 10:32 a.m. registered nurse (RN)-A was interviewed. RN-A stated oxygen tubing, including the humidifier bottle, should be changed weekly. RN-A verified a humidifier bottle dated 1/20/21, was out of date, and should have been changed. -at 5:10 p.m. the director of nursing (DON) was interviewed. The DON verified oxygen tubing and humidifier bottles should be changed weekly. The facility policy Oxygen Administration dated 10/10, lacked indication of frequency of replacing oxygen tubing and humidifier. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents' oxygen nebulizer equipment is change timely. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 270		

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2 750	Continued From page 4	2 750		
2 750	Mn Rule 4658.0505 D. Responsibilities; DNS; Determine staff levels The written job description for the director of nursing services must include responsibility for: D. determining with the administrator the numbers and levels of nursing personnel to be employed; This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient staff was available in order to meet the needs of the residents. Findings include: See F677: The facility failed to ensure facial hair was removed and oral cares were completed for 4 of 4 residents (R10, R17, R194, and R26) who required assistance with hygiene, and were reviewed for activities of daily living. In addition, the facility failed to ensure bathing was completed for 1 of 2 residents (R26) reviewed with bathing concerns. See F688: The facility failed to ensure functional maintenance programs were implemented as directed by the care plan for 5 of 5 residents (R194, R2, R15, R26, and R24). On 2/8/21, at approximately 3:00 p.m. R39 was interviewed. R39 was asked about care at the facility, and stated things were, "Not too good." R39 stated service was slow, there was not enough help, and how long he waited for help depended on the day.	2 750	corrected	4/16/21

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2 750	Continued From page 5 On 2/8/21, at 5:15 p.m. R24 was interviewed. R24 stated she was on a walking program, but wasn't getting walked consistently. R24 stated she walked sometimes, but it was now harder to walk. -at 6:18 p.m. R26 was interviewed and stated sometimes the facility was so short staffed she did not always get her showers or baths done. R26 stated she had complained to the facility about that. R26 stated she was in her room on quarantine for 24 days, and only got one bed bath during that time. R26 said there was only one staff on during the evening today. R26 also stated she had not gotten her leg exercises done as she was supposed to, and she could not remember the last time staff had helped her to get them done. -at 7:17 p.m. R21 was interviewed and stated she did not always get her showers completed due to not having enough staff, and said there was only one staff on duty in the evenings. R21 stated sometimes she has to wait up to an hour when she puts on her call light, and there are times she is in the bathroom during those times, and needs staff assistance. On 2/9/21, at 9:40 a.m. R4 was interviewed and stated she had to wait a long time for staff to answer her call light. She was unsure of how long. Staff Concerns: On 2/10/21, at 10:10 a.m. nursing assistant (NA)-C was interviewed. NA-C stated resident cares were not being done, because there have not been enough staff. NA-C stated residents	2 750		

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2 750	Continued From page 6 who were scheduled to be repositioned every two to three hours had not been repositioned on time. NA-C stated R2 had not been walked because they don't have time. NA-C stated residents were not being toileted or checked and changed on time, and skin breakdown had become more of a problem. NA-C stated baths and showers were not being done according to resident care plans. NA-C stated residents have complained that their care is not being done, and they have to wait long to have their call light answered. NA-C stated there were 16 open positions as of 2/10/21. -at 1:47 p.m. NA-D was interviewed. NA-D stated they used to have four NAs for their wing, now typically have two NAs. NA-D stated "the personal things" don't get done for the residents anymore. NA-D stated "today" with the nurse manager and medication nurse helping them, they were able to get all of the residents repositioned and checked and changed timely. NA-D stated she often has to stay overtime to complete documentation. - at 2:00 p.m. NA-E was interviewed. NA-E stated staffing on the day shift is best, but the afternoon and night shifts are "struggling." NA-E stated on most day shifts they can get all residents checked and changed and repositioned as ordered, but today they would not have been able to accomplish this if the nurse manager and medication nurse wouldn't have helped them. -at 2:20 p.m. NA-B was interviewed. NA-B stated due to poor staffing, they have had to rush residents with cares. NA-B stated sometimes the cares are not completed such as baths, showers, shaving, and walks with residents. NA-B stated residents have long waits after putting on the call light.	2 750		

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-at 2:24 p.m. NA-G was interviewed. NA-G stated "tonight" she is the only NA for 14 residents. Two residents require turning every three hours, the rest are on an every two hour turning schedule. Two residents will need to be transferred in/out of bed using a mechanical lift which requires two staff. NA-G stated the medication nurse's main job was to pass medications, but she would help as she is able. NA-G stated three residents need to be assisted with eating, another needs to be coaxed to eat, one resident doesn't eat but is lonely, and he likes her to sit and visit with him. NA-G stated all she can give him for visiting is 10 minutes. NA-G stated she has two baths tonight which will likely not get done, so will need to do bed baths instead. NA-G stated she would not be able to turn and check and change the residents timely. NA-G stated there was another NA floating between all three units who may be available to help.

-at 2: 44 p.m. registered nurse (RN)-E was interviewed. RN-E stated she would be working with another RN caring for 12 residents. RN-E stated baths and showers don't always get done for the residents.

-at 2:55 p.m. NA-H was interviewed. NA-H stated, "Last night was rough." NA-H stated she would not have gotten through the evening meal without the help of physical therapy (PT) staff who stayed through the evening meal. NA-H stated she had two bath/showers to give last night, but was not able to get them done. NA-H stated she had three bath/showers tonight, and would likely not get them done.

On 2/11/21, at 10:40 a.m. RN-A was interviewed. RN-A stated she had "no control" over the staffing. RN-A stated "sometimes" staff let her

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know when they can't complete all of the resident cares. RN-A stated she couldn't say how often this occurred over the past month. RN-A stated "maybe" staff have quit coming to tell her about not being able to get their work done.

-at 11:05 a.m. a certified occupational therapy aide (COTA)-C was interviewed. COTA-C stated occupational (OT) and PT staff design restorative therapy programs for residents. Once a program was designed, instruction sheets were created and placed in resident rooms. The NA's assist residents in performing restorative therapy exercises. COTA-C stated restorative therapy was not being consistently done, and residents have not been assisted with ambulation or exercise programs. COTA-C stated PT and OT staff have tried to help nursing staff with basic cares when staffing is deficient. COTA-C stated, "I try to help with feeding and basic cares when I can. It is frustrating to see staffing so inadequate. It is frustrating to see the residents not receiving restorative care."

-at 4:32 p.m. the director of nursing (DON) and the administrator were interviewed. The administrator stated ideal staffing for all three houses would be six NAs on the day shift, six NAs on evenings, and three NAs on nights. The administrator stated ideally there would be one RN for each unit on the day shift and evening shift, and two RNs for the night shift. The administrator stated there was always a nurse on call. The DON stated staffing had been "hard" so day nurses will stay through the evening meal to help with the meal, and also help with any admissions, deaths, and evening cares. The DON stated when they were short staffed, staff have to re-prioritize the work. The administrator stated they closed one unit related to insufficient

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staff, and identified they are in a staffing crisis. The administrator stated prior to the COVID-19 outbreak they had ebbs and flows with staffing, but they have lost staff related to COVID-19 and fear. When asked specifically about restorative programs, ambulation and range of motion programs, the DON stated that it was not up to standard, and when residents refused, the staff often moved on, as there was not time to go back and re-approach.

