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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 11VS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00432

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245562**

2.STATE VENDOR OR MEDICAID NO.
(L2) **507042200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELDER'S HOME INC.**
(L4) **SOUTH TOUSLEY, P.O. BOX 188**
(L5) **NEW YORK MILLS, MN** (L6) **56567**

4. TYPE OF ACTION: 7 (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/01/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY ~~02~~ (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date : 07/01/2014
Tammy Williams, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL — Date: 07/11/2014
Kate JohnsTon, Enforcement Specialist (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/03/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245562

July 11, 2014

Mr. Cal Anderson, Administrator
Elders Home Inc
South Tousley, P.O. Box 188
New York Mills, Minnesota 56567

Dear Mr. Anderson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 20, 2014 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 skilled nursing facility beds .

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 11, 2014

Mr. Cal Anderson, Administrator
Elder's Home Inc.
South Tousley, P.O. Box 188
New York Mills, Minnesota 56567

RE: Project Number S5562023

Dear Mr. Anderson:

On May 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on May 16, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. Conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety.

On July 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 16, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 20, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 16, 2014, effective June 20, 2014 and therefore remedies outlined in our letter to you dated May 29, 2014, will not be imposed.

As we notified you in our letter of May 29, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 16, 2014.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245562	A. Building B. Wing	7/1/2014

Name of Facility	Street Address, City, State, Zip Code
ELDERS HOME INC	SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **06/20/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **06/20/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/20/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/06/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/KJ	07/11/2014	32603	07/01/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/16/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245562	01 - 01 MAIN BUILDING	6/16/2014

Name of Facility	Street Address, City, State, Zip Code
ELDERS HOME INC	SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 05/19/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 07/11/2014	Signature of Surveyor: 27200	Date: 06/16/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/13/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 11VS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00432

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245562**

2.STATE VENDOR OR MEDICAID NO.
(L2) **507042200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELDERS HOME INC**
(L4) **SOUTH TOUSLEY, PO BOX 188**
(L5) **NEW YORK MILLS, MN** (L6) **56567**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/16/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Miriam Thornquist, HFE NEII 06/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 07/02/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/03/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3667

May 29, 2014

Mr. Cal Anderson, Administrator
Elders Home Inc
South Tousley, PO Box 188
New York Mills, Minnesota 56567

RE: Project Number S5562023

Dear Mr. Anderson:

On May 16, 2014, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. Conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 25, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 25, 2014 the following remedy will be imposed:

- Per instance civil money penalty (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Elders Home Inc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective May 16, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 16, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 16, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5562s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245562	A. BUILDING _____ B. WING _____	05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERS HOME INC	SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An extended survey was conducted by the Minnesota Department of Health on 5/12/14 thru 5/16/14. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225		

6/23/14 ok attachments

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

Jeff Johnson | Adm | JUN 13 2014

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

RECEIVED
JUN 16 2014
MN Dept of Health
Fergus Falls

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F 225	Continued From page 1 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse/mistreatment were immediately reported to the administrator and to the State agency (SA) for 6 of 6 residents (R53, R60, R1, R28, R51, R27) in the facility. In addition, the facility failed to report in a timely manner to the SA for 2 of 2 residents (R38, R12) identified with injuries of unknown origin and failed to thoroughly investigate incidents of potential abuse/mistreatment for 2 of 2 residents (R53, R60) in the facility. Findings include: Review of the facility incident reports revealed the following: 1. R53's quarterly Minimum Data Set (MDS)	F 225	F-225 Corrective Action: Elders' Home will ensure all alleged violations involving potential mistreatment, neglect, or abuse, including resident to resident abuse are reported immediately to administrator and immediately reported to the State Agency and Common Entry Point in Accordance with State/ Federal law. Corrective Action as It Applies To Residents Involved: 1. VA Report was made to State Agency regarding Resident to Resident Abuse for R-53 and R-60 and for Resident to Resident Abuse for R-1 and R-28 on 5-23-14. 2. Was made aware of incident that needed reporting when received 2567. VA Report was made to State Agency regarding Resident to Resident Verbal Abuse on 6-9-14.	

