



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 6, 2022

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

RE: Project Number(s) SL30638015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 15, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

The total amount you are assessed is \$500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general
reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration
requests should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to

Health.HRD.Appeals@state.mn.us.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30638015 On September 12, 2022, through September 15, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 70 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3.	

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 250	Continued From page 1	0 250		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September	0 250		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 250	Continued From page 3 12, 2022, at 11:43 a.m., executive director-(ED)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 250	Continued From page 4 may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all	0 250		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page four was electronically signed by ED-A on May 20, 2021. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of August 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) handling complaints regarding staff or services provided by staff; (4) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (5) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other	0 250		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 250	Continued From page 6 health care providers as appropriate; (6) orientation to and implementation of the assisted living bill of rights; (7) infection control practices; (8) medication and treatment management; (9) delegation of tasks by registered nurses or licensed health professionals; (10) supervision of registered nurses and licensed health professionals; and (11) supervision of unlicensed personnel performing delegated tasks. On September 15, 2022, at 1:00 p.m., ED-A confirmed the licensee conducted orientation, training, and competency evaluations of staff, and a process for evaluating staff performances, provided medication and treatment management services, followed infection control practices, and supervised ULP performing delegated but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0480, 0510, 0550, 0630, 0640, 0800, 0810, 0950, 0970, 1360, 1370, 1380, 1420, 1440, 1470, 1540, 1620, 1640, 1650, 1700, 1750, 1760, 1790, 1880, 1890, 1910, 1950, 1960, 2040, 2110, 2140, 2170, and 2240, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 480	Continued From page 7 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 12, 2022, for the specific	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 480	Continued From page 8 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure infection control standards were followed for two of two unlicensed personnel (ULP)-D, ULP- E) providing personal cares; and further failed to ensure shared equipment was disinfected after use. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 510	Continued From page 9 Findings include: HAND HYGIENE On September 13, 2022, at approximately 6:23 a.m., the surveyor observed ULP-D and ULP-E assist R9 with personal cares. ULP-D and ULP-E donned gloves and transferred R9 onto the toilet with the EZ-Stand (a lift that helps the patient to rise from the seated position). ULP-E removed R9's incontinent brief, wearing the same pair of gloves, brushed R9's hair, cleaned R9's eyeglasses, and emptied R9's colostomy bag (a plastic pouch over the stoma [surgical opening into the intestines] that collects fecal matter). ULP-E removed gloves, and without performing hand hygiene, put on a clean pair of gloves, and applied a barrier cream to R9's buttock. ULP-E changed gloves, did not perform hand hygiene, applied a pain patch to R9's left hip, assisted R9 with dressing, then R9 was transferred into her Broda chair (a tiltable wheelchair). Wearing the same pair of gloves, ULP-E escorted R9 to the dining table, doffed gloves, and washed hands at the kitchen sink. On September 13, 2022, at approximately 6:44 a.m., the surveyor observed ULP-D and ULP-E assist R8 with her colostomy bag. R8's colostomy bag had partially separated from the skin, and had stool on her recliner chair, clothes, abdomen, legs, and feet. ULP-D and ULP-E donned gloves and assisted R8 into the bathroom. ULP-D gathered, and prepared colostomy supplies and ULP-E washed stool from R8's body. Wearing the same pair of gloves, ULP-E cleaned around R8's stoma with 4 x 4 gauze pads, applied skin prep, and stoma powder to skin. ULP-E changed gloves and continued to assist with dressing. ULP-D applied R8's new colostomy bag, removed	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 510	Continued From page 10 gloves, without performing hand hygiene, began to clean up colostomy supplies. ULP-D and ULP-E transferred R8 into the recliner chair. ULP-D doffed gloves and ULP-D and ULP-E exited R8's room, disposed of garbage in soiled linens, and washed hands at kitchen sink. On September 13, 2022, at approximately 7:41 a.m., ULP-D stated she should have performed hand hygiene in between and after gloves use but the dementia care units do not have hand sanitizer available in the resident rooms for use. On September 13, 2022, at approximately 1:42 p.m., ULP-E confirmed she would wash her hands if visibly soiled. ULP-E further stated, she had not been told to perform hand hygiene in between glove changes, only after you were done wearing gloves. ULP-E confirmed she should have changed gloves after removing R9's urine soiled brief, before brushing R9's hair and cleaning R9's glasses and should not have worn gloves outside of the resident's room. DISINFECTING SHARED/REUSABLE EQUIPMENT On September 13, 2022, at approximately 6:23 p.m., the surveyor observed ULP-D and ULP-E transfer R9 with the EZ Stand from her bed onto the toilet. After personal cares were provided, ULP-D and ULP-E transferred R9 with the EZ Stand into her Broda chair. ULP-D placed the EZ Stand in the activity room area and did not disinfect after resident use. On September 13, 2022, at approximately 7:21 a.m., the surveyor observed ULP-D and ULP-E transfer R6 from her bed into her Broda chair with the use of a mechanical lift (a device used to aide	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 510	Continued From page 11 in transfer of persons with limited weight bearing ability) and proceeded to assist R7 with morning cares and dressing. After the transfer and R6's morning personal cares were completed, ULP-D brought the mechanical lift out of R6's room and placed in the activity room area without disinfecting the mechanical lift. On September 13, 2022, at approximately 7:41 a.m., ULP-D stated she would disinfect the mechanical lift at the end of her shift or if visibly soiled. On September 14, 2022, at approximately 3:05 p.m., licensed practical nurse (LPN)-C confirmed residents were currently sharing the mechanical lifts and confirmed the mechanical lifts should be disinfected after resident use before storing outside of the resident rooms because you don't know when the mechanical lift would be used for another resident transfer. On September 15, 2022, at approximately 10:36 p.m., registered nurse (RN)-C confirmed the mechanical lifts, or any reusable equipment should be disinfected after each resident use. The licensee's Hand Hygiene policy dated January 14, 2021, indicated hands should be washed or decontaminated: -before and after direct contact with a client; -if moving from a contaminated body site to a clean body site during client care; -after contact with environmental surfaces or equipment in the immediate vicinity of the client; -after removal of gloves; and -before and after using the bathroom. The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy, dated July	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 510	Continued From page 12 24, 2021, indicated reusable equipment and environmental surfaces would be properly cleaned and disinfected after use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure to include the contact information for the individuals who are responsible for handling grievances. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 550	Continued From page 13 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on September 12, 2022, at approximately 12:46 p.m., with executive director (ED)-A, and registered nurse (RN)-C, ED-A confirmed the main entrance and/or common areas lacked the required posting of the grievance procedure to include the name, telephone number and e-mail contact information for the individuals who are responsible for handling resident grievances. At approximately 1:33 p.m., ED-A provided the surveyor with a complaint binder kept at the front desk at the main entrance where the complaint procedure was located. ED-A confirmed the complaint procedure lacked the required content noted above. The licensee's Complaint Policy and Procedure dated July 21, 2021, indicated each resident or resident representative received written notice the licensee's facility process for receiving and resolving complaints. The written notice must include, name and contact information of the person representing the facility designated to hand and resolve complaints No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 630	Continued From page 14 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R1, R3, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 On September 12, 2022, at approximately 3:35 p.m., registered nurse (RN)-C stated R1 had a housing only contract and did not receive services. On September 13, 2022, at 2:45 p.m., RN-M	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 630	Continued From page 15 confirmed the "Cognitive Capacities, Mental Health Wellness, Self Preservation & Psychosocial Support", included in the facilities nursing assessment addressed the IAPP. R1's Assisted Living (AL) Nursing Assessment dated March 19, 2022, failed to include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; - the resident's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On September 14, 2022, at approximately 9:00 a.m., RN-C verified IAPP was not completed for R1. RN-C stated, "she [R1] is independent." RN-C verified IAPP's had not been completed for independent residents. R3 R3's diagnoses include diabetes, chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation], chronic kidney disease, sleep apnea, anemia [condition in which body lacks enough healthy red blood cells to carry adequate oxygen to body tissues], major depressive disorder and heart failure. R3's service plan dated October 29, 2021, included linen changes/bed making, escorts, bathing on Sunday, dressing assist twice daily, COVID symptom monitoring, daily weight, laundry, trash removal, CPAP/BIPAP assist [noninvasive ventilation breathing support through a face mask, nasal mask, or helmet], daily oxygen monitoring, filling of oxygen tanks,	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 630	Continued From page 16 medication administration, blood glucose monitoring four times daily, bed mobility assist, emergency evacuation assist, vulnerable adult (VA) risk: chronic conditions/poor endurance/falls/financial management/visual deficit/hearing deficit, and toileting assist. R3's AL Nursing Assessment dated July 7, 2022, failed to include: - the resident's risk of abusing other vulnerable adults. On September 13, 2022, at 10:03 a.m., the surveyor observed unlicensed staff (ULP)-N remove applesauce from R3's refrigerator and put a small amount into a cup. ULP-N put medications into the applesauce and gave the cup to R3. On September 14, 2022, at 3:59 p.m., RN-C verified R3's Nursing Assessment did not contain required content. R6 R6's diagnoses included dementia, Alzheimer's, chronic kidney disease, and anxiety. R6's service plan dated August 30, 2022, indicated R6 received services which included medication management, assistance with dressing, grooming, toileting, transfers, laundry, and housekeeping. R6's AL Nursing Assessment dated signed July 18, 2022, failed to include: - the resident's risk of abusing other vulnerable adults. On September 15, 2022, at approximately 10:16 a.m., RN-C verified R6's IAPP was not fully	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 630	Continued From page 17 completed. RN-C stated, any areas identified in bold was identified by the assessor. RN-C verified R6's IAPP