The daily staff posting for 2/8/21, for a census of 44 was as follows:

Night: RN 2, NA 1
Day: RN 3, RN managers 2, NA 5
Evening: RN 3, LPN 1, NA 2

2/9/21, posted staffing;

Night: RN 2, NA 2
Day: RN 3, RN lead 1, RN managers 2, NA 6
Evening: RN 3, LPN 1, NA 3

2/10/21, posted staffing;

Night: LPN 2, NA 2
Day: RN 3, RN lead 1, RN managers 3, NA 6
Evening: RN 4, NA 3

The Centers for Medicare and Medicaid (CMS) form 672 indicated the facility had eight residents dependent on staff for bathing, and 36 residents who required the assistance of two for bathing. Twelve residents were dependent on staff for toilet use, and 30 residents who required the assistance of two staff for toilet use.
Three residents were dependent on staff for assistance with eating, and eight residents who required some assitance with eating.

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2 750	Continued From page 10 Ten residents had unplanned significant weight loss/gain. Nine residents had pressure ulcers, and of that number only one had a pressure ulcer on admission. Twenty-five residents were receiving preventative skin care. The Facility Assessment reviewed 2/11/21, indicated the facility's staffing was based on case mix and 2018 Resource Utilization Group scores. The facility assessment addendum H was a staffing guideline current as of 2018. The guideline had a staffing pattern for a census 67-49. On 2/10/21, at 9:46 a.m. NA-C stated staffing had been bad. NA-C stated she was unable to complete all cares due to staffing levels. NA-C stated there was usually only one NA on for the afternoon shift on that unit, so some things would most likely not get done. NA-C stated R26's range of motion (ROM) was most likely not getting done, as it was to be done on the afternoon/evening shift, and there was only one NA scheduled during that shift, and it took a long time to do R26's ROM. NA-C stated staff did not have time to do the ROM. NA-C stated she was surprised to see R24 walked that morning, and said it had been so long since she had seen her walk. On 2/10/21, at 3:00 p.m. RN-C stated she worked as an NA some shifts, usually four to five of her seven scheduled shifts per pay period, due to being short-staffed. RN-C stated staff were not able to do all the restorative programs and get showers or baths done, due to being short-handed. RN-C stated they have gotten a small bonus for overtime, but were losing staff. RN-C stated they were unable to get repositioning	2 750		

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done within the time frames. RN-C stated they tried to get the dependent residents done first. RN-C stated she does not have time to complete her document every shift, and gets behind. RN-C stated she would stay over and get her documentation done when working as a nurse. RN-C stated when working as a nurse, she helps the NA's out, but then gets behind with her responsibilities. RN-C stated she tried to do some of R26's ROM program, though is unable to complete it all. RN-C stated therapy staff will sometimes stay over and help them out on the afternoon shift, too. RN-C stated they try to get it all done the best they can for the residents.

On 2/11/21, at 10:17 a.m. RN-B stated staff were supposed to communicate to the nurses if they were unable to get baths done. RN-B verified R26 was to receive a regular bath or shower twice weekly, but it had not been documented as being done the past two weeks. RN-B stated the NAs had not documented restorative programs recently, but felt it was due to a lack of documentation rather than not doing the restorative program. RN-B stated the NA's had not reported they were not able to get them done.

SUGGESTED METHOD OF CORRECTION:
The administrator, DON, or designee, could ensure that adequate policy and procedures are developed for sufficient staffing based on the resident population so residents receive safe, adequate and timely assistance with activities of daily living and restorative nursing services. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for

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2 750	Continued From page 12 further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 750		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure functional maintenance programs were implemented as directed by the care plan for 5 of 5 residents (R194, R2, R15, R26, and R24). Findings include: R194's Admission Record printed on 2/11/21, indicated R194's diagnoses included Alzheimer's disease with late onset, and hemiplegia and hemiparesis (muscle weakness or partial paralysis one side of the body) following cerebral	2 895	corrected	4/16/21

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2 895	Continued From page 13 infarction (stroke) affecting right dominant side, and contracture of right hand. R194's quarterly Minimum Data Set (MDS) dated 12/9/20, indicated R194 had an impairment of one upper extremity, and had not received restorative nursing care programs for range of motion (ROM) or splinting. R194's care plan reviewed 1/7/21, directed a functional maintenance program (FMP) that included complete gentle prolonged stretch of fingers into extension, note do not force. Staff were directed to cue resident to relax fingers and open hand. After ROM apply blue foam roll in palm of his hand. On 9/7/20, occupational therapy (OT) notes indicated R194 was placed on an FMP. The goal was for nursing staff to follow the FMP, resident will report decreased pain in right hand to moderate in order to perform passive ROM (PROM), and reduce contracture related skin breakdown. R194's nursing assistant care sheets directed complete gentle prolonged stretch of fingers into extension, do not force. Cue patient to relax fingers and open hand. Splint placed to hand on a.m. cares off at bedtime. Apply washcloth or pillow case to wick moisture. Document in progress notes. Please place hand splint daily. Documentation Survey Report printed on 2/11/21, for 1/1/21, through 2/11/21, indicated R194 was to have ROM and splint documented twice a day. The documention indicated R194 was not offered ROM or splint 58 times, refused 29 times, and documented as not applicable 6 times.	2 895		

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2 895	Continued From page 14 On 2/10/21, at 7:29 a.m. R194's morning cares were observed. R194 was dressed, and transferred into his wheelchair. Nursing assistant (NA)-D combed R194's hair. There was no offer of of oral care, shaving, face and hand washing, or PROM and splint placement. R194's hand splint was visible on his dresser, but was not placed on his right hand. R194 was wheeled to the dining room. -at 10:10 a.m. registered nurse (RN)-A was interviewed. RN-A stated it was difficult to get R194 to cooperate with PROM and wearing his split. RN-A stated, "He just won't wear it, won't do the stretching." RN-A stated it bothered R194 to wear the splint, and it "might possibly be a time factor for staff to attempt." -12:58 p.m. R194 was seated in the dining room, there was no splint on his right hand. -1:41 p.m. NA-D was interviewed and stated she followed the care sheets for knowing how to care for residents. On 2/11/21, at 10:05 a.m. R194 was in his room. There was no splint on his right hand. R194 stated he stated he couldn't open his right hand, but that was "usual." -at 12:43 NA-D was interviewed. NA-D stated she had never seen R194 wear his splint, so that was why she didn't try to put it on. NA-D stated if they do try to put it on, he cries out and resists. -at 1:19 p.m. occupational therapist (OT)-C was interviewed. OT-C stated R194 did not like to wear the splint related to pain. OT-C stated R194 could be verbally and physically abusive. OT-C stated when staff was able to get R194's hand open, it was odorous.	2 895		