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F 225	Continued From page 2 dated 3/26/14, identified R53 was unable to be interviewed, had both short and long term memory problems. The MDS identified R53 required assistance with all activities of daily living (ADL) and had wandering behaviors. R60's annual MDS, dated 1/3/14, revealed R60 had severe cognitive impairment and required assistance with all ADLs. The Accident/Incident Report form dated 4/30/14, revealed at 3:00 p.m., licensed practical nurse (LPN)-C witnessed R53 approach R60, who was seated in a recliner chair in a lounge area in the facility with a wheeled walker near the chair. R53 attempted to take R60's walker. R60 told R53 that the walker did not belong to R53 and to leave it alone. R53 became verbally and physically aggressive towards R60. R53 then swore at R60 and, with an open hand, slapped R60 across the left side of her face and left arm. The report identified the facility requested an adjustment of the medication regimen for R53 and attempted to keep the residents separated. The report lacked documentation the resident to resident altercation had been immediately reported to the administrator and immediately reported to the SA. On 5/15/14, at 3:01 p.m., LPN-B indicated on numerous occasions in the past, R53 had raised her fist at R60 and attempted to take R60's walker. 2. R1's annual MDS dated 11/14/13, identified R1 was not interviewable, had both short and long term memory problems and required assistance with ADLs. R28's quarterly MDS dated 3/12/14, identified	F 225	3. Investigations were completed for each of these incidents, preventative measures were put into place and effected residents were followed up to ensure no lasting adverse effects. Corrective Action As It Applies To All Residents: 1. All staff training was conducted on the Elders' Home Abuse Prevention Policies regarding Assessing, Reporting, and Investigating-Incidents of Potential Abuse, Resident to Resident Altercations, and Injuries of Unknown Origin on 6-6-14. 2. Facility Abuse Prevention Policy Books for use on each unit were updated with Algorithms, Key Concepts And Definitions of Federal Reporting Requirements on 6-10-14.	

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F 225	Continued From page 3 R28 had moderate cognitive impairment and required assistance with ADLs. The Accident/ Incident report form dated 4/9/14, revealed at 6:30 p.m., nursing assistant (NA)-B was assisting R1 in his room. R28 appeared in the doorway to the room and demanded assistance. NA-B instructed R28 that he would receive assistance after R1 and requested R28 return to his room. After NA-B had assisted R1, R28 continued to stand in the doorway and R1 proceeded to approach R28 and punched R28 in the stomach. The report revealed after investigation it was determined to redirect and reapproach R28 to prevent further incidents from occurring. The report lacked documentation the administrator and SA had been immediately notified of the potential mistreatment. 3. R51's quarterly MDS dated 2/13/14, identified R51 had severe cognitive impairment, was independent with ambulation and utilized a walker. R27's quarterly MDS dated 3/28/14, identified R27 had severe cognitive impairment, required extensive assistance with ADLs and utilized a wheelchair for locomotion. The Accident/Incident Report form dated 12/15/13, revealed at 11:45 a.m., NA-C witnessed a verbal and physical resident to resident altercation between R51 and R27. The report revealed R51 became angry at R27 when R27 was attempting to turn his wheel chair around and went on R51's side of the room. R51 pushed his walker into R27's chair repeatedly and yelled at R27, "Get the hell out of my way." The investigation revealed the shared room by R51	F 225	Recurrance Will Be Prevented By: DON/Designee to conduct audits for three months, on all Incident Reports , to determine the incident was appropriately assessed, and if determined to be reportable, was reported to the Administrator and to the State Agency immediately and thoroughly investigated. Audit Results will be brought to the QA Committee for further recommendations as to continue with audits, do random audits, or to discontinue. Completion Date: 6-20-14	

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F 225	Continued From page 4 and R27 had very limited space, and the facility was considering a room change for one of the residents. The report lacked documentation the administrator and SA were immediately notified of this incident of resident to resident potential mistreatment and/or abuse. On 5/15/15, at 2:44 p.m. the administrator stated incidents between confused residents could not be considered willful. The administrator further stated he did not consider a slap without a mark an injury. The administrator verified the facility did not report resident to resident altercations to the SA unless there was a visible injury on the victim's skin like a bruise or a red mark or scratch. The administrator confirmed these resident to resident altercations had not been reported to the SA. On 5/15/14, at 3:10 p.m. during interview with the administrator and the DON the current facility policy was confirmed. The administrator indicated the usual facility practice was to notify himself and the DON and they would investigate the incident to determine if the incident needed to be reported. The administrator stated he understood the facility had 24 hours to report the incident to the SA and stated he would only report the altercation if either resident sustained a physical injury from the altercation. At 3:12 p.m. the DON stated the staff would call her to notify her of potential reportable incidents. She stated she would make the determination if the incident was reportable, and then if a reportable incident, she would notify the administrator. The DON stated if it was after hours, she would notify the administrator the next day. At 3:17 p.m., the DON indicated the usual facility policy was to complete an incident report when resident to resident	F 225		