did not address whether or not R6 was at risk for abusing other vulnerable adults. The licensee's Individual Abuse Prevention Plans policy dated August 1, 2021, indicated an IAPP was developed for each assisted living resident; -Assisted living residents receiving assisted living services would have an IAPP based upon the nursing assessment; and -Assisted living residents who do not receive assisted living services, would have an individual abuse prevention plan based upon a review of information available to the assisted living staff. The IAPP would include; -individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults; -the resident's risk of abusing other vulnerable adults; -specific measures to minimize the risk of abuse to that person and other vulnerable adults; and -measure to minimize the risk of self-abuse, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 640	Continued From page 18 common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas to include posting the 911 emergency number in common areas and near telephones provided by the assisted living. This had the potential to affect all 70 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on September 12, 2022, at approximately 12:20 p.m., the surveyor did not observe 911 posted in the commons areas or telephones that could be used by residents as required. On September 12, 2022, at 1:15 p.m., registered nurse (RN)-C stated one phone was in the memory care unit, in the resident assistant (RA) room, which residents could use. Licensed practical nurse (LPN)-B added there was one	0 640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 640	Continued From page 19 phone in the RA room on the 2nd floor that could be used, adding residents also have cell phones and staff have "Ipods" (portable computer logging, communicating and information system). On September 12, 2022, at approximately 1:20 p.m., RN-C verified 911 was not posted in common areas or near telephones as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 800	Continued From page 20 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 14, 2022, between 10:30 a.m. and 1:30 p.m., survey staff toured the facility with environmental services (ES)-J and the executive director (ED)-A. During the facility tour, survey staff observed the following: 1. The trash chute door latch was missing on the third floor. 2. Door closers were broken for the third-floor housekeeping room and first-floor storage room. 3. The floor tile was loose in front of the bathtub in the spa room located on the third floor. 4. The door closer was missing from the communication room on the second floor. 5. One dryer vent duct was kinked in the first-floor laundry room. 6. Gypsum board and cove base were missing from the lower walls in the mechanical room on the third floor. The ES-J confirmed during the tour interview that these items required repair. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 810	Continued From page 21 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide the required plans and training for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 810	Continued From page 22 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 14, 2022, between 10:30 a.m. and 1:30 p.m, survey staff toured the facility with environmental services (ES)-J and the executive director (ED)-A. During the facility tour, it was observed that the location and number of resident sleeping rooms were not identified on the evacuation maps posted in the facility. In the exit interview with the ED-A on September 14, 2022, at approximately 2:30 p.m., they explained that the licensee had been working on adding the location of resident sleeping rooms to the evacuation maps. On September 14, 2022, at approximately 1:30 p.m., ED-A and ES-J provided documents for review. Documents were reviewed by survey staff on September 14, 2022, between 1:30 p.m. and 2:10 p.m. The licensee failed to provide annual fire safety and evacuation training for residents. Documentation was requested by survey staff but not provided. On September 14, 2022, at approximately 2:30 p.m., the ED-A confirmed during the exit interview that the licensee had not been providing annual training to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 950	Continued From page 23	0 950		
0 950 SS=C	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer three of three residents (R2, R4, R6) the opportunity to identify or decline a designated representative.	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 950	Continued From page 24 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included diabetes, chronic kidney disease, hypertension (HTN-high blood pressure), enlarged prostate, insomnia and impaired cognition. R2's service plan dated August 12, 2022, indicated R2 received services which included blood glucose (sugar) monitoring (a blood glucose test measures the glucose levels in your blood), medication management, assistance with ambulation, transferring, bed mobility, dressing, grooming, toileting, bathing, laundry, and housekeeping. R4 R4's diagnoses included chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), diabetes, HTN, bipolar disorder, anxiety, and lung transplant status. R4's service plan dated September 8, 2022, indicated R4 received services which included blood glucose monitoring, medication management, assistance with dressing, grooming, toileting, bathing, laundry, and housekeeping.	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 950	Continued From page 25 R2, and R4's record lacked evidence of a notice with the required statutory language for the resident to identify a designated representative or documentation that R2 and R4 declined to name a designated representative. On September 15, 2022, at 11:39 a.m., registered nurse (RN)-C verified R2 and R4's record lacked the required content, "I can't find anything [items listed above]." R6 R6's diagnoses included dementia, Alzheimer's, chronic kidney disease, and anxiety. R6's service plan dated August 30, 2022, indicated R6 received services which included medication management, assistance with dressing, grooming, toileting, transfers, laundry, and housekeeping. R6's Amendment to Resident Agreement signed August 25, 2021, included an opportunity to designate a representative; however, did not include verification the resident or resident's representative declined to assign a designated representative. On September 15, 2022, at approximately 9:00 a.m., executive director (ED)-A provided the surveyor with the licensee's updated Resident Contract dated September 9, 2022 and confirmed all of the licensee's residents would have the new Resident Contract, which had all of the required content for a designated representative starting October 3, 2022. ED-A confirmed the current resident contracts did not include all required content noted above for designating a representative.	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 950	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living with dementia contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 12, 2022, at approximately 11:40 a.m., during entrance conference, a copy of the	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 970	Continued From page 27 licensee's assisted living contract was requested. The licensee's cotntract included the following liability language: -Page 12, #30. "Personal Property" of the contract indicated the resident agrees that the community is not responsible for any loss or damage to resident's personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond the community's control. Residents are strongly encouraged to obtain renter's insurance. Resident acknowledges that the community will not and does not maintain insurance coverage that will reimburse resident or their guests for damage to personal property, accident, or injury. -Page 12, #31. "Indemnification" of the contract indicated the resident would indemnify and hold harmless the community, its employees and agents from and against any and all claims, actions, damages, and liabilities and expenses in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the apartment or any other part of the community's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. -Page 12, #33. "Liability" of the contract indicated the community is not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment or on the community premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident or resident's guests. The community may be liable to resident for it's own negligent acts or those of its employees or agents. Unless caused by one of the mentioned excepted reasons, resident agrees to hold the community harmless from any and all claims for injuries, property damage or any other	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
0 970	Continued From page 28 loss resulting from an accident or other occurrence in the apartment or on the community premises. On September 15, 2022, at approximately 9:00 a.m., executive director (ED)-A confirmed the above noted language was included in the current assisted living contract which indicated the resident's waived the licensee's liability for health, safety, or personal property. ED-A provided the surveyor a copy of the licensee's updated Resident Contract dated September 9, 2022 and stated the licensee's attorney removed any language that would waive the licensee's liability for health, safety, or personal property. ED-A confirmed the new contract had not been implemented and planned to have the new contracts in place for all residents starting October 3, 2022. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01360 SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered	01360		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01360	Continued From page 29 nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations of unlicensed personnel (ULP) providing assisted living services were conducted by a registered nurse (RN) prior to providing care for four of four unlicensed personnel (ULP)-F, ULP-H, ULP-I, ULP-N. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-F was hired June 27, 2022, to provide direct care and services to residents at the assisted living with dementia care facility. On September 13, 2022, at approximately 6:45 a.m., the surveyor observed ULP-F attempt to collect a blood glucose reading from R2 multiple times. ULP-I ULP-I was hired July 5, 2022, to provide direct care and services to residents at the assisted living with dementia care facility. ULP-H ULP-H was hired February 8, 2021, to provide	01360		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01360	Continued From page 30 direct care and services to residents at the assisted living with dementia care facility. ULP-N ULP-N was hired on April 22, 2022, to provide direct care and services to residents at the assisted living with dementia care facility. On September 14, 2022, at 12:02 p.m., the surveyor interviewed ULP-I, ULP-H, ULP-N. The ULPs stated they had on-line training and were assigned to work with other resident assistants (RA, also known as ULP) before the registered nurse (RN) spent a "couple of hours with them" before they were scheduled to work independently. On September 14, 2022, at 12:15 p.m., ULP-H stated she listened to videos, then went "on the floor" with another RA. ULP-H stated she observed the ULP doing tasks once and then ULP-H performed the tasks, "blood sugars (BS), and stuff, yep that is how I did it" adding the RN watched them later and after the RN watched them, they [ULP] can be on their own. On September 14, 2022, at 12:28 p.m., ULP-I stated, "Yeah, yeah, I really was not comfortable at first doing things, so I watched a couple time and then yeah, I did it with them." The surveyor asked who "them" were? ULP-I answered ULPs. The surveyor inquired if ULP-I assisted with catheters [a tube placed in the body to drain and collect urine from the bladder], ostomies [an artificial opening in an organ of the body, created during an operation such as a colostomy, ileostomy, or gastrostomy; a stoma], lifts [devices used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by	01360		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01360	Continued From page 31 caregivers alone], injections [using a needle to inject medication into the body], BG checks, medications? "Yep, all of it" adding later the RN went through these tasks with her. On September 15, 2022, at 1:24 p.m., RN-C explained ULPs are hired and "on-boarding" takes a whole week. ULPs are then scheduled to work on the floor [unit] with another RA for 7 shifts. RN does skills check off with ULP, after the week on the floor. RN-C stated regarding new ULPs, "oh no, we tell them to first watch but after that we want them doing the skills." RN-C added, the facility will need to change their process with training new staff. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated ULP that satisfy the training requirements, have been determined competent to follow the procedures and have been delegated the responsibility by the RN may administer medications orally, by suppository, through eye drops through ear drops, by use of inhalant or nebulizer, gastric tube, insulin injection or topically by following the RN's written instructions for administering the medication to the client. In addition, the RN may delegate treatment and therapy if the unlicensed personnel have satisfied the training requirement listed above if: -before performing the procedures, the RN has instructed the ULP in the proper methods to administer the medications, treatment and therapy and the UP have demonstrated the ability to competently follow the procedures. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	01360		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01360	Continued From page 32 (21) days	01360		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01370	Continued From page 33 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one employee, unlicensed personnel (ULP)-F, to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-F was hired June 27, 2022, to provide direct care and services to residents at the assisted living with dementia care facility. On September 13, 2022, at 6:50 a.m., the surveyor observed ULP-F clean the fourth finger of R2's right hand with a pre-moistened alcohol wipe and use a lancet (small needle used to poke the skin [usually on a finger] to get a blood sample and apply the blood sample to a blood glucose meter (device that will test blood sample to determine blood glucose level). On September 15, 2022, at 10:10 a.m., registered nurse (RN)-C reviewed ULP-F's	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01370	Continued From page 34 training record with the surveyor. RN-C verified ULP-F had not been trained on the following areas: -maintenance of a clean and safe environment; -understanding appropriate boundaries; and -medication, exercise, and treatment reminders. In addition, RN-C confirmed she had not taught medication, exercise, and treatment reminders to any of the ULPs trained by her. The licensee's Assisted Living Orientation-ULP Staff policy dated August 1, 2021, indicated ULPs who were not a registered nursing assistant would receive additional training to include the above-mentioned topics. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01380	Continued From page 35 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training was completed in all required areas for one of one unlicensed personnel (ULP)-F with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired June 27, 2022, to provide direct care and services to residents at the assisted living with dementia care facility. On September 13, 2022, at 6:50 a.m., the surveyor observed ULP-F clean the fourth finger of R2's right hand with a pre-moistened alcohol wipe and use a lancet (small needle used to poke the skin [usually on a finger] to get a blood sample and apply the blood sample to a blood glucose meter (device that will test blood sample to determine blood glucose level). On September 15, 2022, at 10:10 a.m., registered nurse (RN)-C reviewed ULP-F's training record with the surveyor. RN-C verified ULP-F had not been trained on recognizing	01380		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01380	Continued From page 36 physical, emotional, cognitive, and developmental needs of the resident. The licensee's Assisted Living Orientation-ULP Staff policy dated August 1, 2021, indicated ULPs who were not a registered nursing assistant would receive additional training to include recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure the registered	01420		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01420	Continued From page 37 nurse (RN)-C provided training for unlicensed personnel (ULP)-F and all other ULP on the delegated task of using a Broda chair [a wheelchair offering tilt-n-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture]. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-F was hired June 27, 2022, to provide direct care and services to residents at the assisted living with dementia care facility. On September 13, 2022, at 8:27 a.m., the surveyor observed ULP-F leaving R16's room. R16 was seated in a Broda chair. ULP-F pushed the Broda chair down the hallway and into the dining room with R16 in the chair. ULP-F's record lacked documentation to indicate ULP-F had received training and demonstrated competency for the Broda chair. On September 15, 2022, at 11:26 a.m., registered nurse (RN)-C verified she had not trained ULP-F or any of the ULPs on the use of a Broda chair. The licensee's Delegation of Nursing Tasks policy dated July 17, 2021, indicated registered nurse would verify the ULP was trained and competent and was instructed in the proper methods to	01420		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01420	Continued From page 38 perform the task with respect to the specific client. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01440	Continued From page 39 supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP)-F. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired June 27, 2022, to provide direct care and services to residents at the assisted living with dementia care facility. On September 13, 2022, at 8:27 a.m., the surveyor observed ULP-F coming out of R16's room. R16 was positioned in a Broda chair [a wheelchair offering tilt-n-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture]. ULP-F proceeded to transport R16 to the dining area in the Broda chair. ULP-F's employee record lacked documentation of a registered nurse (RN) supervising ULP- F performing a delegated task within 30 days of beginning work with the licensee. ULP-F's employee record contained a "Notes on Supervision of Unlicensed Personnel" form dated August 26, 2022, (30 days late) authenticated by	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01440	Continued From page 40 licensed practical nurse (LPN)-B. On September 14, 2022, at approximately 11:00 a.m., LPN-B confirmed she completed ULP-F's 30 day delegated task supervision, which was completed late. In addition, LPN-B added she does "some" of the 30 day delegated task supervisions. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated July 17, 2021, indicated a registered nurse would supervise staff who perform delegated nursing, treatment or therapy services within 30 calendar days after the staff member begins working and first performs the delegated resident task. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01470	Continued From page 41 responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01470	Continued From page 42 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of one employee registered nurse (RN)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-C had a hire date of January 31, 2022, to provide direct care services to the license's residents and oversight of the licensee's employees. RN-C's employee record lacked the following required orientation content: - an overview of the 144G statutes; -the assisted living bill of rights; and -policies and procedures related to the provision of assisted living services by the individual staff person. On September 15, 2022, at approximately 9:45 p.m., resident service coordinator (RSC)-G stated she was unable to provide documentation RN-C received the orientation trainings noted above. The licensee's Assisted Living & Assisted Living	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01470	Continued From page 43 with Dementia Care Orientation-All Staff policy dated July 17, 2021, indicated all assisted living employees would complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. At minimum, orientation would include: -an overview of Minnesota's assisted living law; -an introduction and review of agency policies and procedures related to the provision of assisted living services; and -assisted living bill of rights and staff responsibilities to ensure the exercise and protection of those rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for	01540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01540	Continued From page 44 each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee, unlicensed personnel (ULP)-F received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired June 27, 2022, to provide direct care and services to residents at the assisted living with dementia care facility. On September 13, 2022, at 6:50 a.m., the surveyor observed ULP-F clean the fourth finger of R2's right hand with a pre-moistened alcohol wipe and use a lancet (small needle used to poke the skin [usually on a finger] to get a blood sample and apply the blood sample to a blood glucose meter (device that will test blood sample to determine blood glucose level)). ULP-F's employee records did not indicate a total of 8 hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-F's employee record indicated the employee had completed 4.75 hours of dementia	01540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01540	Continued From page 45 training. On September 14, 2022, at 11:04 a.m., resident service coordinator (RSC)-G verified ULP-F had not completed the required dementia training required. The licensee's Assisted Living With Dementia Care Dementia Training policy dated July 17, 2021, indicated orientation would include for direct-care employees a minimum of eight hours of initial training of dementia care topics. Initial training would be completed with 80 working hours of the employment start date and would include; -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; -person-centered planning and service delivery; -understanding cognitive impairment; and understanding behavioral and psychological symptoms of dementia. In addition, employees of a licensed assisted living with dementia care who have not completed the initial dementia care training would not provide direct care independently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01620	Continued From page 46 after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment after a change of condition for one of one resident (R6). In addition, the licensee failed to ensure the RN completed ongoing resident assessments not to exceed 90 days for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01620	Continued From page 47 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 12, 2022, at approximately 11:40 a.m., during entrance conference registered nurse (RN)-C verified comprehensive assessments were completed upon admission, at day 14, every 90 days and with any significant change in condition. CHANGE IN CONDITION R6's diagnoses included dementia, Alzheimer's, chronic kidney disease, and anxiety. R6's physician orders dated June 7, 2022, included hospice evaluation and treatment order. R6's service plan dated August 30, 2022, indicated R6 received services which included hospice care, medication management, assistance with dressing, grooming, toileting, transfers, laundry, and housekeeping. R6's progress notes dated June 6, 2022, indicated hospice services were initiated on June 9, 2022. R6's record lacked a change of condition assessment following R6's initiation of hospice services on June 9, 2022. ON GOING ASSESSMENTS R6's record indicated the RN completed a comprehensive assessment on March 23, 2022, and a 90-day assessment initiated on June 22,	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01620	Continued From page 48 2022, and was not completed until July 18, 2022, which exceeded 90 days from the previous completed assessment. On September 15, 2022, at approximately 10:28 a.m., RN-C verified R6 started hospice services June 9, 2022. RN-C verified R6 did not have a change in condition assessment and should have when hospice services were initiated for R6. RN-C verified R6's 90-day assessment had not been completed timely within 90 days from R6's previous assessment as required. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated July 25, 2021, indicated the RN would complete a comprehensive nursing assessment of the resident's physical, mental and cognitive needs as required pre-admission, 14 days after start of services, no less than every 90-days, and with a change in resident's condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01640	Continued From page 49 resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of three residents (R3) service plans were revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 12, 2022, at approximately 11:55 a.m., regarding monitoring/assessments, registered nurse (RN)-C stated, "I meet with the resident, review services scheduled and talk to families." Regarding the devolvement of service plan RN-C	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01640	Continued From page 50 stated "we all make changes based off assessment, and daily needs", adding she [RN-C] may reassess, and a new service plan would be developed and signed by family. R3's diagnosis include diabetes, chronic kidney disease, heart disease, chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), insomnia, major depressive disorder, hypertension (HTN-high blood pressure), and chronic pain syndrome. R3's service plan dated September 29, 2021, included medication management, COVID monitoring (check temperature, oxygen (O2) saturation (sat) and pulse, then document results. Notify nurse if O2 is below 90% sat), filling O2 tanks as needed; using O2 at 2 liters per minute (LPM) via nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) continuous, O2 safety checks, blood sugar checks four times a day, daily weight, Cpap/bipap assist [noninvasive ventilation breathing support through a face mask, nasal mask, or helmet], escorts, assistance with dressing, bathing, laundry, and housekeeping. R3's Assisted Living (AL) Nursing Assessment dated July 7, 2022, indicated R3 required assistance with treatment/therapy management: O2, O2 tanks, O2 concentrator, O2 safety check, needs/receives assistance filing portable O2 tanks. On September 13, 2022, at 10:03 a.m., the surveyor observed unlicensed personnel (ULP)-N enter R3's room. ULP-N asked R3 about O2 administration, offering to get it (nasal cannula)	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01640	Continued From page 51 for R3. R3 commented to ULP-N oxygen is no longer in use. On September 14, 2022, at 11:55 a.m., during an interview R3 told the surveyor O2 was discontinued "a few months ago" adding, "doctor told me I don't need it anymore." On September 16, 2022, RN-M confirmed the last time a ULP had documented an O2 reading was on August 19, 2022. On September 15, 2022, at 9:42 a.m., RN-C confirmed R3's service plan was not revised as required, adding she [RN-C] had not been given the order regarding oxygen administration discontinuation. RN-C verified R3's service plan would be updated to reflect current services. The licensee's Service Plan policy dated July 25, 2021, indicated all assisted living residents have an up-to date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. Service plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01650	Continued From page 52 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R2, R3, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01650	Continued From page 53 The findings include: R2, R4, R5, and R6's Service Plans lacked the following required content: - the method of monitoring assessments of the residents; and - the method of monitoring assessments staff providing services. R2 R2's diagnoses include diabetes, chronic kidney disease, hypertension (HTN-high blood pressure), enlarged prostate, insomnia and impaired cognition. R2's service plan dated August 12, 2022, included medication management, escorts, Covid monitoring, blood sugar checks two times a day, assistance with bathing, and physical assistance. On September 13, 2022, at 6:50 a.m., the surveyor observed unlicensed personnel (ULP)-F clean the fourth finger of R2's right hand with a pre-moistened alcohol wipe and use a lancet (small needle used to poke the skin [usually on a finger] to get a blood sample) and apply the blood sample to a blood glucose meter (device that will test blood sample to determine blood glucose level). R3 R3's diagnosis include diabetes, chronic kidney disease, heart disease, chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), insomnia, major depressive disorder, hypertension (HTN-high blood pressure), and chronic pain syndrome.	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01650	Continued From page 54 R3's service plan dated September 29, 2021, included medication management, Covid monitoring, filling oxygen (O2) tanks as needed; using O2 at 2 liters per minute (LPM) via nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) continuous, O2 safety checks, blood sugar checks four times a day, daily weight, Cpap/bipap assist [noninvasive ventilation breathing support through a face mask, nasal mask, or helmet], escorts, assistance with dressing, bathing, laundry, and housekeeping. R5 R5's diagnoses included congestive heart failure, atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), anxiety, and osteoporosis (brittle bones). R5's service plan dated August 20, 2022, indicated R5 received services which included medication management, assistance with dressing, grooming, toileting, bathing, laundry, and housekeeping. On September 13, 2022, at approximately 9:38 a.m., ULP-D was observed administering R5's morning scheduled medications. R6 R6's diagnoses included dementia, Alzheimer's, chronic kidney disease, and anxiety. R6's service plan dated August 30, 2022, included hospice care, medication management, assistance with dressing, grooming, toileting, transfers, laundry, and housekeeping.	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01650	Continued From page 55 On September 13, 2022, at approximately 7:21 a.m., the surveyor observed ULP-D and ULP-E provide morning personal cares and transfer R6 with the Hoyer lift (mechanical lift used to assist with transfers). On September 13, 2022, at 4:11 p.m., registered nurse (RN)-M verified the licensee's service plans did not include the required content noted above and confirmed all the service plans would be missing the content. On September, 15, 2022, at 10:21 a.m., RN-C verified the licensee's service plans did not include the required content noted above and confirmed all the service plans would be missing the content. The licensee's Service Plan policy dated July 25, 2021, indicated service plans would include a schedule and method for monitoring assessments and staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01700	Continued From page 56 provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a medication management assessment was completed by the registered nurse (RN) which reviewed all required areas for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01700	Continued From page 57 R2 R2's record lacked evidence the registered nurse (RN) conducted a review of all medications the resident was known to be taking to include drug contraindications. R2's diagnoses include diabetes, chronic kidney disease, enlarged prostate, insomnia, and impaired cognition. R2's service plan dated August 12, 2022, indicated R2 received services which included medication management. R2's Assisted Living (AL) Nursing Assessment dated August 9, 2022, included Medication Management: -resident requires assist with medication administration; and -medication contraindications and necessary interventions; blank. R2's prescriber's ordered dated August 9, 2022, included: men's multi-vitamin daily, metformin (diabetes) 1000 milligrams (mg) two times a day (bid), multivitamin tablet daily, Senna S (constipation) 8.6-50 mg on Monday, Wednesday, Friday, simvastatin (high cholesterol) 20 mg at hour of sleep (HS), sulfamethoxazole-trimethoprim (antibiotic) 800-160 mg take for 10 days, tamsulosin (enlarged prostate) 0.4 mg daily, Lantus Pen (diabetes, insulin pen), 100 units (U)/milliliter (ml) 32 U daily, aspirin (heart health) 81 mg daily, finasteride (benign prostatic enlargement) 5 mg daily and glipizide (diabetes) 20 mg daily. On September 13, 2022, at 8:29 a.m., the surveyor observed unlicensed personnel (ULP)-F	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01700	Continued From page 58 place Centrum Silver Flex Men 50, aspirin, and metformin, into a medication cup. ULP-F was not able to locate R2's finasteride 5 mg or Tab-a Vit in the medication cart. ULP-F took the medication cup to R2's room and handed the medication cup to R2. R3 R3's record lacked evidence the RN conducted a review of all medications the resident was known to be taking to include drug contraindications. R3's diagnoses include diabetes, chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation], chronic kidney disease, sleep apnea, anemia [condition in which body lacks enough healthy red blood cells to carry adequate oxygen to body tissues], major depressive disorder and heart failure. R3's service plan dated October 29, 2021, indicated R3 received services which included medication management. R3's AL Nursing Assessment dated July 7, 2022, included Medication Management: -resident requires assist with medication administration; and -medication contraindications and necessary interventions: medication contraindications are identified and reported per medication management policy and procedures. Community nursing receives direction from pharmacist and physician. R3's Physician Order Sheet dated August 10, 2022, included: allopurinol (gout) 300 mg daily, aspirin 81 mg, daily, azelastine 0.05% (allergies)	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01700	Continued From page 59 eye solution 1 drop bid, bisacodyl (constipation) 5 mg daily, cephalexin (antibiotic/infection) 250 mg daily, cetirizine (antihistamine) 10 mg daily, duloxetine (antidepressant) 30 mg daily, estradiol (vaginal insert) 10 micrograms (mcg), twice weekly for 90 days, famotidine (ulcers) 20 mg daily, Humalog (fast acting insulin) 100 u/ml three times daily (tid), hydroxyzine (anxiety) 25 mg daily, lamotrigine (anticonvulsant) 200 mg daily, Lantus (long acting insulin) 100/u 40 u daily, levetiracetam (anticonvulsant) 250 mg bid, losartan (high blood pressure) 25 mg daily, nat/v turmeric (supplement) 500 mg daily, omeprazole (ulcer) 40 mg bid, omron comp A-I-R nebulizer (COPD) daily, pramipexole (aniparkinson) 0.125 mg tid, Reguloid (bowel health) daily, rosuvastatin (high cholesterol) 10 mg daily, Spiriva 18 microgram (mcg) [treat COPD, by relaxing airways] powered for inhalation daily, Trelegy Elliprat 200/62.5/25 mcg [treat COPD] inhalation daily, vitamin D3 (supplement) 25 mcg daily and Advair Diskus 250 mcg [reducing the irritation and swelling of the airways] as needed twice a day. On September 13, 2022, at 10:03 am., the surveyor observed ULP-N give R3 a Spiriva inhaler. R3 inquired if ULP-N had crushed the medication. R3 inhaled 2 puffs for the Spiriva inhaler. ULP-N using correct technique checked R3's blood glucose level and administered insulin to R3. ULP-N handed R3 a Trelegy inhaler which R3 accepted and inhaled. On September 14, 2022, at approximately 10:15 a.m., during an interview, RN-C stated the pharmacy was doing medication contradictions adding, the pharmacy is behind. RN-C added the doctor is also to check for medication contractions. RN-C verified "ultimately" it is the	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01700	Continued From page 60 RN's responsibility. On September 14, 2022, at approximately 11:30 am., a prescriber order dated September 14, 2022, to discontinue Spiriva and Advair was given to the surveyor. On September 15, 2022, at approximately 11:30 a.m., licensed practical nurse (LPN)-B confirmed one of the vitamins R2 was prescribed was discontinued by provider. The manufacturer's instructions for multivitamins dated March 17, 2022, indicate never take more than the recommended dose of a multivitamin. Avoid taking more than one multivitamin product at the same time. Taking similar vitamin products together can result in a vitamin overdose or serious side effects. The manufacturer's instructions for Spiriva and Trelegy inhalers dated June 28, 2022, indicate both inhalers should not be used with other medications containing antimuscarinic drugs [inhibiting the parasympathetic nervous system] (both contain antimuscarinic) for risk of increased side effects. The licensee's Medication Management policy dated March 2018, indicated a comprehensive client assessment performed at start of care and other defined points in time include review of all medications the client is taking (prescribed, samples, over the counter, herbal remedies, as needed medications) and records this in the client record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01700	Continued From page 61 days	01700		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: SPECIFIC