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2 895	Continued From page 15 -at 2:01 p.m. NA-E and NA-F were interviewed. Both NA-E and NA-F stated they no longer try to perform PROM or put R194's splint on his right hand. They stated they report his refusal to the nurse. -at 5:10 p.m. the director of nursing (DON) was interviewed. The DON stated it was her expectation that staff would follow the care plan and perform PROM and the use of splints. R2's Face Sheet printed 2/11/21, indicated diagnosis that included Parkinson's disease. R2's quarterly Minimum Data Set (MDS) dated 11/4/20, indicated R2 had moderate cognitive impairment. R2's care plan dated/revised 2/11/21, indicated R2 needed one or two persons to assist him with walking. R2's plan of care included ambulation to and from all meals, and to other activities with a step walker. R2's Plan of Care Response History was reviewed and indicated R2's ambulation was not conducted at all on the following dates: January 19, 22, 23, 29, 30, 31, and February 1, 2, 4, 6, 7, or 9. Ambulation was reported as "not applicable" on 1/16/21, and 1/17/21. R2 refused to ambulate on 1/26/21. R15's Face Sheet printed 2/11/21, included diagnoses of cerebral infarction (stroke) with right sided hemiplegia, and contractures of right foot and ankle. R15's quarterly MDS dated 12/10/20, indicated	2 895		

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2 895	Continued From page 16 R15 was cognitively intact. R15's FMP dated 5/3/19, indicated staff was to perform right lower extremity PROM exercises twice a day, and massage right foot, ankle, twice a day. R15's treatment record for January 2021, listed prescribed restorative therapies to be done every shift. Therapies included the following restorative cares: dorsiflexion, inversion and eversion, plantar flexion, hip abduction, adduction, hip rotation, flexion/extension left lower extremity (LLE). Active range of motion LLE, PROM right lower extremity (RLE). Gentle massage/stroking to RLE while times when doing PROM. Directions on closet door. For the month of January, 62 opportunities to perform these interventions existed. Interventions were performed 37 times. On 2/09/21, at 1:59 p.m. R15 was interviewed and stated she was able to do her exercises without assistance most of the time. This included moving her arms while using one pound weights and changing position in bed. R15 stated she could not move her right leg without assistance. On 2/10/21, at 7:35 a.m. NA-B stated PROM was not done on R15's right side. NA-B stated, "She is paralyzed on that side. You don't do range of motion on the paralyzed side. There is no point." When asked for clarification NA-B stated, "The paralyzed side does not receive passive range of motion because that side is paralyzed." On 2/11/21, at 10:40 a.m. R15 stated staff offered to help with exercises "only once or twice a week, if that. They are too busy." On 2/11/21, at 11:05 a.m. certified occupational	2 895		

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therapy assistant (COTA)-C stated R15 had been taught various exercise regimes to help increase her mobility and decrease pain. PROM and massage was prescribed to decrease right leg and foot pain, and R15 needed assistance with massage and PROM. COTA-C stated upper body strengthening exercises were prescribed to increase her mobility and stamina. COTA-C stated R15 had hand weights and has done exercises independently while in bed.

On 2/11/21, at 4:15 p.m. the DON stated PROM should be performed as care planned.

R26's Admission Record printed 2/11/21, indicated R26's diagnoses included paraplegia, chronic pain, and muscle weakness.

R26's annual MDS dated 1/13/21, indicated R26 was cognitively intact, and had limited ROM to both of her lower extremities. R26's MDS indicated R26 did not participate in a restorative program during the assessment period.

R26's care plan initiated 2/23/20, identified R26 had limited physical mobility. R26's goal was to remain free from complications related to immobility which included contractures, formation of blood clots, and skin breakdown. R26's interventions included an FMP and active ROM, and strengthening exercises of her upper extremities which included completing two sets, 10 repetitions each, three times weekly. R26's care plan further directed R26 was to have ROM completed with a.m. and p.m. care daily.

R26's undated caresheet, directed staff to provide R26's FMP three times weekly, according to Tasks in the electronic medical record (EMR).

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2 895	Continued From page 18 The caresheet further directed staff to provide bilateral lower extremity passive ROM, twice daily, according to the posted pictures. R26's FMP dated 11/5/20, directed staff to perform bilateral lower extremity passive ROM, twice daily, to maintain bilateral lower extremity ROM. R26's program indicated R26 was able to perform upper extremity and neck ROM independently. Exercises were posted on the door for staff and resident to refer to. R26's physical therapy progress and discharge summary dated 11/18/20, indicated R26 was able to complete a home exercise program for upper extremities independently. R26 required assistance with her lower extremity FMP. Discharge instructions included a FMP for a ROM program. R26's January 2021, Documentation Survey Report directed R26 was to have a functional ROM program of 2 sets, of 10 repetitions, completed three times a week on the afternoon/evening shift. R26's report indicated R26's ROM program was documented as completed once on 1/20/21. The report further directed staff to perform bilateral lower extremity passive ROM (performed by staff), twice daily, and ensure R26 was performing upper extremity and neck ROM independently on day shift and afternoon/evening shift. R26's report indicated R26's ROM programs were completed 7 of 62 opportunities, and potentially offered 15 of 62 possible opportunities. R26's February 2021, Documentation Survey Report directed R26 was to have a functional ROM program of 2 sets, of 10 repetitions, completed three times a week on the	2 895		

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afternoon/evening shift. R26's report indicated R26's ROM program was documented as completed once on 2/5/21, between 2/1/21 and 2/10/21. The report further directed staff to perform bilateral lower extremity passive ROM, twice daily, and ensure R26 was performing upper extremity and neck ROM independently on day shift and afternoon/evening shift. R26's report indicated R26's ROM programs were completed 1 of 19 opportunities, and potentially offered 5 of 19 possible opportunities through 2/10/21.

On 2/8/21, at 6:40 p.m. R26 stated she was supposed to get exercises for her legs, but no one did them. R26 stated she was unable remember the last time her exercises were done. R26 pointed towards exercises which were posted on her bathroom door.

R24's Admission Record dated 2/11/21, indicated R24's diagnoses included left hip pain, osteoarthritis (inflammation of one or more joints), chronic pain, history of a stroke, and spinal stenosis (condition where spinal column narrows and compresses the spinal cord).

R24's quarterly MDS dated 1/7/21, indicated R24 was cognitively intact, and did not participate in a restorative program.

R24's care plan initiated 5/13/20, directed staff to ambulate R24 in her room, bed-to-door and back, twice daily. Staff were also permitted to walk with R24 in the hallway.

R24's undated caresheet, directed staff to ambulate R24 in her room, from bed-to-door and back, twice daily. The caresheet also indicated staff could walk R24 in the hallway with a

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ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

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2 895	Continued From page 20	2 895		

wheelchair following. R24's caresheet further directed staff to document, under the Tasks section of the EMR, every time R24 walked.

R24's Therapist Progress & Discharge Summary dated 5/15/20, indicated R24 was able to walk 20 feet safely with a front wheeled walker, and contact guard assist, on even surfaces. A home exercise program for ambulation and lower extremity strengthening was initiated.

R24's FMP dated 5/20/20, directed staff to ambulate R24 in her room twice daily, from bed-to-door and back, with a walker and assist of one. Additional comments on R24's FMP indicated R24 was slow and needed extra time. R24 could also walk in the hallway as distance increased.