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F 225	Continued From page 5 altercations occurred. She also stated the facility did not report the altercations to the SA unless the altercation resulted in a physical injury for one of the residents. On 5/16/14, at 9:34 a.m. the DON confirmed the altercation with R53 and R60 was willful, and confirmed no further investigation after the completion of the incident report had been conducted. She confirmed the altercations between R53, R60, R1, R28, R51 and R27 should have been reported to the SA. On 5/16/14, at 9:47 a.m. the administrator confirmed he had not been notified on the altercation with R53 and R60 until 5/1/4, and was not aware of the time of the notification. Review of the the facility's vulnerable adult (VA) reports revealed the following: A VA report dated 5/1/14, indicated R38 had a purple-blackish bruise of unknown origin on the right inner thigh during cares. According to the report, the bruise on the inner thigh measured 2 centimeters (cm) and R38 was unable to explain how the bruising occurred. However, the facility had not reported the injury of unknown origin to the SA until 5/2/14 at 9:35 a.m. A VA report dated 10/31/13 identified on 10/30/13, at approximately 2:00 p.m. the facility had found 3 bruises, of unknown origin, on R12's forearm. The 3 bruises were on the left forearm, and one measured 1 centimeter (cm) by 1.5 cm, a second bruise measured 2 cm by 2 cm, and the third bruise measured 2 cm by 2 cm. The documented report indicated the facility staff had questioned R12's cognitive capability and that the staff had	F 225		

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F 225	Continued From page 6 identified the bruises as injuries of unknown origin. However, a report to the SA was not done until 10/31/13 at 2:00 p.m. During interview on 5/15/14, at 4:13 p.m. the administrator confirmed the current policy directed staff to report VA findings immediately, but indicated he understood the facility had up to 24 hours to report to the SA. The administrator stated he and the DON routinely met to determine the cause of any potential abuse or neglect incidents and then would report to the SA if it was determined to be reportable. During interview on 5/16/14, at 9:03 a.m. the DON confirmed the facility had not reported R38's injury of unknown origin until the next day. She also confirmed the facility was aware of the injury of unknown origin for R12 on 10/30/13, but had not reported the injury until 10/31/13.	F 225		

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F 225	Continued From page 7	F 225		

Review of the facility policy titled Maltreatment Reporting Guidelines, dated 11/2013, identified resident to resident abuse and identified even though a resident may have cognitive impairment,

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F 225	Continued From page 8 he/she could still commit a willful act. The policy identified there were instances where the resident's willfulness intent can not be determined. The policy directed this should still be reported and investigated to further identify further risks and ensure adequate interventions are put in place. In addition, the policy identified any injuries of unknown origin would be reported to the appropriate authorities according to state and federal guidelines. Review of the facility policy titled Reporting Mechanisms for Potential Abuse, dated 11/13, included the facility must report any suspected abuse/neglect to MDH immediately ("Immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident). The policy also included direction to immediately notify the administrator of the potential abuse/neglect.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize the facility abuse prohibition policy related to immediate notification of the administrator and to the State agency (SA) potential mistreatment and/or abuse for 6 of 6 residents(R53, R60, R1, R28, R51, R27) involved	F 226		

