



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 1, 2024

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

RE: CCN: 245370
Cycle Start Date: June 17, 2024

Dear Administrator:

On July 16, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in blue ink that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2024

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

Re: Reinspection Results
Event ID: OQX512

Dear Administrator:

On July 16, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 17, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2024

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

RE: CCN: 245370
Cycle Start Date: June 17, 2024

Dear Administrator:

On June 17, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
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 September 17, 2024 (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 December 17, 2024 (six months after

Ecumen North Branch

June 20, 2024

Page 3

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

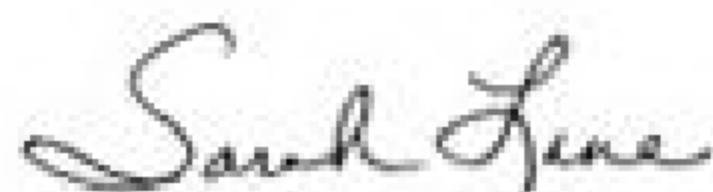
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 07/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245370	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/17/2024
NAME OF PROVIDER OR SUPPLIER ECUMEN NORTH BRANCH			STREET ADDRESS, CITY, STATE, ZIP CODE 5379 -383RD STREET NORTH BRANCH, MN 55056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 6/14/24 and 6/17/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H53704407C (MN00103933) with an incidental finding cited at F656. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths,	F 636		7/10/24	

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

TITLE

(X6) DATE

Electronically Signed

06/30/2024

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 636	<p>Continued From page 1</p> <p>goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:</p> <ul style="list-style-type: none"> (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not</p>	F 636		

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F 636	<p>Continued From page 2</p> <p>apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate fall interventions were provided for 1 of 3 residents (R2) reviewed for resident safety.</p> <p>Findings include:</p> <p>R2's admission Minimum Data Set (MDS) dated 5/20/24 indicated R2 had impaired cognition, was always continent of bladder and bowel, and had a fall prior to entry. R2's diagnoses included dementia and history of falling.</p> <p>R2's nursing assistant Care Sheet undated indicated R2 was at high risk for falls, but the Care Sheet lacked fall interventions.</p> <p>R2's care plan dated 6/10/24 lacked information related to R2's fall risk and fall interventions.</p> <p>A health status note dated 6/12/24 at 10:16 p.m. indicated R2 was found around 5:15 p.m. sitting on his bathroom floor covered in bowel movement.</p> <p>On 6/14/2024 at 11:58 a.m., nurse practitioner (NP)-A stated all residents should have</p>	F 636	<p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>R2 has an updated resident-centered care plan that includes fall prevention plan.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents have been audited for a fall prevention plan within the care plan and fall prevention plan implemented according to individual resident needs as needed.</p> <p>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur?</p> <p>Education will be provided to clinical team members regarding implementation of fall prevention within the resident-centered care plan including specific interventions for the resident.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient</p>	

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F 636	<p>Continued From page 3</p> <p>documented fall interventions. All residents are a fall risk based on previous falls, their current health condition, and/or anxiety related to living in a different environment. If a resident falls, they could sustain a serious injury.</p> <p>On 6/14/2024 at 12:18 p.m., licensed practical nurse (LPN)-A stated she would look in the resident's care plan and on the nursing assistant care sheet to know resident specific fall interventions.</p> <p>On 6/14/2024 at 3:30 p.m., registered nurse (RN)-A stated R2's fall risk assessment indicated high risk for falls. Resident specific fall interventions would be found in the resident's care plan. RN-A confirmed R2's care plan did not include risk for falls or fall interventions.</p> <p>On 6/17/2024 at 2:06 p.m., R2 stated he doesn't not know why he falls, but he does not like falling because he has increased pain after a fall.</p> <p>On 6/17/2024 at 2:40 p.m., LPN-B stated she would look in a resident's care plan for fall risk and fall interventions. LPN-B stated R2 was not a fall risk because he did not have a care plan addressing falls.</p> <p>On 6/17/2024 at 4:30 p.m., RN-B stated a resident's care plan would be updated with a new intervention after a resident fall. It would be hard to know if the care plan was being followed if there is no care plan created. Lack of fall interventions could lead to a resident fall and possible injury.</p> <p>On 6/17/2024 at 3:09 p.m., assistant director of nursing (ADON) stated resident specific fall risk</p>	F 636	<p>practice is being corrected and will not recur?</p> <p>Audit of resident falls will be conducted by DON (or designee) weekly x4 weeks and bi-weekly x4 weeks to monitor for fall prevention plan and interventions within the care plan for each resident that sustains a fall during the audit period. Audit results will be reviewed at QAPI and additional guidance given as needed.</p> <p>Dates corrective action will be completed. July 10, 2024</p>	

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F 636	<p>Continued From page 4</p> <p>and fall interventions would be found in a resident's fall care plan and on nursing assistant care sheets. Every resident needs a fall care plan with interventions specific to the resident. After a fall, the resident's care plan should be updated with the new fall intervention. A resident could fall and sustain an injury if the care plan interventions are not followed. ADON confirmed R2 did not have a fall risk or fall interventions included on the care plan and no fall interventions on the nursing assistant care sheet.</p> <p>The undated Managing Falls and Fall Risk policy directed staff to implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.</p>	F 636		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: OQX511

Dear Administrator:

The above facility was surveyed on June 14, 2024 through June 17, 2024 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.