RESIDENT INSTRUCTIONS	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01750	Continued From page 62 R4's diagnoses include chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), diabetes, hypertension (HTN-high blood pressure), bipolar disorder, anxiety, and lung transplant status. R4's service plan dated September 8, 2022, indicated R4 received services which included insulin administration one time a day. R4's Assist Living (AL) Nursing Assessment dated September 8, 2022, included insulin cue one time a day. R4's prescriber's orders dated August 11, 2022, included Lantus Solostar (long-acting insulin) 100 units (U)/milliliters (ml) injection 14 units daily. R4's medication administration record (MAR) dated September 1, 2022, through September 15, 2022, included: Lantus Solostar 100 U/ml, inject 14 units subcutaneously daily, 9:00 a.m. On September 13, 2022, at 8:56 a.m., the surveyor observed unlicensed personnel (ULP)-P with gloved hands use an alcohol wipe to clean the top of R4's Lantus insulin pen (a multiple dose pen shaped injector device for insulin administration), apply a needle to the pen and dial the pen to 14 units at the medication cart in the hallway of the third floor. ULP-P went to R4's room and handed R4 an alcohol wipe and the prepared insulin pen to R4. R4 cleaned a general area on her upper right arm, removed the safety cover for the insulin pen, put the insulin pen up to her right upper arm and inject the insulin. ULP-P was not observed to prime (removing air bubbles from the needle, and ensures that the needle is	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01750	Continued From page 63 open and working) the insulin pens prior to dialing up the prescribed insulin dosage. On September 14, 2022, at 4:06 p.m., RN-C verified R4's record failed to include specific written instructions regarding insulin administration. The licensee's Administration of Medication, Treatment and Therapy by ULP policy dated July 25, 2021, indicated ULP's were to follow RN's written instructions for administering the medication to the client, the RN had developed written, specific instruction for each client. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01760	Continued From page 64 by: Based on observation, interview and record review, the licensee failed to ensure medication was administered according to manufacturer's instructions for residents (R3, R4). In addition, the licensee failed to ensure medications were administered as ordered for resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: FOLLOWING MANUFACTURER'S INSTRUCTIONS R3 R3's diagnosis include diabetes, chronic kidney disease, heart disease, chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), insomnia, major depressive disorder, hypertension (HTN-high blood pressure) and chronic pain syndrome. R3's service plan dated September 29, 2021, included medication administration. R3's providers orders dated August 10, 2022, included an order for Spiriva 18 micrograms (mcg) for inhalation 1 puff by mouth once daily. On September 13, 2022, at 7:49 a.m., the	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01760	Continued From page 65 surveyor observed unlicensed personnel (ULP)-N remove R3's medications from the medication cart in the hallway of the second floor. ULP-N removed a Spiriva capsule from a foil packet and place the capsule into the handheld inhaler. ULP-N went to R3's room with R3's medications. R3 was in bed with her eyes closed and appeared to be sleeping. ULP-N returned the medication to the medication cart and placed the Spiriva inhaler in the top drawer of the medication cart along with another inhaler and the content of a medication cup she put into a small medication envelope and labeled it with R3's name. On September 13, 2022, at 10:03 am., the surveyor observed ULP-N take R3's medications including the prepared Spiriva inhaler from the top drawer of the medication cart and bring it to R3. R3 inquired if ULP-N had "crushed" the medication as ULP-N was handing the inhaler to R3. ULP-N replied she had crushed the Spiriva. R3 put the inhaler to her lips and inhaled the Spiriva medication. On September 13, 2022, directly following the above medication administration ULP-N stated she had no training regarding how long after Spirivas removal from the foil packaging it should be given or how long it could be given after it was crushed. On September 13, 2022, at 12:00 p.m., registered nurse (RN)-C stated her expectation would be to give the Spiriva "right away" after removing it from the foil package/crushing it. RN-C verified the medication was not given per manufacturer's instructions. The manufacturer's instructions for use of the Spiriva inhaler dated December 31, 2011,	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01760	Continued From page 66 indicated: - remove one Spiriva capsule from its package immediately before use. Separate the blister strip. Pull back the foil to the Stop line. If any other capsules are exposed to air by mistake, throw them out. Do not save exposed capsules for later use. R4 R4's diagnoses included COPD, diabetes, HTN, bipolar disorder, anxiety, and lung transplant status. R4's service plan dated September 8, 2022, indicated R4 received services which included blood glucose monitoring and medication management. R4's prescriber's orders dated August 11, 2022, included Lantus Solostar (long-acting insulin) 100 units (U)/milliliters (ml) injection 14 units daily. On September 13, 2022, at 8:56 a.m., the surveyor observed ULP-P with gloved hands use an alcohol wipe to clean the top of R4's Lantus insulin pen (a multiple dose pen shaped injector device for insulin administration), apply a needle to the pen and dial the pen to 14 U at the medication cart in the hallway of the third floor. ULP-P went to R4's room and handed R4 an alcohol wipe and the prepared insulin pen to R4. R4 cleaned a general area on her upper right arm, removed the safety cover for the insulin pen, put the insulin pen up to her right upper arm and inject the insulin. ULP-P was not observed to prime (removing air bubbles from the needle, and ensures that the needle is open and working) the insulin pen prior to dialing up the prescribed Lantus insulin dose.	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01760	Continued From page 67 On September 13, 2022, immediately following the above noted observation, ULP-P confirmed she had not primed R4's insulin pen prior to dialing up the prescribed dose. ULP-P added she is "normally really good about it, my bad." On September 13, 2022, at 11: 56 a.m., RN-B reviewed the process for insulin pen administration which included priming the insulin pen prior to dialing up the prescribed dose. The manufacturer's instructions for the use of Lantus insulin pens, dated March 2020, directed for Lantus insulin pen to be primed with two units prior to dialing the prescribed dosage. If this was not completed before each injection too much or too little insulin may be administered. FOLLOWING PROVIDER'S ORDERS R2's diagnoses include diabetes, chronic kidney disease, HTN, enlarged prostate, insomnia and impaired cognition. R2's service plan dated August 12, 2022, included medication management. R2's prescriber's ordered dated August 9, 2022, included finasteride 5 mg tablet daily, Flexeril 5 mg daily, and Men's multi-vitamin, 1 tablet daily. On September 13, 2022, at 8:29 a.m., the surveyor observed ULP-F place Centrum Silver Flex Men 50, aspirin, and metformin into a medication cup. ULP-F was not able to locate R2's finasteride, Flexeril, or Tab-a Vit in the medication cart. ULP-F took the medication cup to R2's room and handed the medication cup to R2.	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01760	Continued From page 68 On September 14, 2022, at 10:13 a.m., licensed practical nurse (LPN)-B verified a medication error had occurred regarding R2's medications confirming R2's finasteride 5 mg and Flexeril should have been given, adding those medications were in the medication cart. LPN-B added the Tab-a Vit was not in the medication cart. LPN-B confirmed ULP's should be calling the pharmacy or the RN to find out why a medication is not in the cart, adding it was possible that family supplies medication and they had not brought it in. The licensee's Medication Error Educational and Corrective Action Guidelines policy dated February 2016, indicated medication is administered according to physicians or other authorized health care providers. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01790	Continued From page 69 medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01790	Continued From page 70 completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-F) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 12, 2022, at 11:57 a.m., registered nurse (RN)-C confirmed the facility provided medication management services. ULP-F's records lacked evidence to indicate a RN provided training and determined competency to prepare medications for unplanned times away. ULP-F was hired June 27, 2022, to provide direct care and services to residents at the assisted	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01790	Continued From page 71 living with dementia care facility. ULP-F's employee record lacked documentation indicating ULP-F had been trained and the RN had deemed competent in preparing medications for unplanned time away. On September 14, 2022, at 3:44 p.m., ULP-K stated she had not received training for the task, but she could call the RN. ULP-K added, "I don't like doing it, but I have been here for 3 years and I know how to go into the computer and see all the medications a person takes, 80% of the people here don't know how to do that [see medication that are scheduled for different times then the present]." On September 15, 2022, at 11:42 a.m., RN-C verified ULP-F and all other ULPs that were hired after she started were not trained or had not demonstrated competency to prepare or give medications for any of the licensee's residents for unplanned times away. The licensee's Procedure For Delegation of Medications to be Given to Clients by Unlicensed Staff for Clients Time Away From Home, dated July 24, 2017, confirmed only unlicensed staff that had been trained and have satisfactorily demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for a leave of absence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01880	Continued From page 72	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures for two of two medication refrigerators (second floor, dementia unit). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 12, 2022, at approximately 11:40 a.m., executive director (ED)-A and registered nurse (RN)-C confirmed the licensee provided medication management services to the licensee's residents, including storage of medication. SECOND FLOOR MEDICATION REFRIGERATOR On September 12, 2022, at 12:41 p.m., RN-C confirmed the thermometer inside the second	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01880	Continued From page 73 floor refrigerator was 50 degrees Fahrenheit (F). RN-C stated the recommended temperature for refrigerator medication storage was between 32 degrees to 40 degrees. The surveyor requested a history of recorded temperature logs to review. RN-C "thought" the evening (pm) shift was monitoring the refrigerator temperature. RN-C called LPN-B. LPN-B would print off the temperature log for the surveyor to review. RN-C verified the second floor refrigerator contained: - one full box of five Lantus (long acting) 100 units (U)/ milliliter (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for R2; -one full box of five Lantus 100 u/ ml insulin pens and 2 unopened Lantus 100 U/ml insulin pens for R3; -two unopened Humalog (fast acting insulin) 100 U/ml insulin pens for R3; -one full box of five Lantus 100 U/ml insulin pens and 2 unopened Lantus 100 U/ml insulin pens for R4; -one full box of five Lantus 100 U/ml insulin pens and 3 unopened Lantus 100 U/ml insulin pens for R12; -one unopened latanoprost 0.05% eye solution (medication to treat high pressure in the eye) for R13; -four full boxes of five Basaglar (long acting) 100 U/ml insulin pens and 1 unopened Basaglar 100 U/ml insulin pen; and -one unopened latanoprost 0.05% eye solution R15. DEMENTIA UNIT MEDICATION REFRIGERATOR On September 12, 2022, at approximately 1:08	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01880	Continued From page 74 p.m., the surveyor observed the dementia unit refrigerator with licensed practical nurse (LPN)-B. LPN-B checked the thermometer inside the refrigerator and verified a reading of 38 degrees