R24's FMP dated 7/15/20, directed R24 was to ambulate twice daily with staff and a 4-wheeled walker.

R24's Documentation Survey Report for December 2020, indicated R24 walked in her room, from bed-to-door and back, or hallway, 5 of 62 opportunities. R24's refused 14 times; was documented not completed/not applicable/not available 5 of 62 opportunities; and, was blank 38 times. R24 walked either in her room, or hallway, an additional 5 times.

R24's Documentation Survey Report for January 2020, indicated R24 walked in her room, from bed-to-door and back, or hallway, 4 of 62 opportunities; R24's refused 7 times; was documented as not applicable/not available 3 times; and, was blank 47 times. R24 walked either in her room, or hallway, an additional 6 times.

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2 895	Continued From page 21 R24's Documentation Survey Report for February 2020, indicated R24 walked in her room, from bed-to-door and back, or hallway, 0 of 20 opportunities between 2/1/20, and 2/10/20. R24's refused 2 times; was documented as not applicable/not available 1 time; and was blank 17 shifts. R24 walked either in her room, or hallway, 1 time. R24's Treatment Administration Record (TAR) for December 2020, indicated R24 had ambulated 9 of 33 possible shifts. R24's TAR indicated R24's ambulation was on hold from 12/17/20, afternoon shift through the end of the month. R24's TAR for January 2021, indicated R24 had not ambulated, and her ambulation was on hold from 1/1/21 through 1/28/21, p.m. shift. Though R24's Documentation Survey Report indicated R24 had ambulated during the time it was on hold. R24'S TAR for February 2021, indicated R24 ambulated 2 of 20 opportunities. On 2/8/21, at 5:15 p.m. R24 stated she was on a walking program, but wasn't getting walked during Coronavirus 2019. R24 stated she walked sometimes now, but it was now harder to walk since she wasn't previously walked. On 2/10/21, at approximately 8:45 a.m. R24 was observed walking in the hallway using a 4-wheeled walker and a wheelchair followed. One staff assisted her. On 2/10/21, at 9:46 a.m. NA-C stated restorative programs were not getting done. NA-C stated R26's ROM was most likely not getting done, as it	2 895		

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2 895	Continued From page 22	2 895		

was to be done on the afternoon/evening shift, and there was only one NA scheduled for all residents during that shift. NA-C stated R26's ROM took a long time to do, and staff did not have time. NA-C stated she was surprised R24 walked that morning, and it had been so long since she had seen R24 walk.

On 2/10/21, at 3:00 p.m. RN-C stated staff was not able to do all the restorative programs due to being short-handed. RN-C stated R26's restorative program does not always get done, but staff tried to do part of the program, when able.

On 2/11/21, at 10:17 a.m. RN-B stated R26 had ROM programs, and was to do the upper extremity exercises herself. RN-B stated NA's had not documented restorative programs recently and felt it was a lack of documentation. RN-B stated the nurse also assured the ROM was getting done and documented it on the TAR, or the nurse was doing the restorative program. RN-B stated NA's had not reported they were not able to get them done.

On 2/11/21, at 2:39 p.m. LPN-A and RN-D stated therapy gave them a restorative programs and they entered them into the TAR. LPN-A and RN-D stated the NA's told them if a resident refused restorative cares, and then they would re-approach the resident. Both LPN-A and RN-B stated if a NA did not say anything to them, they would assume the restorative program was done, and they documented it as being done in the TAR.

On 2/11/21, at 4:32 p.m. the DON stated documentation was not up to par, and when a resident refused, they were to encourage and find

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2 895	Continued From page 23 alternatives. The facility policy Range of Motion Exercises, revised 10/10, directed staff to ensure the resident had an order, check the resident's care plan for special needs, and how to perform range of motion. The facility policy and procedure directed staff what to document in the resident's medical record regarding the ROM exercises performed, and directed staff to notify the supervisor if the resident refused ROM. The facility policy Rehabilitative Nursing Care, revised 7/13, directed the rehabilitative nursing care program is to assist each resident to achieve and maintain their optimal level of self-care and independence, and was to be performed daily for those residents who required the service. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure restorative programs are implemented as care planned to prevent functional declines. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	2 910		4/16/21

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2 910	Continued From page 24 unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure catheter drainage bags and tubing were kept off the floor for 2 of 3 residents (R17, R194) reviewed for catheters or urinary tract infections. Findings include: R17's Admission Record printed 2/11/21, indicated R17's diagnoses included Alzheimer's disease with late onset, and retention of urine. R17's admission Minimum Data Set (MDS) dated 12/8/20, indicated R17 was severely cognitively impaired. In addition, R17's MDS indicated she had an indwelling catheter, and required extensive assistance of one with toilet use. R17's care plan reviewed on 1/11/21, lacked identification of catheter care. On 2/8/21, at 6:17 p.m. R17 was observed seated in her room. R17's urinary drainage bag was	2 910	corrected	

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2 910	Continued From page 25 resting on the floor. On 2/10/21, at 7:13 a.m. R17's catheter drainage bag was observed resting on the floor. R194's Admission Record printed on 2/11/21, indicated R194's diagnoses included Alzheimer's disease with late onset, benign prostatic hyperplasia with lower urinary tract symptoms (age-associated prostate gland enlargement that can cause urination difficulty), obstructive and reflux uropathy (urine cannot flow through the ureter, bladder, or urethra due to some type of obstruction), artificial openings of urinary tract (a surgical procedure that creates an opening of the urinary system), and neuromuscular dysfunction of bladder (a bladder which is flaccid or spastic which can cause incontinence, frequency, urgency, and retention). R194's Medication Review Report dated 2/11/21, identified R194 had an order for a urinary catheter. R194's care plan reviewed 1/7/21, identified R194 had a supra-pubic catheter (type of urinary catheter surgically inserted through the abdomen). R194's care plan directed staff to check tubing for kinks, patency and ensure it was covered each shift. On 2/8/21, at approximately 5:30 p.m. R194 was seated in the dining room waiting for the evening meal. R194's catheter drainage bag was observed resting on the floor. On 2/11/21, at 10:10 a.m. registered nurse (RN)-A was interviewed. RN-A verified urinary drainage bags should not touch the floor.	2 910		

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2 910	Continued From page 26 -at 5:10 p.m. the director of nursing (DON) was interviewed. The DON verified urinary drainage bags should not touch the floor. The facility policy Catheter Care, Urinary dated 9/14, directed staff to be sure the catheter tubing and drainage bag are kept off the floor. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure necessary urinary catheter care and are provided according to the care plan to prevent cross contamination. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and	2 915		4/16/21

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2 915	Continued From page 27 (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed and oral cares were completed for 4 of 4 residents (R10, R17, R194, and R26) who required assistance with hygiene, and were reviewed for activities of daily living. In addition, the facility failed to ensure bathing was completed for 1 of 2 residents (R26) reviewed with bathing concerns. Findings include: R10's Admission Record dated 4/16/20, indicated R10's diagnoses included Parkinson's disease, liver failure, diabetes, and muscle weakness. R10's quarterly Minimum Data Set (MDS) dated 11/27/20, indicated R10 had intact cognition, and required supervision with hygiene. R10's care plan revised 8/24/20, identified R10 had a self-care deficit which required R10 to have her facial hair removed every Wednesday and Saturday, during showers. On 2/8/21, at 6:22 p.m. R10 was observed to have several long white chin hairs which were approximately 1 centimeter (cm.) long. R10 stated she did not like having chin hairs, and preferred to have her chin hairs cut with scissors.	2 915	corrected	

