DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 17, 2022

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

RE: CCN: 245370
Cycle Start Date: June 23, 2022

Dear Administrator:

On August 11, 2022, the Minnesota Departments 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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 7, 2022

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

RE: CCN: 245370
Cycle Start Date: June 23, 2022

Dear Administrator:

On June 23, 2022, 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"and/or an E tag), i.e., the plan of correction should be directed to:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 23, 2022 (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 23, 2022 (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, Compliance Analyst
Minnesota Department of Health
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 06/23/2022

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 On 6/21/22 - 6/23/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. 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 substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		8/5/22

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

Electronically Signed | 07/15/2022

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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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012	E 041	¿ How corrective action will be accomplished for those residents found to have been affected by the deficient practice?	

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E 041	Continued From page 3 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 6/23/2022 at 9:45 a.m., it was revealed by a review of available documentation of the emergency generator maintenance and testing an annual load bank test was not completed in the last 12 months when the generator did not reach 30%. An interview with Maintenance Director and Executive Director verified these deficient findings at the time of discovery.	E 041	¿ We will conduct an annual load bank test. ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice? ¿ As noted in the 2567 by the State Fire Marshal the alleged deficient practice could have widespread impact on all residents. ¿ What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? ¿ Load bank tests will be put into TELS preventive maintenance where automatic alerts will be set up to help ensure the task will not become overdue. We will ensure the annual load bank test is on contract. ¿ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ Load test inspection will be included in the TELS building preventive maintenance system and set up on an annual basis. The Executive Director, Assistant Executive Director or designee will review the documentation with the Environmental Service Manager annually. ¿ QAPI committee will monitor test results for compliance and determine if additional auditing/education will need to be completed.	
F 000	INITIAL COMMENTS On 6/21/ 22 -6/23/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility	F 000		

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F 000	Continued From page 4 was found to be 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 SUBSTANTIATED H5370064C (MN75345), H5370063C (MN82102) however NO deficiencies were cited due to actions implemented by the facility prior to survey: 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		8/5/22

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F 578	Continued From page 5 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their system of red and green dots for identifying code status matched the resident's Provider Order for Life Sustaining Treatment (POLST) for 1 of 1 residents (R14) reviewed for advance directives. Findings include: R14's Admission Record printed on 6/22/22, indicated R14's diagnoses included an encounter	F 578	¿ How corrective action will be accomplished for those residents found to have been affected by the deficient practice? ¿ The red and green dot system was discontinued and removed from each resident's doors on 6/21/2022. 100% chart review of resident□s charts was completed to ensure an updated code status is in place. ¿ How the facility will identify other	

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F 578	Continued From page 6 for palliative care, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), ischemic cardiomyopathy (the heart's ability to pump blood is decreased), and depression. R14's care plan revised on 6/9/22, indicated R14's wishes were for do not resuscitate (DNR) and would be reviewed with resident and family as needed. R14's Active Order Status dated 6/23/22, identified DNR and comfort cares as of 6/21/22. On 6/21/22, at 4:25 p.m. nursing assistant (NA)-A stated the green dots on the name plate outside each resident's room meant the resident wanted to have cardiopulmonary resuscitation (CPR). On 6/21/22, at 4:30 p.m. R14's name plate outside his room had a green dot under his name. On 6/21/22, at 5:31 p.m. registered nurse (RN)-A stated the red and green dots were meant to be a quick look for CPR. RN-A went on to state the staff knew R14 was on hospice. RN-A stated she would look in the computer for code status and would check the POLST in the hard chart and not rely solely on the dots. RN-A verified there was a green dot on R14's door. RN-A stated "that's not right", she stated R14 recently decided to go into hospice care and the dot on the door had not been updated. On 6/21/22, at 5:35 p.m. licensed practical nurse	F 578	residents having the potential to be affected by the same deficient practice? ¿ All residents had the red dot and green dot system in place and could have been affected by the alleged deficient practice. ¿ The red and green dot system was discontinued and removed from each resident's doors on 6/21/2022. 100% chart review of resident□s charts was completed to ensure an updated code status is in place. ¿ What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? ¿ 100% Dot system removal from all residents□ doors. ¿ Training with staff during mandatory in-service on 7/21/22 to educate about removal of the dot system. ¿ Educate staff at mandatory in-service on 7/21/22 about the new process and what to do in the event of a potential code and where/how to find the current code status. ¿ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ DON, Nurse Manager or designee will monitor this process for compliance by auditing 25% of the residents each week for four weeks. Routine audits and competencies will continue to be performed quarterly and annually thereafter. ¿ QAPI committee will monitor audit results for compliance monthly for three months and determine if additional	