F. LPN-B dialed down the internal temperature of the refrigerator. LPN-B verified the temperature was above the recommended temperature for medication storage of 38 degrees F. LPN-B stated the medication refrigerator temperature logs were recorded in the electronic charting system by the night staff. The surveyor requested a history of recorded temperature logs to review. LPN-B verified refrigerator B contained two unopened syringes of Trulicity 1.5 mg/0.5 ml (a medication to treat diabetes). On September 12, 2022, at 2:25 p.m., LPN-B confirmed refrigerator temperatures were not being recorded regularly and provided the surveyor with the only temperature logs that were recorded. LPN-B stated the nurses learned the task to check temperature logs into in the Ipad's [portable computer logging and information system] was not set up in the system correctly, to ensure the nurses had to verify the task was completed. The recorded temperature logs provided by LPN-B indicated the following dates and times: -August 9, 2022, at 2:00 p.m., of 40 degrees F; -August 17, 2022, at 2:00 p.m., of 35 degrees F; -August 14, 2022, at 2:00 p.m., of 35 degrees F; -August 23, 2022, at 2:00 p.m., of 37 degrees F; and -August 25, 2022, at 2:00 p.m., of 35 degrees F. On September 12, 2022, at 4:45 p.m., LPN-B stated, "I am going to be honest, there are no temperature logs for the second floor refrigerator." LPN-B confirmed the temperature	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01880	Continued From page 75 logs provided to the surveyor, were the only logs the licensee recorded from the dementia care unit medication refrigerator. The manufacturer's instructions for Lantus insulin pens, dated March 2020, indicated store the insulin pens in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for Humalog insulin pens, dated June 4, 2021, indicated store the insulin pens in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for latanoprost eye drops dated September 16, 2015, indicated the drop solution should be stored at 36-46 degrees F. The manufacturer's instructions for Basaglar dated June 4, 2021, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze. The manufacturer's instructions for Trulicity pen revised September 2018, directed to store the pen in the refrigerator between 36-46 degrees F. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01890	Continued From page 76 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration date for R3, R4, R11, R17, R18, R20 and an unknown resident. In addition, the licensee failed to monitor for expired medications for R5, R10, R17, R19 and further, the licensee failed to ensure medication containers had the original prescription label for R3, R17, R18. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TIME SENSITIVE MEDICATIONS/ORIGINAL PRESCRIPTION LABEL On September 12, 2022, at 12:25 p.m., the surveyor observed medication carts with registered nurse (RN)-C. RN-C confirmed the following: -R3's opened Humalog (fast acting insulin) 100/units (u) 3 milliliter (ml) insulin pen (a multiple dose pen shaped injector device for insulin administration) lacked a date the insulin pen was removed from the refrigerator and when the insulin pen would expire;	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01890	Continued From page 77 -R3's Lantus (long acting insulin) 100 u/3 ml insulin pen lacked a date had been insulin pen was removed from the refrigerator and when the insulin pen would expire; -R3's Advair Diskus 250 micrograms (mcg)/50 milligrams (mg), lacked a date the inhaler was removed from the foil package and when the inhaler would expire. In addition, the inhaler failed to include R3's name; -R4's Lantus insulin 100 u/3 ml insulin pen lacked a date had been insulin pen was removed from the refrigerator and when the insulin pen would expire; -R17's opened Refresh Tears (lubricating eye drops) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire. In addition, the bottle failed to include R17's name; -R11's opened Muro 128 5% ophthalmic (eye) drops (reduce swelling of the surface of the eye) lacked a date the eye drops were opened and when the eye drops would expire; -R11's 2 opened brimonidine tartrate eye solution (treat glaucoma/high fluid pressure in the eye) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire; -R18's Serevent Diskus (long-term treatment to prevent or decrease wheezing and troubled breathing) 50 mcg inhaler lacked a date the inhaler had been removed from the foil packet and when the inhaler would expire. In addition, the inhaler failed include R18's name; and -Unknown Resident's opened bottle of ear drop medication 6.5 %, 0.5 fluid ounces (oz) (ear wax softener) label with information regarding the directions for use, medication name, medication dosage, resident's name, and if dated or not was illegible.	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01890	Continued From page 78 On September 12, 2022, at approximately 1:00 p.m., the surveyor observed the dementia unit medication cart with licensed practical nurse (LPN)-B. LPN-B confirmed the following: -R20's albuterol sulfate inhaler (used to treat chronic obstructive pulmonary disease), lacked a date the inhaler had been opened and when the inhaler would expire; and -R20's dorzolamide HCl (eye drops used to treat glaucoma), lacked a dated the eye drop was opened and would expire. On September 12, 2022, at approximately 1:03 p.m., LPN-B stated eye drops, inhalers, and insulin should have an open and expiration date written on the label. On September 15, 2022, at approximately, 10:11 a.m., RN-C stated staff who opened the inhaler, eye drop, or insulin should write on the label or sticker the date the medication was opened to ensure the medication was not used past the manufacturer's recommended use date. EXPIRED MEDICATION On September 12, 2022, at 12:25 p.m., the surveyor observed medication carts with RN-C. RN-C confirmed the following: -R5's Proventil HFA/Ventolin (to prevent and treat wheezing and shortness of breath caused by breathing problems) had expired September 6, 2022; -R10's prednisolone acetate eye drops (used to treat certain eye conditions due to inflammation) had expired April 2022; -R17's neomycin and polymyxin b sulfate ointment (sterile antimicrobial ointment for topical ophthalmic use) had expired July 2022; and -R19's antifungal power with miconazole nitrate	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01890	Continued From page 79 2% (treats superficial fungal infection) had expired September 12, 2021. The manufacturer's instructions for Humalog insulin pens dated June 4, 2021, directed to discard the pen 28 days after it had been opened or removed for refrigerator, even if it still has insulin left in it. The manufacturer's instructions for Lantus insulin pens dated June 4, 2021, directed to discard the pen 28 days after it had been opened or removed for refrigerator, even if it still has insulin left in it. The manufacturer's instructions for Advair Diskus dated 2019, directed to discard after 30 days after removal from foil pouch. The manufacturer's instructions for Refresh liquid gel dated March 2018, directed to discard the eye drop solution 90 days after opening. The manufacturer's instructions for Muro 128 5% dated March 31, 2022, directed once opened, the product must be used within 30 days. The manufacturer's instructions for brimonidine tatrate eye solution dated December 7, 2021, direct to use for four weeks once the bottle have been opened, even if there is still some solution remaining after this time. The manufacturer's instructions for Serevent Diskus dated 2019 directed to discard 6 weeks after removal from foil pouch. The manufacturer's instructions with the expiration date of ear drop medication was illegible.	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01890	Continued From page 80 The manufacturer's instructions dated January 2022, indicated the eye drops should be use within 28 days after the bottle is first opened. Therefore, you must throw away the bottle 4 weeks after you first opened it, even if some solution is left. To help you remember, write down the date that you opened it in the space on the carton. The licensee's Storage of Medications policy dated, July 24, 2021, indicated prescription drugs must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drugs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01910	Continued From page 81	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R7) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01910	Continued From page 82 situation has occurred only occasionally). The findings include: R7 was discharged on May 16, 2022. R7's May 2022, Medication Administration Record (MAR), included one medication to decrease secretions, two pain medications, one medication to treat muscle spasms, two medications to treat constipation, one anti-anxiety medication, one medication to treat shortness of breath, two anti-itch creams, one anti-fungal cream, one medication to treat ear wax build up, one eye drop to treat dry eyes, and cough syrup. R7's discharge summary dated May 16, 2022, noted R7's services were initiated on April 11, 2016, and R7 was discharged on May 16, 2022. In addition, the summary noted R7 received assistance with medications and R7's medications were destroyed per facility policy and procedure. R7's medication disposal records noted the name of the medications, prescription numbers, quantity, and method of disposition, however; R7's discharge summary lacked the strength of the medications destroyed. On September 14, 2022, at approximately 2:55 p.m., licensed practical nurse (LPN)-B confirmed R7's disposition of medications lacked the strength of the medications which were destroyed. LPN-B stated she was not aware documentation of the medication strength for all medications was required. The licensee's Disposition or Disposal of Medication policy dated July 24, 2021, indicated	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01910	Continued From page 83 documentation of the destruction, listing the date, quantity, name of the drug, prescription number and signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the client's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	01950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01950	Continued From page 84 Based on observation, interview and record review, the licensee failed to ensure instructions, specified in writing, for each resident were documented in the resident's record for two of two resident (R2, R3) who received blood glucose (sugar) monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2's diagnoses include diabetes, chronic kidney disease, hypertension (HTN-high blood pressure), enlarged prostate, insomnia and impaired cognition. R2's service plan dated August 12, 2022, included; -check blood sugar (BS) 2 times daily. See Medication Administration Record (MAR) for specific medication instructions. On September 13, 2022, at 6:50 a.m., the surveyor observed unlicensed personnel (ULP)-F clean the fourth finger of R2's right hand with a pre-moistened alcohol wipe and use a lancet (small needle used to poke the skin [usually on a finger] to get a blood sample and apply the blood sample to a blood glucose meter (device that will test blood sample to determine blood glucose	01950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01950	Continued From page 85 level). R2s provider's order dated August 9, 2022, included an order for BS checks two times a day. R2's MAR dated September 1, 2022, through September 12, 2022, directed for BS to be completed at 7:30 a.m. and 4:00 p.m. daily. R2's MAR lacked specific written instructions for BS monitoring to include parameters for evaluation of results. R3 R3's diagnosis include diabetes, chronic kidney disease, heart disease, chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), insomnia, major depressive disorder, HTN and chronic pain syndrome. R3's service plan dated September 29, 2021, included; -check BS four times daily and record, see MAR for specific instructions. R3's providers orders dated August 8, 2022, included an order for BS checks four times a day before meals and at bedtime. R2's MAR dated September 1, 2022, through September 12, 2022, directed for BS to be completed four times a day (7:30 a.m., 11:30 a.m., 4:00 p.m., and hour of sleep (HS.) R3's MAR lacked specific written instructions for BS monitoring to include parameters for evaluation of results.	01950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE	