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2 915	Continued From page 28 On 2/10/21, at 9:38 a.m. R10 was observed to have several white chin hairs approximately 1 cm long. On 2/11/21, at 8:15 a.m. R10 was observed to have several white chin hairs approximately 1 cm. long. During interview, R10 stated she received a shower the night before, but staff was in a hurry and didn't trim her chin hairs. On 2/11/21, at 8:26 a.m. nursing assistant (NA)-A verified R10 had facial hair. NA-A stated the overnight shift assisted R10 get ready for the day earlier that morning. On 2/11/21, at 8:38 a.m. registered nurse (RN)-A stated R10 wanted her chin hairs trimmed with a scissor. RN-A stated staff should trim R10's facial hairs when they noticed them. RN-A verified R10's care plan directed facial hair needed be groomed on shower days, which was the night before, but there was no documentation that verified the shower. On 2/11/21, at 8:47 a.m. the director of nursing (DON) stated staff should offer or assist residents with activities of daily living (ADLs). The DON stated if a resident refused. the nurse needed to be notified. The facility policy Shaving the Resident revised 10/10, directed the purpose of the procedure is to promote cleanliness and to provide skin care. The policy further directed the following information should be recorded in the resident's medical record: date and time that the procedure was performed. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure and if the resident refused the	2 915		

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2 915	Continued From page 29	2 915		

treatment, the reason(s) why and the interventions taken.

R17's Admission Record printed 2/11/21, indicated R17's diagnoses included Alzheimer's disease with late onset.

R17's admission MDS dated 12/8/20, indicated R17 required extensive assistance with bed mobility, transfers, dressing, personal hygiene, and toilet use. In addition R17's MDS indicated she was severely cognitively impaired.

R17's Care Area Assessment (CAA) for ADLs dated 12/15/20, indicated she was weak and required increased assistance to complete ADLs. Staff were directed to anticipate her needs and assist with completion of ADLs.

R17's care plan dated 1/11/21, indicated R17 had an ADL self-care deficit. R17's care plan directed staff to set R17 up for oral cares and grooming.

On 2/10/21, at 7:49 a.m. R17's morning cares were observed with NA-D. NA-D assisted R17 with washing up, brushed her hair, then brought R17 out of her room. R17 was not brought to the sink and/or set up for oral care.

The facility's Documentation Survey Report printed on 2/11/21, for 1/1/21, through 2/11/21, indicated R17 was to have oral care twice a day. R17 had one refusal documented, 35 times she accepted oral care, and 48 times she was not offered oral care.

On 2/11/21, at 9:53 a.m. R17 was interviewed. R17 stated she had not had the opportunity to brush her teeth yet. She stated it was bothering her. R17's documentation indicated she had

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2 915	Continued From page 30 received oral care at 1:27 p.m. on 2/11/21. - at 10:21 a.m. RN-A was interviewed. RN-A verified R17 should be set up for oral care. RN-A stated it might not be getting done, because staff were rushing to get everyone up for the day, and ready for breakfast. R194's Admission Record printed on 2/11/21, indicated R194's diagnoses included Alzheimer's disease with late onset, and hemiplegia and hemiparesis (muscle weakness or partial paralysis one side of the body) following cerebral infarction (stroke) affecting right dominant side, and contracture of right hand. R194's quarterly MDS dated 12/9/20, indicated R194 was totally dependent on staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. R194's MDS further indicated he was severely cognitively impaired. R194's care plan reviewed 1/7/21, identified R194 had an ADL self-care performance deficit. Staff were directed to assist with upper and lower body washing, oral cares, and grooming. It was noted he would decline shaving frequently, but staff were to offer shaving daily. On 2/9/21, at 10:43 a.m. R194 stated he didn't get his teeth brushed yet today. R194 was observed with orange and red stains around his mouth and lips. R194 stated he had orange and cranberry juice with breakfast. R194 had white stubble on his cheeks, chin, and neck. R194 stated he preferred to be clean shaven. On 2/10/21, at 7:29 a.m. R194's morning cares were observed. NA-D cleansed R194's lower body and dressed R194, combed his hair, and	2 915		

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2 915	Continued From page 31	2 915		

then brought him to the dining room. R194 was not offered oral care, shaving, or hand and face washing.

R194's Documentation Survey Report printed on 2/11/21, for 1/1/21, through 2/11/21, indicated R194 was to be offered oral care twice a day. There were 11 times R194 accepted oral care, 25 times he refused oral care, 1 not applicable, and 46 times he was not offered oral care.

On 2/10/21, at 1:41 p.m. NA-D was interviewed. NA-D verified she did not offer oral care or shaving stating, "He won't let anyone do it."

On 2/11/21, at 10:10 a.m. RN-A was interviewed. RN-A verified oral care should be offered even if the staff think the resident will refuse. RN-A was aware that R194 prefers to be clean shaven, but would often refuse. RN-A stated staff should be trying at least weekly to shave him.

-at 5:10 p.m. the DON was interviewed. The DON verified staff need to offer/try to get residents to perform oral care and shaving, even if they think the resident will refuse.

The facility policy Teeth, Brushing dated 10/10, indicated the purpose of oral care is to clean and freshen the resident's mouth, to prevent infection of the mouth, to maintain the teeth and gums in a healthy condition, to stimulate the gums, and to remove food particles from between the teeth. The policy directed staff to document the time a.m. or p.m., to document refusals, the reason, and the intervention take. The policy further indicated staff were to report to the supervisor if the resident refuses the procedure.

R26's Admission Record dated 2/11/21, indicated

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2 915	Continued From page 32 R26's diagnoses included paraplegia, and muscle weakness. R26's annual MDS dated 1/13/21, indicated R26 was cognitively intact, and required extensive assistance with bed mobility, dressing, and personal hygiene, required physical help in part of bathing activity, and had limited functional ROM of both lower extremities. R26's care plan for ADLs initiated 2/23/20, indicated R26 had an ADL self-care performance deficit, preferred a bath twice weekly on Wednesday and Saturday evenings, and required extensive assistance by one staff for bathing. R26's care plan directed staff to provide a sponge bath when a full bath or shower could not be tolerated. R26's undated caresheet directed staff to give R26 a tub bath on Wednesday and Saturday evening shifts. R26's Documentation Survey Report of tasks for January 2021, indicated R26 received a shower on 1/2/21, 1/16/21, and 1/20/21. R26's report indicated no baths were provided 6 of the 9 scheduled bath days for January 2021. R26's Documentation Survey Report of tasks for February 2021, indicated R26 had not received either of the 2 scheduled baths or showers between 2/1/20 and 2/9/20, so had not received a bath or shower since 1/20/21. On 2/8/21, at 6:18 p.m. R26 stated the staff was so short staffed, they couldn't always do her baths or showers. R26 stated she had complained about that. R26 stated she had only one bed bath while quarantined for 24 days, and	2 915		