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F 226	Continued From page 9 in resident to resident altercations, and for 2 of 2 residents (R38, R12) identified with injuries of unknown origin. In addition, the facility failed to implement the abuse prevention policy for thorough investigations for 2 of 6 (R53, R60) residents involving potential mistreatment and/or abuse. Findings include: Review of the facility policy titled Maltreatment Reporting Guidelines, dated 11/2013, identified resident to resident abuse and identified even though a resident may have cognitive impairment, he/she could still commit a willful act. The policy identified there were instances where the resident's willfulness intent can not be determined. The policy directed this should still be reported and investigated to further identify further risks and ensure adequate interventions are put in place. In addition, the policy identified any injuries of unknown origin would be reported to the appropriate authorities according to state and federal guidelines. Review of the facility policy titled Reporting Mechanisms for Potential Abuse, dated 11/13, included the facility must report any suspected abuse/neglect to MDH immediately ("Immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident). The policy also included direction to immediately notify the administrator of the potential abuse/neglect. Review of the facility incident reports revealed the following:	F 226	F-226 Corrective Action: Elders Home will ensure all alleged violations involving potential mistreatment, neglect, or abuse, including resident to resident abuse and unexplained injury are reported immediately to administrator and immediately reported to the State Agency and Common Entry Point, in accordance with State/Federal law. Corrective Action As It Applies To Residents Involved: 1. VA Report was made to State Agency regarding Resident to Resident Abuse for R-53 and R-60 and for Resident to Resident Abuse for R-1 and R-28 on 5-23-14.	

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F 226	Continued From page 10 1. R53's quarterly Minimum Data Set (MDS) dated 3/26/14, identified R53 was unable to be interviewed, had both short and long term memory problems. The MDS identified R53 required assistance with all activities of daily living (ADL) and had wandering behaviors. R60's annual MDS, dated 1/3/14, revealed R60 had severe cognitive impairment and required assistance with all ADLs. The Accident/Incident Report form dated 4/30/14, revealed at 3:00 p.m., licensed practical nurse (LPN)-C witnessed R53 approach R60, who was seated in a recliner chair in a lounge area in the facility with a wheeled walker near the chair. R53 attempted to take R60's walker. R60 told R53 that the walker did not belong to R53 and to leave it alone. R53 became verbally and physically aggressive towards R60. R53 then swore at R60 and, with an open hand, slapped R60 across the left side of her face and left arm. The report identified the facility requested an adjustment of the medication regimen for R 53 and attempted to keep the residents separated. The report lacked documentation the resident to resident altercation had been immediately reported to the administrator and immediately reported to the SA. On 5/15/14, at 3:01 p.m., LPN-B indicated on numerous occasions in the past, R53 had raised her fist at R60 and attempted to take R60's walker. 2. R1's annual MDS dated 11/14/13, identified R1 was not interviewable, had both short and long term memory problems and required assistance with ADLs.	F 226	2. Was made aware of incident that needed reporting when received 2567. VA Report was made to State Agency regarding Resident to Resident Verbal Abuse on 6-9-14. 3. Investigations were completed for each of these incidents, preventative measures were put into place and effected residents were followed up to ensure no lasting adverse effects.	

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F 226	Continued From page 11 R28's quarterly MDS dated 3/12/14, identified R28 had moderate cognitive impairment and required assistance with ADLs. The Accident/ Incident report form dated 4/9/14, revealed at 6:30 p.m., nursing assistant (NA)-B was assisting R1 in his room. R28 appeared in the doorway to the room and demanded assistance. NA-B instructed R28 that he would receive assistance after R1 and requested R28 return to his room. After NA-B had assisted R1, R28 continued to stand in the doorway and R1 proceeded to approach R28 and punched R28 in the stomach. The report revealed after investigation it was determined to redirect and reapproach R28 to prevent further incidents from occurring. The report lacked documentation the administrator and SA had been immediately notified of the potential mistreatment. 3. R51's quarterly MDS dated 2/13/14, identified R51 had severe cognitive impairment, was independent with ambulation and utilized a walker. R27's quarterly MDS dated 3/28/14, identified R27 had severe cognitive impairment, required extensive assistance with ADLs and utilized a wheelchair for locomotion. The Accident/Incident Report form dated 12/15/13, revealed at 11:45 a.m., NA-C witnessed a verbal and physical resident to resident altercation between R51 and R27. The report revealed R51 became angry at R27 when R27 was attempting to turn his wheel chair around and went on R51's side of the room. R51 pushed his walker into R27's chair repeatedly and yelled at	F 226	Corrective Action As It Applies To All Residents: 1. All Staff Training was conducted on the Elders Home Abuse Prevention Policy regarding assessing, Reporting, and Investigating-Incidents of Potential Abuse, Resident to Resident Altercations, and Injuries of Unknown Origin on 6-6-14. 2. Facility Abuse Prevention Policy Books for use on each unit were updated with Algorithms, Key Concepts, and Definitions of Federal Reporting Requirements on 6-10-14.	