01950	Continued From page 86 On September 15, 2022, registered nurse (RN)-C confirmed R2 and R3's records did not include all the required information. The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy dated July 25, 2021, indicated RN had developed written, specific instruction for each client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed, or to document the reason they were not provided to meet the resident's needs for one of two residents (R3).	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01960	Continued From page 87 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnosis include diabetes, chronic kidney disease, heart disease, chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), insomnia, major depressive disorder, hypertension (HTN-high blood pressure), and chronic pain syndrome. R3's service plan dated September 29, 2021, included: -monitor weight every day, to notify nurse of any wight gain of 3 pounds in a day or 5 pounds in a week; -COVID 19/monitor oxygen (O2) saturation and document results, notify the nurse promptly is O2 stat is below 90%; -check for safe storage of O2 tanks and cleanliness of equipment daily; and -check blood sugar (BS) four times daily and record, see medication administration record (MAR) for specific instructions. R3's providers orders dated August 8, 2022, included: -O2 continuously at 2 liters per minute (LPM); -BS checks four times a day before meals and at bedtime.	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01960	Continued From page 88 On September 13, 2022, at 10:03 a.m., the surveyor observed unlicensed personnel (ULP)-N enter R3's room. ULP-N asked R3 about O2 administration, offering to get it (nasal cannula) [lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental O2] for R3. R3's Service Delivery Record dated September 1, 2022, through September 12, 2022, included: Daily weights: September 1, 2022, September 5, 2022, and September 12, 2022; range of 3 pounds. There was no additional documentation to support R3's refusal or cancellation of service. Monitoring: COVID symptoms: to include O2 saturation (sats) monitoring [measuring how saturated the resident's blood is with oxygen. using a probe/monitor attached to a resident's finger], dated September 1, 2022, through September 12, 2022, included: -canceled service, September 3, 2022; and -canceled service, September 10, 2022. There was no additional documentation to support R3's refusal or cancellation of service. O2 safety checks: dated September 1, 2022, through September 12, 2022, indicated O2 checks were completed: -1 time (x) September 1, 2022, September 7, 2022, September 9, 2022, September 9, 2022, and September 11, 2022; -2 x's September 3, 2022, September 4, 2022, September 8, 2022, and September 12, 2022; and -3 x's September 5, 2022. There was no additional documentation to support R3's refusal or cancellation of service.	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01960	Continued From page 89 Fasting blood glucose (FSBG-sugar): [A blood glucose test measures the glucose levels in your blood]; -2 x's September 1, 2022, September 3, 2022, September 4, 2022, and September 12, 2022; -4 x's September 5, 2022; and -1x September 10, 2022. There was no additional documentation to support R3's refusal or cancellation service any other days. On September 14, 2022, at approximately 3:55 p.m., the surveyor requested documentation of R3's daily weight records, daily O2 record, and BS record from September 1, 2022, through September 12, 2022. -R3's weight record completed during this time frame indicated weights 3 of 12 opportunities were documented in R'3 record. -R3's O2 monitoring record were not produced. On September 15, 2022, registered nurse (RN)-C confirmed R3's services were not being provided and documented as required. On September 16, 2022, RN-M confirmed the last time a ULP had documented an O2 reading was on August 19, 2022. The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy dated July 25, 2021, indicated ULPs providing assistance with medication, treatment and therapy administration would be trained and competency tested by RN for: -documentation, after assisting with self-administration of medications or medication, treatment and therapy administration, consistent with agency procedures for documenting the	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
01960	Continued From page 90 MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	02040		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02040	Continued From page 91 of the residents). The findings include: On September 14, 2022, at approximately 1:30 p.m., the executive director (ED)-A and environmental services (ES)-J provided documents for review. Documents were reviewed by survey staff on September 14, 2022, between 1:30 p.m. and 2:10 p.m. The hazard vulnerability assessment did not include hazards or safety risks identified on and around the property. Mitigation of hazards to protect residents from harm was not included in the assessment. On September 14, 2022, at approximately 2:30 p.m., the ED-A confirmed during the exit interview that the licensee failed to include safety risks or hazards identified on and around the property in the assessment. They also confirmed that mitigation was not included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans,	02110		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02110	Continued From page 92 including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to each resident and/or designated representative. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	02110		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02110	Continued From page 93 the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a capacity of 112 residents. The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative. On September 15, 2022, at approximately 10:26 a.m., registered nurse (RN)-C stated she was unaware if and/or how the dementia care policies were being provided to the resident and/or resident's representative. RN-C stated she had not been providing the dementia care policies and procedures with resident admissions. On September 15, 2022, at approximately 1:07 p.m., executive director (ED)-A and RN-M confirmed the required dementia care policies and procedures were not provided to each resident and or/resident's representative or were included in the admission packets and planned on adding it to the admission process moving forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care	02140		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02140	Continued From page 94 of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and (2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During entrance conference on September 12, 2022, at approximately 10:40 a.m., executive director (ED)-A identified licensed assisted living director (LALD)-O as the license's LALD who had completed the required dementia care training and knowledge test. ED-A stated LALD-O was currently out on leave. On September 14, 2022, at approximately 12:28 p.m., the director of people (DOP)-L confirmed she was unable to find evidence LALD-O's or any staff completed the required competency or	02140		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02140	Continued From page 95 knowledge test in dementia training. On September 15, 2022, at approximately 1:07 p.m., ED-A and RN-C confirmed LALD-O's employee record lacked evidence LALD-O completed a competency or knowledge test in dementia training. ED-A further confirmed, he was unable to provide evidence any staff completed the required dementia training and knowledge test. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based	02170		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02170	Continued From page 96 on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a comprehensive evaluation for activities and an individual activity plan for two of two residents (R5, R6) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R5	02170		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02170	Continued From page 97 R5's diagnoses included congestive heart failure, atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), anxiety, and osteoporosis (brittle bones). R5's AL Life Enrichment Assessment dated September 12, 2022, identified R5's activity preferences and emotional and social needs. R6 R6's diagnoses included dementia, Alzheimer's, chronic kidney disease, and anxiety. R6's AL Life Enrichment Assessment dated June 21, 2022, identified R6's activity preferences and emotional and social needs. R5 and R6's records lacked evidence the residents had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R5 and R6's record lacked the development of an individualized activity plan. On September 14, 2022, at approximately 11:35 a.m., registered nurse (RN)-C confirmed the licensee's current AL Life Enrichment Assessment being used for residents did not address all the required content noted above. In addition, RN-C confirmed the licensee had not developed an individualized activity plan for the residents.	02170		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02170	Continued From page 98 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must	02240		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02240	Continued From page 99 include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident for four of four residents (R2, R4, R5, R6) upon admission to the assisted living with dementia care facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021 and was licensed of a capacity of 112 residents. R2 R2's diagnoses included diabetes, chronic kidney disease, hypertension (HTN), enlarged prostate,	02240		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE
02240	Continued From page 100 insomnia and impaired cognition. R2's service plan dated August 12, 2022, indicated R2 received services which included blood glucose monitoring, medication management, assistance with ambulation, transferring, bed mobility, dressing, grooming, toileting, bathing, laundry, and housekeeping. R2's recorded included an authenticated acknowledgement form dated January 12, 2022, which indicated R2 received the Minnesota Bill of Rights for Assisted Living Residents. R4 R4's diagnoses included chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), diabetes, HTN, bipolar disorder, anxiety, and lung transplant status. R4's service plan dated September 8, 2022, indicated R4 received services which included blood glucose monitoring, medication management, assistance with dressing, grooming, toileting, bathing, laundry, and housekeeping. R4's resident recorded included an authenticated acknowledgement form dated December 8, 2021, which indicated R4 received the Minnesota Bill of Rights for Assisted Living Residents. R5 R5's diagnoses included congestive heart failure, atrial fibrillation (irregular heartbeat), HTN, anxiety, and osteoporosis (brittle bones). R5's service plan dated August 20, 2022,	02240		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE	
02240	Continued From page 101 indicated R5 received services which included medication management, assistance with dressing, grooming, toileting, bathing, laundry, and housekeeping. R5's resident record included an authenticated Acknowledgement of Recipient's Rights form dated May 27, 2021, which indicated R5 had received a copy of the Home Care Bill of Rights. R6 R6's diagnoses included dementia, Alzheimer's, chronic kidney disease, and anxiety. R6's service plan dated August 30, 2022, indicated R6 received services which included medication management, assistance with dressing, grooming, toileting, transfers, laundry, and housekeeping. R6's record included an authenticated acknowledgement form dated June 14, 2021, which indicated R6 received a copy of the Home Care Bill of Rights. On September 12, 2022, at approximately 2:03 p.m., executive director (ED)-A confirmed the Minnesota Assisted Living Bill of Rights dated May 16, 2022, which was posted on the first floor of the assisted living and provided in the admission packet was not the updated Minnesota Assisted Living Bill of Rights. On September 14, 2022, at approximately 3:15 p.m., registered nurse (RN)-C confirmed the licensee was in the process of attaining signatures from the residents or their representatives and updating all resident records with an updated Minnesota Bill of Rights for	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30638	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/15/2022
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) COMPLETE DATE	
02240	Continued From page 102 Assisted Living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			