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F 578	Continued From page 7 (LPN)-A stated she did not know what the red and green dots on the door meant. RN-B was standing nearby and volunteered the following information about the red and green dots; the doors were not up to date but were meant to signify if the resident wanted to have CPR or not. LPN-A then pulled out a chart and stated staff needed to physically look at the POLST in the chart. Both nurses stated the POLST was the place to look for code status, not the residents' doors. On 6/21/22, at 5:44 p.m. LPN-B stated the red and green dots were meant to help guide staff to CPR or DNR, but she would check the POLST in the hard chart. LPN-B went to look at R14's door and the dot had been changed to red. On 6/22/22, at 7:47 a.m. R14's door no longer had any dots. On 6/22/22, at 12:32 p.m. RN-B stated the policy had been reviewed and the dots were not part of the policy so all the name plates were changed to remove all dots. RN-B stated the policy had always been to check POLST no matter what color dot was on the door. On 6/22/22, at 2:24 p.m. the administrator stated they had changed the system because of the error that was found (the dot didn't reflect the updated POLST). The facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation revised 2/2018, did not address the use of red and/or green dots on the resident's name plate outside their door.	F 578	auditing/education will need to be completed.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment	F 584		8/5/22

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F 584	Continued From page 8 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. 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	F 584		

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	245370	A. BUILDING _____ B. WING _____	C 06/23/2022

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F 584	Continued From page 9 §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 clean and maintain sheepskin coverings on resident equipment for 1 of 3 residents (R19) reviewed for sheepskin covers on equipment. Findings include: R19's Admission Record printed on 6/23/22, indicated R19's diagnoses included hemiplegia (paralysis of one side of the body) affecting the left non-dominant side, abnormal posture, low back pain, dementia, and history of traumatic brain injury. R19's quarterly Minimum Data Set (MDS) dated 5/6/22, indicated R19 was moderately cognitively intact and required extensive assistance with activities of daily living. In addition, R19's MDS indicated he was at risk for pressure ulcers. R19's care plan last reviewed on 7/11/21, did not address the sheepskin covers for his wheelchair arms. R19's skin assessment dated 6/22/22, indicated R19 had scattered bruises to bilateral arms, wrists, and top of hands. R19's Order Summary Report printed 6/23/22, indicated R19 was on clopidogrel bisulfate (a blood thinner medication used to prevent heart attack or stroke). The medication had the potential to cause bruising if R19 bumped his	F 584	¿ How corrective action will be accomplished for those residents found to have been affected by the deficient practice? ¿ Sheepskin to R19□s arm rests were replaced on 6/23/22 with new sheepskin and adhesive velcro strips that can be hidden and easily removed/replaced. Manufacturer's instruction reviewed and stated sheepskin in use at this time is washable, however new sheepskin had already been applied, washing to occur on a scheduled basis and added to TAR. ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All residents who are requiring lambswool/sheepskin or skin integrity preventative accessories application to the wheelchair or a surface could have the potential to be affected. ¿ House-wide wheelchair audit completed, sheepskin removed when not clinically necessary. Remaining residents with sheepskin added to washing schedule. ¿ What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? ¿ Education to nursing and therapy staff at mandatory in-service on 7/21/22 to notify nurse management when sheepskin is added so that proper housekeeping can be implemented for those residents.	