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(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) COMPLETE DATE
2 915	Continued From page 33 there was only one staff that knew how to give a proper bed bath. R26 stated she preferred to sit in the bathtub. R26 stated there was only one nursing assistant (NA) on in the evening. On 2/10/21, at 9:46 a.m. NA-C stated she was unable to complete all cares due to staffing levels. NA-C stated there was usually only one NA on for the afternoon shift on that unit, so some things would most likely not get done. On 2/10/21, at 3:00 p.m. RN-C stated she works as an NA some shifts, and stated they could not always get showers done due to staffing. On 2/11/21, at 10:17 a.m. RN-B stated staff communicate to the nurses if they were unable to get baths done. RN-B verified R26 was to receive a regular bath or shower twice weekly, but it had not been documented as being done the previous couple of weeks. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure grooming, to include removal of facial hair are provided for dependent residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance	21695		4/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00066	A. BUILDING: _____ B. WING _____	C 02/12/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 34 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure walls were in good repair to create a home-like environment for 1 of 1 residents (R17) reviewed for room environment. Findings include: R17's Admission Record printed 2/11/21, indicated R17's diagnoses included Alzheimer's disease with late onset, and dementia without behavioral disturbance, R17's admission Minimum Data Set (MDS) dated 12/8/20, indicated R17 was able to understand and be understood. On 2/10/21, at 7:56 a.m. the wall in R17's room was observed to be damaged. The area was approximately two feet by three feet about the height of a chair back. The wall had gray areas were the paint appeared to be scratched off and white areas where the dry wall appeared to be showing. Nursing assistant (NA)-D stated she was not sure how long the damage had been present. At 10:50 a.m. registered nurse (RN)-A was in the room. RN-A stated she did not know if a work request for repair of the wall had been filled out.	21695	corrected	

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ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

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21695	Continued From page 35 On 2/11/21, at 9:53 a.m. R17 was interviewed. R17 stated she had noticed the wall was scratched and damaged. R17 stated the damage to the wall was present when she moved in. She stated someone came in and looked at it but it hadn't been fixed yet. R17 stated it didn't look very nice. -at 10:21 a.m. RN-A verified the wall had extensive damage, and again stated she was not sure if a repair ticket had been filled out. -at 10:44 a.m. the environmental services director (ESD)-A was interviewed. ESD-A stated he was unsure if he had a work order for repair. -at 10:56 a.m. ESD-A verified there was not a repair ticket for R17's wall. -at 5:10 p.m. the director of nursing (DON) was interviewed. The DON verified damaged walls were not home-like, and a repair request should have been made. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

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	00066	A. BUILDING: _____ B. WING _____	C 02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21880	Continued From page 36	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		4/16/21

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21880	Continued From page 37 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written letter of resolution for grievances, were provided to 2 of 2 residents (R26, R21) reviewed for grievances. Findings include: R26's Admission Record dated 2/11/21, indicated R21's diagnoses included anxiety disorder and major depressive disorder. R26's annual Minimum Data Set (MDS) dated 1/13/21, indicated R26 was cognitively intact, was able to clearly verbalize her needs, understood others, and did not display signs or symptoms of delirium, psychosis, behaviors or rejection of care. R26 required extensive assistance with bed mobility, dressing, and personal hygiene. R26 filed the following Resident Concern Reports, or grievances: -5/15/20, R26 was missing her rings, though did not feel they were stolen. After an investigation, R26 was informed the facility was unable to find them. The documentation lacked evidence a written letter of resolution was provided to R26. -10/7/20, R26 was missing three sweatshirts. After the initial investigation, R26 was informed the facility was unable to locate her sweatshirts.	21880	corrected	

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	00066	A. BUILDING: _____ B. WING _____	C 02/12/2021

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ECUMEN NORTH BRANCH	5379 -383RD STREET NORTH BRANCH, MN 55056

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21880	Continued From page 38	21880		

R26's sweatshirts were found at a later date. The documentation lacked evidence a written letter of resolution was provided to R26.

-10/30/20, R26 had concerns about food being cold and wanted more options, needed more heat in her room, and nursing staff needed more help. Each department addressed her concerns, but the documentation lacked evidence a written letter of resolution was provided to R26.

-1/20/21, R26 had concerns about staffing at night and stated it had affected her baths and showers. R26 stated she had not received a bath, and stated staff did not seem to have time when her baths were scheduled. It was determined R26 had had an extra bath during that time frame. The documentation lacked evidence a written letter of resolution was provided to R26.

On 2/8/21, at 6:23 p.m. R26 was interviewed and stated she had lost her rings, and felt they were lost in the sheets. R26 stated the facility had done what they could to look for them, but was hoping her son would move the furniture to look for them underneath. R26 stated she had not received a letter of resolution for any of her grievances from the facility.

R21's Admission Record dated 2/11/21, indicated R21's diagnoses included major depressive disorder.

R21's annual MDS dated 12/29/20, indicated R21 was cognitively intact, was able to clearly verbalize her needs, and understood others. R21's MDS further indicated R21 had no signs or symptoms of delirium, psychosis, behaviors, rejection of care, and was independent or

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21880	Continued From page 39 independent with supervision with activities of daily living. Over the previous 6 months, R21 had filed the following Resident Concern Reports, or grievances: -8/24/20, R21 expressed concerns her care conference was missed, rugs needed to be washed, she would like more to do, and would like 1:1 visits. Each appropriate department met with R21 and worked to resolve R21's concerns. The documentation lacked evidence a written letter of resolution was provided to R21. -10/1/20, a housekeeper broke R21's vase and picture frame. The facility addressed R21's concerns, but documentation lacked evidence a written letter of resolution was provided to R21. -12/18/20, R21 was missing a special pillowcase. The facility searched for it, but was unable to find it. The documentation lacked evidence a written letter of resolution was provided to R21. On 2/8/21, at 6:53 p.m. R21 stated she has had ongoing concerns about the food she is served for her special diet needs. R21 stated she has talked with the dietary manager and social worker several times, and they provide her with some options, but had not liked their resolutions. R26 also stated she had missed a care conference. R21 verified she had not received a written letter of resolution. On 2/10/21, at 1:33 p.m. the social services director (SS)-A stated they investigate the concern, and verbal resolutions were provided. SS-A verified written letters of resolution for concerns, or grievances, were not provided.	21880		

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21880	Continued From page 40 On 2/10/21, at 2:00 p.m. the dietary manager (DM)-A stated he had worked with R21 several times and had provided several options and attempts to resolve R21's concerns. DM-A stated he continued to try to find a resolution. On 2/11/21, at 12:07 p.m. SS-A stated R21's concerns had slowed down since the ombudsman became involved in September. SS-A stated it had been a long process to try to find a resolution to R21's concerns. SS-A verified R21 had not received any written letters of resolution, only verbal responses. On 2/11/21, at 5:15 pm. the administrator was interviewed and verified it was not the facility's practice to provide a written letter of resolution for concerns or grievances. The facility policy Filing Grievances/Complaints revised 11/10, directed the administrator or designee would make oral reports of findings of the investigation and actions taken within 5 days of the filing of the grievance or complaint to the person filing the grievance or complaint. The policy lacked directives to provide a written letter of resolution to the complainant. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for grievances. The director of nursing (DON), social worker (SW) or designee could review and/or revise the current grievances/concerns policies and procedures to ensure residents receive an appropriate and written resolution. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality	21880		