Type: Full
Date: 09/12/22
Time: 13:00:00
Report: 1025221186

Food and Beverage Establishment Inspection Report

Page 1

Location:

Ecumen North Branch
5379 383rd Street
North Branch, MN55056
Chisago County, 13

Establishment Info:

ID #: 0038354
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512373001
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Ambient temperature in Memory serving kitchen, to-go upright cooler above 41 deg F. Monitor and adjust coolers to maintain cold TCS foods at or below 41 deg F. Refrigerator adjusted during inspection.

Comply By: 09/12/22

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

Repair backflow device and/or device cover in dish area (below the spray arm).

Comply By: 09/30/22

Surface and Equipment Sanitizers

Hot Water: = at 162 Degrees Fahrenheit

Location: Dish machine 163 W, 180 R, 162 C, 25 PSI

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Milk

Temperature: 41 Degrees Fahrenheit - Location: Upright cooler

Violation Issued: No

Type: Full
Date: 09/12/22
Time: 13:00:00
Report: 1025221186
Ecumen North Branch

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Milk, pkg
Temperature: 45 Degrees Fahrenheit - Location: Receiving, in walk-in cooler
Violation Issued: No

Process/Item: Tuna salad
Temperature: 73 Degrees Fahrenheit - Location: Cooling < 2 hr for reheat and service
Violation Issued: No

Process/Item: Ground beef, pkg
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Deli meat, pkg
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Ambient
Temperature: 43 Degrees Fahrenheit - Location: To-go cooler
Violation Issued: Yes

Process/Item: Ambient
Temperature: 44 Degrees Fahrenheit - Location: Memory care refrigerator
Violation Issued: Yes

Process/Item: Diced ham
Temperature: 38 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Process/Item: Diced tomato
Temperature: 38 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	0	1

Discussed menu, food course, highly susceptible population and restrictions on raw animal food service, to-go/commissary area and food labeling (provide information at the front desk to-go area, fact sheet reviewed during inspection), cooling TCS foods, dish machine operation and testing, segregation and disposal of food, pest control, service, use of residential refrigerator (do not use for cooling TCS foods) and single basin sink in Memory Care area (reserve sink for handwashing instead of utensil washing; discussed activities for residents washing dishes clean and not used for food and reserved for the purpose of resident care).

Type: Full
Date: 09/12/22
Time: 13:00:00
Report: 1025221186
Ecumen North Branch

Food and Beverage Establishment Inspection Report

Page 3

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025221186 of 09/12/22.

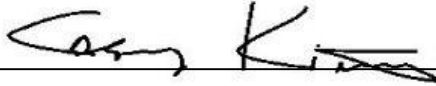
Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed:  _____

Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025221186

Food Establishment Inspection Report



Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out

1

Date 09/12/22

No. of Repeat RF/PHI Categories Out

0

Time In 13:00:00

Legal Authority MN Rules Chapter 4626

Time Out

Ecumen North Branch

Address

5379 383rd Street

City/State

North Branch, MN

Zip Code

55056

Telephone

6512373001

License/Permit #
0038354

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN= in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS= corrected on-site during inspection

R= repeat violation

Compliance Status

COS R

Supervision

1	IN	OUT	PIC knowledgeable; duties & oversight		
2	IN	OUT N/A	Certified food protection manager, duties		

Employee Health

3	IN	OUT	Mgmt/Staff; knowledge, responsibilities & reporting		
4	IN	OUT	Proper use of reporting, restriction & exclusion		
5	IN	OUT	Procedures for responding to vomiting & diarrheal events		

Good Hygienic Practices

6	IN	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN	OUT	N/O	No discharge from eyes, nose, & mouth		

Preventing Contamination by Hands

8	IN	OUT	N/O	Hands clean & properly washed		
9	IN	OUT	N/A N/O	No bare hand contact with RTE foods or pre-approved alternate procedure properly followed		
10	IN	OUT		Adequate handwashing sinks supplied/accessible		

Approved Source

11	IN	OUT		Food obtained from approved source		
12	IN	OUT	N/A N/O	Food received at proper temperature		
13	IN	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	N/A N/O	Required records available; shellstock tags, parasite destruction		

Protection from Contamination

15	IN	OUT	N/A N/O	Food separated and protected		
16	IN	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	IN	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status

COS R

Time/Temperature Control for Safety

18	IN	OUT	N/A N/O	Proper cooking time & temperature		
19	IN	OUT	N/A N/O	Proper reheating procedures for hot holding		
20	IN	OUT	N/A N/O	Proper cooling time & temperature		
21	IN	OUT	N/A N/O	Proper hot holding temperatures		
22	IN	OUT	N/A	Proper cold holding temperatures		
23	IN	OUT	N/A N/O	Proper date marking & disposition		
24	IN	OUT	N/A N/O	Time as a public health control: procedures & records		

Consumer Advisory

25	IN	OUT	N/A	Consumer advisory provided for raw/undercooked food		
----	----	-----	-----	---	--	--

Highly Susceptible Populations

26	IN	OUT	N/A	Pasteurized foods used; prohibited foods not offered		
----	----	-----	-----	--	--	--

Food and Color Additives and Toxic Substances

27	IN	OUT	N/A	Food additives: approved & properly used		
28	IN	OUT		Toxic substances properly identified, stored, & used		

Conformance with Approved Procedures

29	IN	OUT	N/A	Compliance with variance/specialized process/HACCP		
----	----	-----	-----	--	--	--

Risk factors (RF) are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions (PHI)** are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance

Mark "X" in appropriate box for COS and/or R

COS= corrected on-site during inspection

R= repeat violation

Safe Food and Water

30	IN	OUT	N/A	Pasteurized eggs used where required		
31				Water & ice obtained from an approved source		
32	IN	OUT	N/A	Variance obtained for specialized processing methods		

Food Temperature Control

33				Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	N/A N/O	Plant food properly cooked for hot holding		
35	IN	OUT	N/A N/O	Approved thawing methods used		
36				Thermometers provided & accurate		

Food Identification

37				Food properly labeled; original container		
----	--	--	--	---	--	--

Prevention of Food Contamination

38				Insects, rodents, & animals not present		
39				Contamination prevented during food prep, storage & display		
40				Personal cleanliness		
41				Wiping cloths: properly used & stored		
42				Washing fruits & vegetables		

Proper Use of Utensils

43				In-use utensils: properly stored		
44				Utensils, equipment & linens: properly stored, dried, & handled		
45				Single-use/single service articles: properly stored & used		
46				Gloves used properly		

Utensil Equipment and Vending

47				Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48				Warewashing facilities: installed, maintained, & used; test strips		
49				Non-food contact surfaces clean		

Physical Facilities

50				Hot & cold water available; adequate pressure		
51	X			Plumbing installed; proper backflow devices		
52				Sewage & waste water properly disposed		
53				Toilet facilities: properly constructed, supplied, & cleaned		
54				Garbage & refuse properly disposed; facilities maintained		
55				Physical facilities installed, maintained, & clean		
56				Adequate ventilation & lighting; designated areas used		
57				Compliance with MCIAA		
58				Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature)

Date: 09/13/22

Inspector (Signature)