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	245562	A. BUILDING _____ B. WING _____	05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 12 R27, "Get the hell out of my way." The investigation revealed the shared room by R51 and R27 had very limited space, and the facility was considering a room change for one of the residents. The report lacked documentation the administrator and SA were immediately notified of this incident of resident to resident potential mistreatment and/or abuse. On 5/15/15, at 2:44 p.m. the administrator stated incidents between confused residents could not be considered willful. The administrator further stated he did not consider a slap without a mark an injury. The administrator verified the facility did not report resident to resident altercations to the SA unless there was a visible injury on the victim's skin like a bruise or a red mark or scratch. The administrator confirmed these resident to resident altercations had not been reported to the SA. On 5/15/14, at 3:10 p.m. during interview with the administrator and the DON the current facility policy was confirmed. The administrator indicated the usual facility practice was to notify himself and the DON and they would investigate the incident to determine if the incident needed to be reported. The administrator stated he understood the facility had 24 hours to report the incident to the SA and stated he would only report the altercation if either resident sustained a physical injury from the altercation. At 3:12 p.m. the DON stated the staff would call her to notify her of potential reportable incidents. She stated she would make the determination if the incident was reportable, and then if a reportable incident, she would notify the administrator. The DON stated if it was after hours, she would notify the administrator the next day. At 3:17 p.m., the DON	F 226	Recurrence will be Prevented By: DON/designee, to conduct audits, weekly for three months on all incident reports to determine if the incident was appropriately assessed, and if determined to be reportable, was reported to the Administrator and to the State Agency immediately and thoroughly investigated. Audit Results will be brought to the QA Committee for further recommendations as to continue with audits, do random audits, or to discontinue. Completion Date: 6-20-14	

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F 226	Continued From page 13 indicated the usual facility policy was to complete an incident report when resident to resident altercations occurred. She also stated the facility did not report the altercations to the SA unless the altercation resulted in a physical injury for one of the residents. On 5/16/14, at 9:34 a.m. the DON confirmed the altercation with R53 and R60 was willful, and confirmed no further investigation after the completion of the incident report had been conducted. She confirmed the altercations between R53, R60, R1, R28, R51 and R27 should have been reported to the SA. On 5/16/14, at 9:47 a.m. the administrator confirmed he had not been notified on the altercation with R53 and R60 until 5/1/4, and was not aware of the time of the notification. Review of the the facility's vulnerable adult (VA) reports revealed the following: A VA report dated 5/1/14, indicated R38 had a purple-blackish bruise of unknown origin on the right inner thigh during cares. According to the report, the bruise on the inner thigh measured 2 centimeters (cm) and R38 was unable to explain how the bruising occurred. However, the facility had not reported the injury of unknown origin to the SA until 5/2/14 at 9:35 a.m. A VA report dated 10/31/13 identified on 10/30/13, at approximately 2:00 p.m. the facility had found 3 bruises, of unknown origin, on R12's forearm. The 3 bruises were on the left forearm, and one measured 1 centimeter (cm) by 1.5 cm, a second bruise measured 2 cm by 2 cm, and the third bruise measured 2 cm by 2 cm. The documented	F 226		

