Electronically delivered
August 25, 2020

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

RE: CCN: 245370
Cycle Start Date: August 7, 2020

Dear Administrator:

On August 7, 2020, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC and this note)

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

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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 08/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/4/20, through 8/7/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5370053C. However, NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be unsubstantiated: H5370049C H5370050C H5370051C H5370052C H5370054C H5370055C However, as a result of the investigation a deficiency was identified at F732. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		8/28/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/28/2020

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

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F 689 SS=G	Continued From page 1 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 interview and document review, the facility failed to offer timely toileting assistance, in accordance with the care plan, for 1 of 3 residents (R3) reviewed for falls. This deficient practice resulted in actual harm for R3, who self-transferred to the bathroom, had a fall, and was subsequently diagnosed with a pelvic fracture. However, the facility implemented corrective action on 2/21/20, therefore the deficiency is being cited at past non-compliance. Findings include: R3's Admission Record printed 7/30/20, indicated R3's diagnoses included muscle weakness, history of falling, and right pubis fracture (pelvic fracture). R3's quarterly Minimum Data Set (MDS) dated 12/10/19, identified R3 had moderately impaired cognition. The MDS further identified R3 required extensive assistance with transfers and toileting. R3 was assessed to be not steady moving on and off a toilet. R3 was occasionally incontinent of bladder and always continent of bowel. R3's care plan dated 4/11/17, indicted R3 was at	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

risk for falls with fracture related to cardiac disease, and generalized weakness. The care plan further indicated R3 had a history of taking herself to and from the bathroom without the use of a call light. Interventions included anticipating and meeting the resident's needs. R3's care plan dated 4/17/17, also identified R3 had activity of daily living self-care deficits related to impaired balance and directed R3 was to be toileted every two hours and as needed.

A progress note dated 1/18/20, at 10:20 p.m. indicated R3 was found lying on the floor of her bathroom. R3 was noted to be lying on her right side. R3 informed staff she was unable to remember if she was "going to the toilet or coming from the toilet." R3 then informed staff "she had used the toilet and was coming out of the bathroom." Staff observed toilet paper in the toilet. R3 reported right knee pain, with movement, and was unable to bear weight on her right leg. R3 was transferred to the hospital.

An interdisciplinary team (IDT) progress note dated 2/6/20, at 11:40 p.m. indicated R3 had an unwitnessed fall on 1/18/20, at 9:00 p.m. in her bathroom. The IDT progress note identified R3 had a history of being offered toileting, declining assistance, and subsequently self-toileted. Staff was to offer R3 toileting every two hours and as needed. The IDT progress note revealed R3 was last offered toileting at 6:15 p.m. on 2/6/20.

R3's history and physical (H&P) dated 1/19/20, indicated R3 had a history of falls and memory loss. The H&P further indicated R3 had an unwitnessed fall in her bathroom, and it was presumed R3 fell when she was getting up from the toilet to use her walker. The H&P revealed

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F 689	Continued From page 3	F 689		

R3 was diagnosed with a closed pelvic fracture and would return to the long-term care facility with hospice services.

A document titled Ecumen North Branch Investigation Guidelines dated 1/18/20, indicated R3 was toileted at 4:15 p.m., declined to be toileted at 6:15 p.m., and was visualized in her room seated in a wheelchair at 8:00 p.m. on 8/19/20. Immediate interventions put in-place included every two hour toileting was to be followed.

A document titled QAPI (quality assurance process improvement) Action Plan: Fall with Fracture 1/18/20, dated 1/22/20, revealed a root cause analysis was conducted and determined R3 fell attempting to self-transfer "due to not being toileted on time."

On 8/6/20, at 2:00 p.m. an interview was conducted with registered nurse (RN)-A. RN-A stated R3 was a quiet and content resident who would not go out of her way to burden anyone. RN-A stated R3 was able to use her call light, but didn't always do so. RN-A stated R3 was forgetful, was known to self-transfer to the bathroom, and was to be offered toileting every two hours. RN-A stated she was unable to remember the details of R3's fall on 1/18/20. RN-A recalled a nursing assistant (NA), who was new to long-term care, was assigned to care for R3 on the evening of the fall. RN-A confirmed it was determined R3 was not toileted timely in accordance to the care plan and R3 suffered a fracture from the fall. RN-A stated the fall was caused by "time management issue." RN-A stated the facility completed audits and education after the occurrence

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F 689	Continued From page 4 On 8/6/20, at 2:51 p.m. an interview was conducted with the assistant director of nursing (ADON). The ADON stated she received a call from a facility nurse on 1/18/20, after R3 was found on the floor of her bathroom. The ADON stated R3 was noted to be fully clothed and had a dry incontinence product. The ADON stated staff noted toilet paper was in R3's toilet. The ADON stated she inquired when R3 was last toileted, and the nurse responded they were unsure if the resident's care plan was followed. The ADON stated R3 initially verbalized she was unable to recall what had happened, however, R3 later stated she tried to use the toilet. The ADON stated after the fall, R3 had trouble bearing weight and complained of pain. The ADON confirmed R3 was found on the floor at 9:00 p.m. and stated R3 was last toileted at 4:15 p.m. on 1/18/20. The ADON stated R3 was offered and refused toileting at 6:15 p.m. The ADON confirmed R3 was not offered toileting again after 6:15 p.m., and stated R3 was supposed to be toileted every two hours. The ADON confirmed R3's fall on 1/18/20, resulted in a pelvic fracture. The ADON stated staff were expected to re-approach a resident if toileting was refused. The ADON stated if a resident still refused assistance a nurse needed to be notified. On 8/7/20, at 11:03 a.m. an interview was conducted with the director of nursing (DON). The DON confirmed R3 was not toileted in accordance with the care plan on 1/18/20. The DON confirmed R3 was toileted at 4:15 p.m., refused toileting at 6:15 p.m., and was not offered toileting again prior to the fall on 1/18/20. The DON stated the facility standard was to notify a nurse and re-approach a resident if care was	F 689		

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F 689	Continued From page 5	F 689		

refused. The DON stated if staff were unable to be timely with cares they were expected to call for help. The DON stated the facility learned R3 suffered a fracture when the hospital was called during the night. The DON stated after the incident, all staff were educated to follow resident care plans and how to call for assistance. The DON stated education was included in orientation packets, for new hires, and was ongoing. The DON stated residents at risk for falls were reviewed and audits were completed. The DON stated staffing patterns and call light usage were also reviewed, and it was determined staffing did not contribute to the fall.

The facility policy Falls - Clinical Protocol dated 9/12, directed, "If interventions have been successful in preventing falling, the staff will continue with current approaches ..."

R3 had a fall which resulted in a pelvic fracture, after a self-initiated transfer to the bathroom, as staff failed to provide toileting in accordance with the care plan. However, by 2/21/20, the facility had implemented corrective action to prevent recurrence which included a quality assurance action plan, staff education, audits, review of staffing patterns, and reviewed residents who fell frequently or were at high risk for falls.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 25, 2020

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

Re: Event ID: LLEL11

Dear Administrator:

The above facility survey was completed on August 7, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted 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,

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

cc: Licensing and Certification File

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/4/20, to 8/7/20, surveyors of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaints: H5370049C, H5370050C, H5370051C, H5370052C, H5370053C, H5370054C, and H5370055C.	2 000		

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

Electronically Signed | 08/28/20

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2 000	Continued From page 1 No correction orders were issued. The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		