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F 584	Continued From page 10 arm. On 6/21/22, at 1:38 p.m. R19's sheepskin on the arms of his wheelchair looked gray, was matted down, and attached to the arms of his wheelchair with Kerlix (bandage roll). R19 stated they looked "dirty" to him and added, "they never change them." On 6/23/22, at 10:00 a.m. R19's sheepskin on the arms of his wheelchairs remained unchanged. R19 stated the sheepskin no longer gave him any padding, should be changed, and added they never changed or washed them. On 6/23/22, at 10:04 a.m. nursing assistant (NA)-B stated she was not aware of any process to ensure the sheepskins would get cleaned or replaced. NA-B looked at the sheepskin on the arms of R19's wheelchair and verified they were secured with Kerlix. NA-B stated, "they're kind of grimy" and should have been replaced. On 6/23/22, at 10:09 a.m. NA-C stated she was unsure how sheepskin padding was cleaned. NA-C looked at R19's sheepskin padding on the arms of his wheelchair and said, "they look dingy, they should be replaced". On 6/23/22, at 10:20 a.m. licensed practical nurse (LPN)-C stated the nurse managers generally put the orders in the computer for sheepskin padding. The sheepskin padding should have been in the computer as an order to be changed on bath days. LPN-C looked at the sheepskin padding on the arms of his wheelchair arms and noted they were attached by using Kerlix and were matted and gray. LPN-C verified they were "dirty" and stated he needed them to prevent bruises as he	F 584	¿ House-wide wheelchair audit completed, sheepskin removed when not clinically necessary. Remaining residents with sheepskin added to washing schedule. ¿ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ Weekly audit tool will be used for four weeks to monitor for compliance of weekly washing and effectiveness of sheepskin and then bi-weekly thereafter for another two months. ¿ QAPI committee will monitor audit results for compliance monthly for three months and determine if additional auditing/education will need to be completed.	

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F 584	Continued From page 11 tended to bump his arms and was on a blood thinner. LPN-C verified there were no orders in the computer and there was nothing in his care plan to direct staff to change or wash the sheepskin padding. On 6/23/22, at 10:29 a.m. registered nurse (RN)-B and the director of nursing (DON) verified the sheepskin on R19's wheelchair arms needed to be replaced as they were gray, matted, worn, and attached with Kerlix. A policy on care of sheepskin was requested but not provided.	F 584		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure implementation of care planned fall interventions for 1 of 2 residents (R4) reviewed for accidents. Findings include: R4's Admission Record printed on 6/22/22, indicated R4's diagnoses included Alzheimer's disease, dementia, age-related osteoporosis (a condition in which bones become weak and	F 689	¿ How corrective action will be accomplished for those residents found to have been affected by the deficient practice? ¿ Identified resident R4□s bed was immediately placed in the low position and R4 was educated on the risk of injury. Care plan updated. ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice?	8/5/22

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F 689	Continued From page 12 brittle), moderate protein-calorie malnutrition, chronic pain syndrome, schizophreniform disorder (psychotic disorder that affects how a person acts, thinks, and relates to others), history of falling, and glaucoma (a group of eye conditions that can cause blindness). R4's significant change Minimum Data Set (MDS) dated 3/25/22, indicated R4 was severely cognitively impaired. R4's MDS indicated she had moderate hearing difficulty and did not wear hearing aides and was able to understand and be understood. R4's MDS indicated she required extensive assistance with activities of daily living. R4's care plan revised on 10/30/20, indicated R4 was at risk for falls related to pain, weakness, impaired cognition, impaired mobility, antidepressant medication, and history of delusions and hallucinations. R4's interventions included spending time in the common area in a recliner, routine checks, anticipate needs, follow the facility fall protocol, be sure the resident's call light was within reach and encourage the resident to use it, and keep the bed in low locked position. On 6/21/22, at 1:21 p.m. R4 was in bed, the bed was in the high position (at about waist level for staff standing next to the bed). No staff were in the room. On 6/22/22, at 7:20 a.m. R4 was in bed, the bed was in the high position, the lights were off, the blinds were shut, she was talking out loud but no one was in the room. On 6/22/22, at 9:00 a.m. R4 was in bed eating her breakfast her overbed table was across the bed and in front of her. R4's bed was in the high	F 689	¿ Audit completed of current resident care plans to ensure bed height is care planned appropriately. ¿ What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? ¿ Education for staff during mandatory in-service on 7/21/22 about safe functional bed height and proper reflection in care plan. ¿ Education to the identified resident about the risk for injury associated with potential fall from keeping bed in a high position. ¿ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ A weekly audit tool will be used for four weeks and then monthly thereafter for another two months to ensure bed heights are within safe heights according to care plans. ¿ QAPI committee will monitor audit results for compliance monthly for three months and determine if additional auditing/education will need to be completed.	