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F 226	Continued From page 14 report indicated the facility staff had questioned R12's cognitive capability and that the staff had identified the bruises as injuries of unknown origin. However, a report to the SA was not done until 10/31/13 at 2:00 p.m. During interview on 5/15/14, at 4:13 p.m. the administrator confirmed the current policy directed staff to report VA findings immediately, but indicated he understood the facility had up to 24 hours to report to the SA. The administrator stated he and the DON routinely met to determine the cause of any potential abuse or neglect incidents and then would report to the SA if it was determined to be reportable. During interview on 5/16/14, at 9:03 a.m. the DON confirmed the facility had not reported R38's injury of unknown origin until the next day. She also confirmed the facility was aware of the injury of unknown origin for R12 on 10/30/13, but had not reported the injury until 10/31/13.	F 226		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 15 Based on observation, interview and document review the facility failed to serve food in a sanitary manner to prevent food borne illness for 25 of 39 residents (R4,R6,R7,R9,R13,R14,R15,R17,R18,R20,R21,R25,R29,R30,R32,R36,R39,R42,R46,R48,R49, R50,R51,R57 and R58) served regular food items from the steamtable in both dining rooms in the facility. In addition, the facility failed to ensure clean dishes were dried in a sanitary manner, this had the potential to affect all 44 residents residing in the facility. Findings included: During a kitchen tour on 5/14/14, at 11:26 a.m. a 16 inch white Lasko brand oscillating fan was observed in the dishwashing room, blowing over the clean dishes. The front grate of the fan was covered with a layer of gray debris. During interview on 5/14/14, at 11:26 a.m. the dietary assistant (DA)-B stated the fan was cleaned last week, however, DA-B confirmed the cleaning was not documented. During interview on 5/14/14, at 11:34 a.m. the DM confirmed the fan was dirty with noticeable dust and blew directly towards the clean dishes. The DM confirmed the cleaning of the fan was not identified on the weekly cleaning schedule and stated she would expect the fan to be cleaned weekly. During observation in the main dining room on 5/12/14, at 5:06 p.m. dietary assistant (DA)-A was observed standing next to the steam table, with	F 371	F371 All oscillating fans in the Kitchen were cleaned on 5-15. They will be placed on a weekly cleaning schedule and the cleaning will be documented, with date of cleaning and employee initials. The Dietary Manager is responsible, to ensure that the schedule is being followed. Dietary staff will be in-serviced on serving food in a sanitary manner, to prevent food borne illness on 6-18. Random audits will be conducted by the DM, 3 times a week for one week, 2 times a week for 3 weeks and weekly thereafter, regarding the proper hand washing technique, use of gloves and utensils/tongs during the meal service.	

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F 371	Continued From page 16 vinyl type gloves on both hands. DA-A picked up a highlighter and clipboard with her gloved hands and used the highlighter to write on the clipboard. DA-A immediately walked to the steam table and started serving food items from the steam table onto individual residents plates. During continuous observation from 5:06 p.m. to 5:25 p.m., wearing the same dirty gloves, DA-A picked up individual pancakes from the pancake container on the steam table and placed the pancake on individual resident's plates. She proceeded to reach into a nearby cardboard paper box, picked up syrup and butter condiments and placed on the condiments on the resident plates. At 5:17 p.m. DA-A, wearing the same dirty gloves, picked up a hashbrown patty and an individual pancake from the steam table and placed the items on a resident plate. She proceeded to pick up the pancake, tear the pancake in half and returned both pieces of the pancake to the plate next to the hashbrown patty. DA-A repeated the same process of placing individual pancakes and condiments on individual resident plates using the same dirty gloves throughout the entire observation. At 5:25 p.m., DA-A removed the vinyl type gloves from both hands and donned a fresh pair of gloves to both hands at 5:26 p.m. At 5:27 p.m., DA-A opened/shut a drawer with the right gloved hand, and removed the steam lids from the steam table, using all of the handles with both gloved hands. DA-A then proceeded to serve pancakes onto individual resident plates with both gloved hands contaminated by the handles of the steam table lids and drawer. During interview on 5/12/14, at 5:34 p.m. DA-A stated all residents in the facility were served	F 371	DM, will bring audit results to the next Quality Assurance Committee meeting, for further recommendations.	

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F 371	Continued From page 17 meals from the steam table. DA-A confirmed she handled non-food items with the same gloves used to serve pancakes and hashrowns for all residents that chose the regular menu option. She stated staff had been directed to wear gloves if handling ready to eat foods, and to change gloves if staff touch anything else. During interview on 5/12/14, at 5:56 p.m. the dietary manager (DM) confirmed gloves should be removed, hand washing should be performed and new gloves applied after touching non-food items. Review of the facility's undated Fan Cleaning Policy, directed the fan to be cleaned at least once a week on the routine cleaning schedule by the P.M. Dietary aides. Review of the facility's undated Meal Service Safety policy, directed gloves to be worn when food that is ready for consumption is being handled. The policy did not address when gloves should be changed nor did the policy address the use of utensils or tongs during meal service.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		

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F 441	Continued From page 18 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an ongoing infection control program that included surveillance, investigation, analysis of data that included specific organisms, resident location, symptoms of infections in the facility. This deficient practice had the potential to affect all 44 residents currently residing the facility.	F 441	F-441 Corrective Action: 1.The facility implemented new, comprehensive Infection Control (IC) Policies on 6/6/14. IC Policies include Infection Surveillance procedures with IC Logs that include data regarding resident location in the facility, symptoms of possible infection, identified pathogens, ABI use and follow up on effectiveness of intervention (s). Policies also address the need to document an analysis of tracking and trending. 2.Symptoms of potential infections will be documented on a daily basis on the IC Logs, and will be analyzed by the Infection Control Nurse to determine trends that will help to identify the need for training, preventative measures or isolation techniques to control the spread of any potential outbreak.	