Ecumen North Branch

June 20, 2024

Page 2

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, Rapid Response
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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2024
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NAME OF PROVIDER OR SUPPLIER ECUMEN NORTH BRANCH	STREET ADDRESS, CITY, STATE, ZIP CODE 5379 -383RD STREET NORTH BRANCH, MN 55056
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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
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 6/14/24 and 6/17/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/30/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2024
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NAME OF PROVIDER OR SUPPLIER ECUMEN NORTH BRANCH	STREET ADDRESS, CITY, STATE, ZIP CODE 5379 -383RD STREET NORTH BRANCH, MN 55056
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2 000	<p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaints were reviewed: H53704407C (MN00103933) with a licensing order issued at 4658.0405 Subp. 3. 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 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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/ib14_1.html> 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p>	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2024
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NAME OF PROVIDER OR SUPPLIER ECUMEN NORTH BRANCH	STREET ADDRESS, CITY, STATE, ZIP CODE 5379 -383RD STREET NORTH BRANCH, MN 55056
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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
2 000	Continued From page 2	2 000		
2 565	<p>MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use</p> <p>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate fall interventions were provided for 1 of 3 residents (R2) reviewed for resident safety.</p> <p>Findings include:</p> <p>R2's admission Minimum Data Set (MDS) dated 5/20/24 indicated R2 had impaired cognition, was always continent of bladder and bowel, and had a fall prior to entry. R2's diagnoses included dementia and history of falling.</p> <p>R2's nursing assistant Care Sheet undated indicted R2 was at high risk for falls, but the Care Sheet lacked fall interventions.</p> <p>R2's care plan dated 6/10/24 lacked information related to R2's fall risk and fall interventions.</p>	2 565	<ul style="list-style-type: none"> How corrective action will be accomplished for those residents found to have been affected by the deficient practice? R2 has an updated resident-centered care plan that includes fall prevention plan. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have been audited for a fall prevention plan within the care plan and fall prevention plan implemented according to individual resident needs as needed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? 	7/10/24

Minnesota Department of Health

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2 565	<p>Continued From page 3</p> <p>A health status note dated 6/12/24 at 10:16 p.m. indicated R2 was found around 5:15 p.m. sitting on his bathroom floor covered in bowel movement.</p> <p>On 6/14/2024 at 11:58 a.m., nurse practitioner (NP)-A stated all residents should have documented fall interventions. All residents are a fall risk based on previous falls, their current health condition, and/or anxiety related to living in a different environment. If a resident falls, they could sustain a serious injury.</p> <p>On 6/14/2024 at 12:18 p.m., licensed practical nurse (LPN)-A stated she would look in the resident's care plan and on the nursing assistant care sheet to know resident specific fall interventions.</p> <p>On 6/14/2024 at 3:30 p.m., registered nurse (RN)-A stated R2's fall risk assessment indicated high risk for falls. Resident specific fall interventions would be found in the resident's care plan. RN-A confirmed R2's care plan did not include risk for falls or fall interventions.</p> <p>On 6/17/2024 at 2:06 p.m., R2 stated he doesn't not know why he falls, but he does not like falling because he has increased pain after a fall.</p> <p>On 6/17/2024 at 2:40 p.m., LPN-B stated she would look in a resident's care plan for fall risk and fall interventions. LPN-B stated R2 was not a fall risk because he did not have a care plan addressing falls.</p> <p>On 6/17/2024 at 4:30 p.m., RN-B stated a resident's care plan would be updated with a new intervention after a resident fall. It would be hard</p>	2 565	<p>Education will be provided to clinical team members regarding implementation of fall prevention within the resident-centered care plan including specific interventions for the resident.</p> <ul style="list-style-type: none"> How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audit of resident falls will be conducted by DON (or designee) weekly x4 weeks and bi-weekly x4 weeks to monitor for fall prevention plan and interventions within the care plan for each resident that sustains a fall during the audit period. Audit results will be reviewed at QAPI and additional guidance given as needed. Dates corrective action will be completed. July 10, 2024 	

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2 565	<p>Continued From page 4</p> <p>to know if the care plan was being followed if there is no care plan created. Lack of fall interventions could lead to a resident fall and possible injury.</p> <p>On 6/17/2024 at 3:09 p.m., assistant director of nursing (ADON) stated resident specific fall risk and fall interventions would be found in a resident's fall care plan and on nursing assistant care sheets. Every resident needs a fall care plan with interventions specific to the resident. After a fall, the resident's care plan should be updated with the new fall intervention. A resident could fall and sustain an injury if the care plan interventions are not followed. ADON confirmed R2 did not have a fall risk or fall interventions included on the care plan and no fall interventions on the nursing assistant care sheet.</p> <p>The undated Managing Falls and Fall Risk policy directed staff to implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise, as necessary, policy and procedures related to care planning. The DON or designee could educate staff on the policy and procedures. The DON or designee could monitor and develop an audit system to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days.</p>	2 565		