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F 689	Continued From page 13 position. Nursing Assistant (NA)-D was in the room and removed the breakfast tray. Outside of the room NA-D was asked about the bed being in the high position; NA-D stated R4 "messes with her bed all day" and concluded by stating the bed was sometimes in the high position. NA-D did not go back into the room and lower the bed. On 6/22/22, at 9:48 a.m. R4 was in bed, the bed was in the high position, lights off, shades pulled. On 6/22/22, at 10:42 a.m. R4 was in bed, the bed remained in the high position. On 6/22/22, at 12:30 p.m. R4 was in bed, the bed was in the high position, lights off, shades pulled, and overbed table in front of her. On 6/22/22, at 1:00 p.m. R4 was in bed, an unidentified staff member brought in a snack, the bed was in the high position, the staff member did not lower the bed. On 6/22/22, at 1:12 p.m. NA-D stated to prevent residents from falls staff should keep the call light within reach, timely toileting, and round frequently. NA-D stated R4 kept putting the bed up high, she went on to say R4 was not a fall risk as she never got out of bed, didn't roll side to side, but maybe she would sometimes put her feet out a little. On 6/22/22, at 1:19 p.m. NA-A stated to prevent falls staff needed to keep the bed low, keep the call light and items within reach. NA-A stated she had not noticed R4's bed up high and stated she was not aware of any care planned interventions to keep R4's bed in the high position.	F 689		

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F 689	Continued From page 14 On 6/22/22, at 1:25 p.m. NA-E stated to prevent falls staff needed to make sure residents wear non-skid shoes, coach them with standing, use the right lift, and stated those residents with a fall risk should have their bed all the way to the floor. NA-E stated R4 was very particular and she wanted her bed up high. R4 went on to say there was a risk for injury if a resident would fall out of bed from high up. NA-E asked her if she could lower the bed and R4 said she was "alright." On 6/22/22, at 1:58 p.m. licensed practical nurse (LPN)-C stated R4 plays with the remote so the bed would get into the high position. LPN-C went on to state "she is not a fall risk", LPN-C stated she doesn't get out of bed. LPN-C stated a fall out of bed in the high position would put R4 at risk for a serious injury. On 6/22/22, at 2:03 p.m. registered nurse (RN)-C verified R4's bed was in the high position. RN-C stated R4's bed should be at a comfortable height for getting in and out of bed. RN-C stated R4 had not had any falls over the past two years. RN-C lowered R4's bed and she stated if R4 fell out of bed when it was in the high position there would be a risk for a significant injury. On 6/22/22, at 2:11 p.m. the director of nursing (DON) stated she would expect staff to prevent falls by keeping the floor free of clutter, having them wear non-skid footwear, keeping the call light in reach, and following the care plan. The DON verified there was a risk for serious injury from a fall out of a bed in the high position. The DON was not sure if there was a way to lock R4's bed into the low position. The facility Falls-Clinical Protocol revised 3/2018,	F 689		

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F 689	Continued From page 15 directed staff to identify individuals for falls and risk factors for falling. The facility Falls and Fall Risk, Managing revised 3/2018, directed staff would identify interventions related to specific risks and causes to try to prevent the resident from falling. Some of the risk factors identified in the policy were incorrect bed height, poor lighting, pain, visual deficits, and cognitive impairment.	F 689		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/23/2022. At the time of this survey, Ecumen North Branch 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, 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		07/15/2022

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, 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 detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Ecumen North Branch was constructed in 2006 & 2007; that is a one-story building with no basement. The construction type was determined to be of Type V(111). The building is separated from the rest of the Assisted Living facility by two-hour fire-rated construction with 90-minute rated fire doors. The facility consists of three separate smoke, two separate smoke compartments are used as resident sleeping rooms, and one smoke compartment is used for cooking, support functions, and staff offices.	K 000		

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K 000	Continued From page 2 The facility has a complete automatic fire sprinkler system and has smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. All resident rooms have single-station smoke detectors that transmit to the nurse's station. The facility has a capacity of 67 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through	K 324		8/5/22