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F 441	Continued From page 19 Findings include: During review of the facility's Resident Infection Control Log (s) from April 2013, through December 2013, the following infections were entered: 6 pneumonia, 1 swollen gland, 12 urinary, 7 urinary infections (UTI), 1 cough/congestion, 6 respiratory, 4 wheezing. However, the logs lacked the following data for infection control surveillance on the Resident Infection Control Log (s): location of resident within the facility, symptoms, diagnosis, and culture results performed. The logs had been completed by the infection control coordinator (ICC) and the director of nurses(DON), however, neither one had analyzed the data to track trends and patterns of the infections within the facility. The DON indicated she was unable to provide any further documentation related to infection control logs completed since December 2013. During an interview 5/13/14 at 2:05 p.m. the DON reviewed the Resident Infection Control Logs, and confirmed there had not been documentation to support analysis of the infection control data. The DON stated a summary of the infection control logs had been brought to the quality assurance (QA) meetings, however those reports did not contain any further information to track or trend the infections of residents. The DON stated the infection control report to the quality assurance(QA) committee, dated April 9 2014, identified 1 UTI with no antibiotic, 2 respiratory/ cough with no antibiotic used, 10 diarrhea and emesis, 8 respiratory 3 of which had been treated with an antibiotic. The DON indicated the report was the usual information reviewed with the QA committee.	F 441	3.Training on the new IC Policies was completed at the All Staff meeting on 6-6-14. Recurrance Will Be Prevented By: DON/Designee will conduct random audits of IC Logs two times a week for two weeks, then one time a week for four weeks to ensure Logs are being filled out appropriately and tracking and trending is being conducted with appropriate follow up. Audit results will be brought to the QA Committee for further recommendations and follow up. Completion Date: 6-6-14	

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F 441	Continued From page 20 During an interview on 5/15/14, at 4:00 p.m. the DON confirmed she was unable to produce any other documentation to support infection control surveillance within the facility. Review of the facility's policy titled Elders' Home Infection Control Program dated 2011, identified the infection control program had been designed to prevent the development and transmission of disease and infection. Review of the facility's undated policy titled Infection Control Data Collection, analysis and Action Plan revealed the facility would track all resident and employee infections in categories. The action plan identified the Infection Control Nurse was responsible to analyze the data, including individual resident location within the facility, antibiotic use, to look for patterns or trends to identify any "hot spots" of interest with infections. Further, the action plan directed this information would be brought to the QA committee for review routinely.	F 441		

Elders Home Inc.

Exit Date: 5-16-2014

Addendum:

F-225

Recurrance Will Be Prevented By:

Audits will be done daily by DON/designee of all Incident Reports, for three months, to determine the incident was appropriately assessed, and if determined to be reportable, was reported to the Administrator and to the State Agency immediately and thoroughly investigated.

Claudia Stuart RN
6-23-14

Elders Home Inc.

Exit Date: 5-16-2014

Addendum:

F-226

Recurrance Will Be Prevented By:

Audits will be done daily by DON/designee of all Incident Reports, for three months, to determine the incident was appropriately assessed, and if determined to be reportable, was reported to the Administrator and to the State Agency immediately and thoroughly investigated.

Claudia Stiroi RN
6-23-14

Elders Home Inc.

