



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

February 16, 2022

Administrator
Ecumen Hospice
3530 Lexington Avenue North
Shoreview, MN 55126

RE: Event ID: W9KH11

Dear Administrator:

On February 7, 2022 a survey was completed at your facility for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, your agency was found to be in compliance with Federal certification regulations.

Electronically attached is your copy of the Federal Form CMS-2567 indicating your facility's compliance with the Federal regulations.

Thank you for your cooperation.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

PRINTED: 02/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 241557	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2022
NAME OF PROVIDER OR SUPPLIER ECUMEN HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 LEXINGTON AVENUE NORTH SHOREVIEW, MN 55126		
(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	
L 000	<p>INITIAL COMMENTS</p> <p>On 2/7/22, an abbreviated survey was completed at your facility to conduct a complaint investigation to determine compliance with the regulations at 42 CFR Part §418, Conditions of Participation for Hospice Services.</p> <p>Complaints H1557005C (MN78241), H1557006C (MN78245), H1557007C (MN78246), H1557008C (MN78247), H1557009C (MN78248), H1557010C (MN78249), H1557011C (MN78369), H1557012C (MN78376), H1557013C (MN78494), H1557014C (MN78495), H1557015C (MN78496), H1557016C (MN78497), H1557017C (MN78653), H1557018C (MN78654), and H1557019C (MN78655), were reviewed and found to be substantiated with no deficiencies issued.</p> <p>Complaint H1557004C (MN77207), was reviewed and found to be unsubstantiated.</p>	L 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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



Protecting, Maintaining and Improving the Health of All Minnesotans

February 16, 2022

Administrator
Ecumen Hospice
3530 Lexington Avenue North
Shoreview, MN 55126

Re: Event ID: W9KH11

Dear Administrator:

On February 7, 2022, a survey was completed at your agency for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under MN Rule 4664.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 03129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2022
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NAME OF PROVIDER OR SUPPLIER ECUMEN HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 LEXINGTON AVENUE NORTH SHOREVIEW, MN 55126
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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
4 000	<p>Initial Comments</p> <p>An abbreviated hospice survey was conducted as part of a complaint investigation on 2/7/22, by the surveyors from the Minnesota Department of Health (MDH) to determine compliance with MN State Licensing Chapter Rule at 4664, for Hospice Services.</p> <p>Complaints H1557005C (MN78241), H1557006C (MN78245), H1557007C (MN78246), H1557008C (MN78247), H1557009C (MN78248), H1557010C (MN78249), H1557011C (MN78369), H1557012C (MN78376), H1557013C (MN78494), H1557014C (MN78495), H1557015C (MN78496), H1557016C (MN78497), H1557017C (MN78653), H1557018C (MN78654), and H1557019C (MN78655), were reviewed and found to be substantiated with no state licensing tags issued.</p> <p>Complaint H1557004C (MN77207), was reviewed and found to be unsubstantiated.</p>	4 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____