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21880	Continued From page 41 assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. .	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**09/17/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	**1415 MADISON AVENUE** **DETROIT LAKES, MN 56501**

(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
K 000	INITIAL COMMENTS FIRE SAFETY Building 02 - Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey Emmanuel Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code NFPA 99 IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/16/2020

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 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Emmanuel Nursing Home was built in 1963 as a 1-story building with a partial walkout basement and was determined to be Type II (111) construction. In 1966 addition to the east wing was constructed, are 1-story without basements and are Type II (111) construction. In 1978 an addition to the north of the north wing of the 1963 building was constructed, is 1-story with a partial basement, was determined to be of Type II (000) construction, and is separated with a 2-hour fire barrier. A chapel addition was constructed in 1992 and attached to the south of the 1963	K 000		

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	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**09/17/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	**1415 MADISON AVENUE** **DETROIT LAKES, MN 56501**

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K 000	Continued From page 2 building, is 1-story with a basement and was determined to be of Type II (000) construction. In 1997 a sleeping room addition was constructed to the west of the 1978 addition, is one story without a basement and which is a Type II (111) construction. In 2004 a separate building (building 02) was constructed west of the 1963 main building, is 1-story with a partial basement, which is a Type II (000) construction and separated with a 2-hour fire rated barrier. In 2008 a kitchen expansion was constructed to the south west corner of the 1963 building, is 1-story, full basement and is separated form the new assisted living building with a 2-hour fire barrier and was determined to be Type II (111) construction. In 2014 the Transitional Care was added and was determined to be of Type II (111) construction. The building is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system that includes 30-foot on center corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code". The 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations. The facility has a capacity of 102 beds and had a census of 85 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		

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K 131	Continued From page 3	K 131		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the fire separations was found not to be in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 6.1.14, 8.3.5, and 19.1.3. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 32 of 102 residents, as well as an undetermined number of staff, and visitors.	K 131	1)Contractor Olaf Anderson Construction removed all residential type spray foam used in the space and replaced with commercial Hilti type fire barrier products. - For the small gaps, Hilti FS-One caulking was used. - For the larger gaps, a thermafiber (safing insulation) with a Hilti CFS-SP sealant spray over the top was applied.	10/16/20

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K 131	Continued From page 4 Findings include: 1. On 09/15/2020, at 12:15 p.m. during the facility tour observations revealed that there are multiple through penetrations around conduit, and a 2 1/2 inch be 4 inch opening located above the 2 hour fire barrier leading into the Memory Care Unit. 2. On 09/15/2020, at 12:20 p.m. during the facility tour observations revealed that the facility used a non-compliant expanding spray foam product to fill in penetrations in the 2 hour fire barrier. The expanding spray foam product details stated that the product is for "Type V residential penetration" and the facility is a Type II constructed I occupancy structure. This deficient condition was verified by a Maintenance Supervisor.	K 131	2)Completion date: 10/16/2020. 3)Environmental Services Director responsible for correction and monitoring to prevent reoccurrence.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of	K 321		10/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**09/17/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	**1415 MADISON AVENUE** **DETROIT LAKES, MN 56501**

(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
K 321	Continued From page 5 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 10 of 102 residents. Findings include: On 09/15/2020, at 3:45 p.m. during the facility tour observations revealed that the facility used a non-compliant expanding spray foam product to fill in penetrations located in the 4-A storage room on the lower level of the structure. The expanding spray foam product details stated that the product is for "Type V residential penetration"	K 321	1)Expanding residential spray foam removed by the EVS department and replaced with Hilti commercial grade fire rated caulking. 2)Completion date: 09/16/2020. 3)Environmental Services Director responsible for correction and monitoring to prevent reoccurrence.	

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K 321	Continued From page 6 and the facility is a Type II constructed I occupancy structure. This deficient condition was verified by a Maintenance Supervisor.	K 321		
K 351 SS=J	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed the fire sprinkler system in accordance with NFPA 13 - 2010 edition, Sections 8.5.4, 8.5.4.1.4. This deficient practice potentially affected 32 of the 102 residents. The Facility Administrator was informed on 09/15/2020 at 12:00 p.m., which the missing ceiling tiles in the construction/remodeling area	K 351	1)K351 Non-Compliance has the potential to affect all residents on the Memory Care Unit therefore a unit wide response has been initiated. 2)The facility was notified at 12:00pm on 9/15/2020 by James Anderson, Fire Marshal that there was a concern with the	10/16/20

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EMMANUEL NURSING HOME	**1415 MADISON AVENUE** **DETROIT LAKES, MN 56501**

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K 351	Continued From page 7 will the fire sprinkler response capability and posed an immediate jeopardy to the health and safety of residents. The surveyor confirmed through observations and staff interviews that the immediate jeopardy was removed at 4:27 p.m. on 09/16/2020. Findings include: On 09/15/2020 at 12:00 p.m., observation revealed that upon entering the memory care unit the south and west wings the unit was missing all ceiling tiles except those ceiling tiles that had fire sprinklers and smoke detectors and HVAC intake/exhaust diffusers located in their associated ceiling tiles. It was also noted that the residents in the memory care unit were found to be living in the same construction/remodeling area and that this area had not been provided with any dust or construction separation. When the surveyor questioned the facility Maintenance Supervisor on 09/15/2020 at 12:00 p.m. as to how long have the ceiling tile had been missing he stated that the tiles had been out since the CMS 20-18 memorandum had initiated a facility lock down/shutdown to outside vendors and contractors which did not allow the contractors to complete that construction/remodeling project. The Maintenance Supervisor had also stated that the COVID 19 lock down/shutdown started approximately the end of March and the beginning of April of 2020. The timeline as to how long the ceiling tile had been missing was also verified on 09/15/2020 at 12:05 p.m. by the Facility Administrator. The surveyor also asked why the ceiling tile had been missing from this area and was told by both the Maintenance Supervisor and Administrator that the contractors had removed the ceiling tiles and grid system	K 351	lack of ceiling tile in the south and west corridors on the memory care unit with the potential for causing serious injury or harm to residents in the south and west corridors. James and facility representatives left the unit around 12:45pm and waited for James Anderson to complete phone calls with his supervisor. Around 1:30 it was determined the ceiling tile needed to be installed and/or seal the ceiling lid. 3)The facility immediately: A. Contacted Ben Mallow, project manager for Olaf Anderson construction. Ben indicated Olaf Anderson worked with the DOLI inspector to determine that it was acceptable to leave the ceiling tile off the grid given the CMS 20-18 memo, which directed providers to restrict all visitors and vendors from skilled nursing facilities. B. Danielle Olson, Executive Director and Paul Rudolph, Environmental Services Director coordinated with Olaf Anderson and the facility team to immediately begin placing ceiling tile in the hallways. Tile installation started at approximately 2:00pm. All supply of onsite ceiling tile were installed by 4:00pm on 9/15/2020. C. Ceiling tile subcontractors with Olaf Anderson arrived at around 5:00pm with additional tile. D. Subcontractors began installing tile immediately and areas that did not require	