Exit Date:

5-16-2014

Addendum:

F-371

Completion Date: 6-20-2014

Claudia Stussa RN

6-23-14

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Elders Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us	K 000	POC ok FB 6-9-14 RECEIVED JUN - 5 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 6-25-14
EXIT: 5-16-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Adm.	JUN - 5 2014

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

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Elders Home is a 1-story building with a partial basement. The original building was constructed in 1959 and was determined to be of Type II(111) construction. In 1993, an addition was added to the south that was determined to be of Type II (111). In 1999 an addition was added onto the Dinning Room to the west which is Type V (111). The building is divided into 4 smoke zones divided by 30 minute and 90 minute fire barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms have single smoke detectors that are battery operated.	K 000		

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERS HOME INC	SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a capacity of 51 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all 44 residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 2:30 PM on 05/13/2014, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. The last smoke detector sensitivity test was 07/22/2008. This was confirmed by the Maintenance	K 054	**K054** **Facility hired Protection Systems, from Fargo ND to conduct a sensitivity inspection on all smoke detectors in the facility. The inspection, was completed on May 19, 2014 (see attached invoice).** **Administration has revised our contract with Protection Systems, to test all smoke detectors for sensitivity on all even numbered years. The contract (attached) was signed on June 5, 2014.** **The facility maintenance supervisor, will be responsible to ensure that the testing, as prescribed in the contract is completed, in accordance with applicable NFPA code.**	5-19-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245562	A. BUILDING 01 - 01 MAIN BUILDING B. WING _____	05/13/2014

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K 054	Continued From page 3 Supervisor (DA).	K 054		

Protection Systems, Inc.
901 Page Drive
Fargo, ND 58103
Ph (701) 280-2144
Fax (701) 356-4013

MAY 21 2014

Invoice

DATE	INVOICE #
5/20/2014	24369

BILL TO
Elder's Home 215 S. Tousley P.O. Box 188 New York Mills, MN 56567

SHIP TO
Elder's Home 215 S. Tousley New York Mills, MN 56567

NFPA MEMBER 2012-13

NICET CERTIFIED

We support and encourage NICET certification

P.O. NUMBER	TERMS	REP	SHIP	VIA	PROJECT
	Due upon Receipt	FHM	5/20/2014	Service	Sensitivity 2014

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
	PMI MN	Sensitivity Preventive Maintenance Inspection Jerry W Technician 5/19/14 5/23/14 D. Anderson #4650		

We appreciate your business.

Total

Past due invoices are subject to a 1.5% finance charge monthly.

Fire Alarm Testing Agreement

Protection Systems, Inc.
901 Page Drive
Fargo, ND 58103 St Cloud, MN
Phone 701-280-2144 320-252-2982
Fax 701-356-4013
www.protectionsys.com

We support and encourage NICET certification

Contract Period: 4/1/15 TO 3/31/16

Testing Month/Months: April

Annual Fee for Following Option..

Customer:
Elders Nursing Home
215 S Tousley
New York Mills, MN 56567

- [ ] Annual Test Only
- [X] Annual Test with Maintenance & Sensitivity
- [ ] Off Premise 12 Month Monitoring

EQUIPMENT TO BE TESTED

Qty	Model	Description	Location
1	Mircom FX2000	Fire Control Panel	
	ANN	Annunciator	
46	PSD	Photoelectric Smoke Detector	
2	PDD	Photo Duct Detector	
12	PS	Pull Station	
21	ROR/FT	Rate of Rise/Fixed Temperature Heat Detector	
15	AV & V & A	Horn/ Strobe, Strobe & Horn only	
4	SV	Supervisory Switches	
1	WF	Waterflow Switches	
All	Firmware	Firmware upgrades (No Charge)	
	Sensitivity	Sensitivity Test Even Years	
		*Last Sensitivity Test completed 5/19/14	

Additional information:
Protection Systems, Inc. shall test peripheral devices annually (unless otherwise noted) to keep system in peak operating form. Protection Systems, Inc. will inform customer of the results and the customer shall make arrangements to correct any deficiencies. An Annual Test with Maintenance also covers service calls provided during normal business hours - 8:00AM to 4:30PM Monday thru Friday, except holidays. Service required outside normal business hours will be billed at overtime rates.

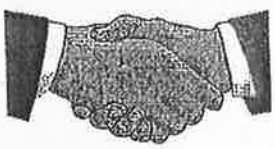
This contract does not cover service needed due to lightning, water, vandalism, misuse, faulty wiring, or any installation not in accordance with manufactures installation instructions.

Testing of the sprinkler system is not part of this contract, but can be arranged upon request.

This Agreement will be automatically renewed for successive one year periods and will be invoiced annually 30 days prior to renewal date. Either party may cancel on 30 days written notice.

Authorized Signature adm. **Date** JUN - 5 2014

PO Number _____



Protection Systems, Inc. Rep. Heidi Gelsing