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K 324	Continued From page 3 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 06/23/2022 at 10:00 AM, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports and interview with the Maintenance Director, the facility could not provide completed test/inspection documentation for the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with Maintenance Director and Executive Director verified these deficient findings at the time of discovery.	K 324	¿ How corrective action will be accomplished for those residents found to have been affected by the deficient practice? ¿ Vendor was contacted and documentation was provided. ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice? ¿ The alleged deficient practice has the potential to impact all residents. ¿ What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? ¿ Future documentation will be kept in a Fire and Life Safety Documentation binder specific to LSC survey related inspections under tab 10 Kitchen hood systems and also in our TELS computerized maintenance system so it will alert us every 6 months. ¿ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The QAPI committee will review tab 10 of the Fire and Life Safety binder. Environmental Services Manager or Designee will also monitor TELS tasks to ensure the vendor completes work on time.	

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K 345	Continued From page 4	K 345		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/23/2022 at 9:30 AM, it was revealed by a review of available documentation that the semi-annual fire alarm testing documentation was not available at the time of the survey. An interview with Maintenance Director and Executive Director verified these deficient findings at the time of discovery.	K 345	¿ How corrective action will be accomplished for those residents found to have been affected by the deficient practice? ¿ Vendor was notified and will begin conducting semi-annual fire alarm inspections. ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice? ¿ This deficient finding could have a widespread impact on the residents within the facility. ¿ What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? ¿ Future documentation will be kept in a Fire and Life Safety Documentation binder specific to LSC survey related inspections under tab 6 Fire Alarm/Automatic dialer systems. and also in our TELS computerized maintenance system so it will alert us every 6 months. ¿ How the facility will monitor its corrective actions to ensure that the	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245370	A. BUILDING **02 - BLDG 2** B. WING _____	**06/23/2022**

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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K 345	Continued From page 5	K 345	deficient practice is being corrected and will not recur. ¿ The QAPI committee will review tab 6 of the Fire and Life Safety binder. Environmental Services Manager or Designee will also monitor TELS tasks to ensure the vendor completes work on time.	
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 9.7.5 and 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of	K 353	¿ How corrective action will be accomplished for those residents found to have been affected by the deficient practice? ¿ Quarterly Flow test will be conducted at the beginning of quarter.	8/5/22

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	245370	A. BUILDING **02 - BLDG 2** B. WING _____	**06/23/2022**

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K 353	Continued From page 6 Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/23/2022 at 9:20 AM, it was revealed by a review of available documentation the facility performed the 2021 4th quarter flow test of the sprinkler system in January 2022. An interview with Maintenance Director and Executive Director verified these deficient findings at the time of discovery.	K 353	¿ How the facility will identify other residents having the potential to be affected by the same deficient practice? ¿ This deficient finding could have a widespread impact on the residents within the facility. ¿ What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? ¿ Future documentation will be kept in a Fire and Life Safety Documentation binder according to the Fire Life Safety Code documentation guide under tab 9 E sprinkler system/fire pump and also in our TELS computerized maintenance system so it will alert us every 3 months. ¿ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The QAPI committee will review tab 9 of the Life Safety binder. Environmental Services Manager or Designee will also monitor TELS tasks to ensure the vendor completes work on time.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		8/5/22

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	245370	A. BUILDING **02 - BLDG 2** B. WING _____	**06/23/2022**

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K 918	Continued From page 7 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. This deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 918	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. We will conduct an annual load bank test. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? a. As noted in the 2567 by the State Fire Marshal the alleged deficient practice could have widespread impact on all residents.	

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K 918	Continued From page 8 On 06/23/2022 at 09:45 AM, it was revealed by a review of available documentation of the emergency generator maintenance and testing an annual load bank test was not completed in the last 12 months when the generator did not reach 30 percent of the nameplate KW rating. An interview with Maintenance Director and Executive Director verified these deficient findings at the time of discovery.	K 918	3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? a. Load bank tests will be put into TELS preventive maintenance where automatic alerts will be set up to help ensure the task will not become overdue. We will ensure the annual load bank test is on contract. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. Load test inspection will be included in the TELS building preventive maintenance system and set up on an annual basis. The Executive Director, Assistant Executive Director or designee will review the documentation with the Environmental Service Manager annually. b. QAPI committee will monitor test results for compliance and determine if additional auditing/education will need to be completed.	