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K 351	Continued From page 8 from the facility prior to installing the new grid work which then was interrupted by the CMS 20-18 Memorandum. They also state that they had contacted the Project Manager, who had instructed them that the State Building Code Official from the Minnesota Department of Labor and Industry said that it was acceptable to leave the ceiling tile out of place so that an above ceiling inspection could be completed of the newly installed some/fire dampers. The exact date and time of the conversation with the Project Manager and when the facility was told that they could leave the tiles out of place was not given to the surveyor at the time of the Life Safety Code Inspection. When the surveyor questioned the Maintenance Supervisor and the Facility Administrator on 09/15/2020 at 12:30 p.m., why the construction/remodeling area did not have any separation from the rest of the memory care unit and the residents living in that unit they stated that the plans review conducted by the Minnesota Department of Health Engineer did not specifically state or provide direction that this work needed or required any construction/remodeling separation. On 09/17/2020 at 11:35 a.m., the surveyor questioned the Clinical Manager who was working in the memory care unit on how long have the ceiling tile been missing from the memory care unit construction/remodeling project area and she had stated that it was "probably around April when the construction guys were last in the unit." The Clinical Manager was also asked if there had been any special instructions, fire watched, extra fire drills given in the memory care unit or if the emergency procedures had been reviewed with her in regards to the construction/remodeling project, she stated that they had participated in fire drills as normal on a	K 351	specialty cuts were sealed with plastic to create a smoke barrier. Work was completed around 7:30pm. E. Pictures of the completed work were sent at 7:54pm to James Anderson by Paul Rudolph. F. On 9/16/2020 the tile subcontractors completed the reveal cuts and finished the areas that had been sealed with plastic on 9/15/2020. G. Pictures of the completed work were sent at 4:27pm to James Anderson by Paul Rudolph. Facility was in compliance with F351 at 4:27pm on 9/16/2020. H. Fire procedure policy and procedures were reviewed on 9/15/2020 and determined there were no updates to be made. 4)Compliance will be monitored by Paul Rudolph, Environmental Services Director.	

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K 351	Continued From page 9 one per shift per quarter basis, and that she did not know of any fire watches conducted during the time between April and the date of this survey. The surveyor also asked the Clinical Manager if any of the residents located in the memory care unit would be able to participate in an interview and be able to answer any questions regarding the missing ceiling tiles. The Clinical Manager stated that due to the cognitive abilities of the residents that they would not be able to participate in an interview nor be able to accurately answer any questions. On 09/17/2020 during an interview with the Regional Director of Operations, Facility Administrator, and the Maintenance Supervisor, the surveyor asked if the facility had contacted anyone from the Minnesota Department of Health Engineering Department concerning the construction/remodeling project and what actions to take after the CMS 20-18 Memorandum had place a lock down/shutdown of facilities and the ability to have contractors enter their facility and was told that they had not. During this same meeting the Regional Director of Operations, Facility Administrator, and the Maintenance Supervisor were asked if they had contacted their assigned AHJ, Minnesota Deputy State Fire Marshal, and they had state that they had not. During this same meeting the Regional Director of Operations, Facility Administrator, and the Maintenance Supervisor, were asked if they had initiated a fire watch in the memory care unit while the ceiling tile were missing, and was told that the fire sprinkler system had not been taken out of service and was functional which would not trigger the need for a fire watch to be implemented. After the completion of all observations and interviews if was determined that the facility had missing ceiling tiles in the	K 351		

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K 351	Continued From page 10 memory care unit since April 2020, that there were residents in the construction/remodeling areas located in the memory care unit, and that the facility had not contacted anyone from the Minnesota Department of Health Engineering Department or their Minnesota Deputy State fire Marshal representative (AHJ) on what actions should be taken concerning the current unique pandemic situation that was complicated by the directives of the CMS 20-18 Memorandum. At 1:45 p.m., on 09/15/2020, the Facility Administrator and the Maintenance Supervisor were informed that an immediate jeopardy situation was present. They were informed that the missing ceiling tiles located in the memory care unit would severely delay fire protection systems activation. They were also informed that the missing ceiling tiles were in direct violation with the fire sprinkler installation code requirements and that they need to have all the missing ceiling tiles replaced or the ceiling needs to be sealed so that the fire protection systems would function as designed and required in accordance with the applicable codes. At 2:00 p.m., on 09/17/2020, the Regional Director of Operations, Facility Administrator, and the Maintenance Supervisor presented evidence that supported their claim that the immediate jeopardy had been removed. A visual inspection and staff interviews conducted by the surveyor on 09/17/2020 confirmed that all of the missing ceiling tiles had been replaced and installed as per the facility's claims. The Facility Administrator confirmed that she had reviewed all applicable fire safety policies and procedures and that she had determined that no updates to these policies and procedures were needed. The facility's	K 351		

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K 351	Continued From page 11 emergency procedures and policies were also verified on 09/17/2020 as being code complaint by the surveyor as per the facility's claims. The surveyor was presented with the facility's Immediate Jeopardy Removal Plan on 09/17/2020 at 2:15 p.m.	K 351		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for vertical penetrations in the corridors located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.6.2.3.	K 362	1)Contractor Olaf Anderson Construction removed all residential type spray foam used in the space and replaced with commercial Hilti type fire barrier products. - For the small gaps, Hilti FS-One	10/16/20

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K 362	Continued From page 12 This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 32 of 102 residents. Findings include: On 09/15/2020, at 12:15 p.m. during the facility tour observations revealed that the facility used a non-compliant expanding spray foam product to fill in numerous penetrations located in the corridor walls above the ceiling tile grid work located throughout the Memory Care Unit. The expanding spray foam product details stated that the product is for "Type V residential penetration" and the facility is a Type II constructed I occupancy structure. This deficient condition was verified by a Maintenance Supervisor.	K 362	caulking was used. - For the larger gaps, a thermafiber (safing insulation) with a Hilti CFS-SP sealant spray over the top was applied. 2)Completion date: 10/16/2020. 3)Environmental Services Director responsible for correction and monitoring to prevent reoccurrence.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These	K 363		10/16/20

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K 363	Continued From page 13 requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had multiple corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.6.3. This deficient practice could affect 20 of 102 residents. Findings include: 1. On 09/15/2020, at 11:43 a.m. observations revealed that resident room 209 being propped open.	K 363	1) Staff have been educated that the erasers placed to hold a door open is not acceptable. The EVS team is shimming the hinges to keep the doors more balanced. 2)Kick down door hold device on the conference room door was removed by the EVS department. 3)Completion date 9/16/20.	

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K 363	Continued From page 14 2. On 09/15/2020, at 2:54 p.m. observations revealed that the door to the conference room located by the main entrance had a non-code compliant kick down style of door hold device affixed to it. This deficient condition was verified by a Maintenance Supervisor.	K 363	4)Environmental Services Director responsible for correction and monitoring to prevent reoccurrence.	