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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2F3H

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: **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 **01/22/2015** (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 :
Patrici Bernstetter, HFE NEII — 01/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 02/13/2015 (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
01/20/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245562

February 13, 2015

Mr. Cal Anderson, Administrator
Elders Home Inc
South Tousley, PO 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 January 7, 2015 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.

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.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 27, 2015

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

RE: Project Number S5562024

Dear Mr. Anderson:

On December 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 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.

On January 22, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 7, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2014, effective January 7, 2015 and therefore remedies outlined in our letter to you dated December 18, 2014, will not be imposed.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

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

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	(Y3) Date of Revisit
245562	A. Building B. Wing	1/22/2015

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	01/05/2015	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	01/07/2015	ID Prefix F0441 Reg. # 483.65 LSC	01/07/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/KFD	01/28/2015	32600	1/22/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
12/4/2014	

Protecting, Maintaining and Improving the Health of Minnesotans

January 26, 2015

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

Re: Enclosed Reinspection Results - Project Number S5562024

Dear Mr. Anderson:

On January 22, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 22, 2015, with orders received by you on December 24, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00432	A. Building B. Wing	1/22/2015

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20302** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **01/05/2015**	ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4** LSC	Correction Completed **01/07/2015**	ID Prefix **21615** Reg. # **MN Rule 4658.1340 Subp. 2** LSC	Correction Completed **01/07/2015**
ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	Correction Completed **01/05/2015**	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/KFD	01/27/2015	32600	01/22/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/4/2014

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: 2F3H

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 **12/04/2014** (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 :
Christina Martinson, HFE NE II 01/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/14/2015 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2491

December 18, 2014

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

RE: Project Number S5562024

Dear Mr. Anderson:

On December 4, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that 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;

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

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;

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
Fergus Falls Survey Team
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: Gail.anderson@state.mn.us

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 January 13, 3014, 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 January 13, 2014 the following remedy will be imposed:

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

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) 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 March 4, 2015 (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 June 4, 2015 (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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5562s15

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 _____	12/04/2014

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 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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a sanitary and homelike environment was maintained in resident rooms for 6 of 30 residents (R24, R42, R6, R29, R37, R45) reviewed during the environmental tour. Findings include: On 12/2/14, at 3:00 p.m. an environmental tour of the facility was conducted with the administrator and maintenance supervisor (MS) present on the tour. The administrator and MS confirmed the following findings: In R24's room, several large black scuff marks	F 253	**F253** **The following repairs have been/ will be made:** **Room for R24:** **Wall was repainted on Dec. 31st.** **Bathroom for R42:** **Dave's Floor Covering from Sebeka will replace the floor on Jan. 5th** **Room for R6:** **Heat registers were painted on Dec. 10th** **Bathroom for R29:** **Dave's Floor Covering from Sebeka will replace the floor on Jan. 5th**	

1/8/15 OK addendum

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

JAN - 2 2015

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
JAN 05 2015
MN Dept of Health
Fergus Falls

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 _____	12/04/2014

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

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F 253	Continued From page 1 were observed on the wall above the bed, near the bed side rail. In R42's bathroom, a dark brown/black substance was observed around the entire base of the toilet. In addition, the tiles on the wall behind the toilet were discolored with a gray/black substance. In R6's room, several areas with paint missing from the heat registers was observed in the bathroom and the register in the bed room. In R29's bathroom, a large section of discolored tiles with gray/black substance were observed behind the toilet. In R37's bathroom, sections of dark rust spots were observed on the tile walls next to the toilet and a large area of dark brown spots were observed on the tiles below the bathroom register. In R45's bathroom, an large area of large black scuff marks were observed on the walls in the bathroom, with several areas of paint missing on the bathroom door jam facing out into the bedroom. On 12/2/14, at 3:10 p.m. the administrator indicated resident rooms were cleaned weekly, and housekeeping and maintenance were responsible for painting and cleaning that needed to be done in the facility. He verified the wall in R37's bathroom would be a "quick fix" and stated "take out the tile and put new in where it is wearing out." At 3:12 p.m. MS confirmed he does not do routine room audits and indicated he only fixes what he is told to fix.	F 253	**Bathroom for R37:** **Tiled were cleaned and tile walls were painted on Dec. 31st.** **Bathroom for R45:** **Walls and door jam, were painted on Dec. 15th** **On Dec. 30th, a mandatory in-service was conducted for all staff in Housekeeping, Laundry and Maintenance, to review the MDH survey results. Housekeeping staff was re-inserviced on the requirement that they report any maintenance and/or safety concerns, to the Maintenance Dept., by completing a maintenance request, in the repair book, located at the Central nurses station. Maintenance staff will review the book on a daily basis and make necessary repairs.** **The Housekeeping/Laundry supervisor, is responsible to, make sure that Maintenance staff, is completing the requested repairs, in a timely manner.**	

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F 253	Continued From page 2 On 12/3/14, at 11:11 a.m. MS confirmed he fixes issues that are wrote in the log book up at the nurses station and MS indicated he was not aware of the areas observed on the environmental tour. MS stated "we can do better with fixing things and looking at the rooms." A facility maintenance policy was requested, and the administrator indicated the facility did not have a policy to address routine maintenance in the facility. Review of facility policy titled, Housekeeper, revised 11/27/2000 directed staff to report to maintenance and /or safety concerns to supervisor. The policy indicated a maintenance request was to be completed for repair needs and was to be sent to the maintenance department.	F 253	**The Housekeeping/Laundry Supervisor, is also responsible to make random room inspections, to verify that the resident rooms are in a safe and clean condition. Supervisor will make these inspections for three months and report her findings to the QA Committee at their next quarterly meeting.**	**Jan. 5, 2015**
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		

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F 431	Continued From page 3 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store schedule II (medications that have a high potential for abuse) controlled medications (narcotics) in a permanently affixed compartment for 1 of 3 medication carts. In addition, the facility failed to ensure the integrity of emergency medications in 1 of 1 emergency kits utilized in the facility. Findings include: On 12/1/14, at 6:27 p.m. licensed practical nurse (LPN)-B unlocked the central medication cart, opened the bottom drawer and retrieved a locked green tackle box which she set on the top of the medication cart. LPN-B unlocked the tackle box which contained several different schedule II medications, and prepared one tablet of hydrocodone apap 325 mg (a narcotic pain medication) for R5. LPN-B locked the green	F 431	**F431** **The policy and procedures for the following items of concern, were reviewed and revised on December 29th and 30th:** • **Controlled Drugs / Counted Medications.** • **Physician's Emergency Drug Supply. (E-kit)** • **Narcotic Medication Verification** **A mandatory in-service for all licensed Nurses and TMA's , discussing the review and revisions of the policies and procedures, will be held on Jan. 7, 2015.** **Bi-weekly audits will be conducted for 90 days on: documentation of controlled medications, locked storage on controlled medications, compliance of staff related to controlled medications and e-kit maintenance and documentation. The results of the audits will be reported to the next Quality Assurance Committee, quarterly meeting.**	

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F 431	Continued From page 4 tackle box, returned the box to the bottom drawer of the central medication cart. The following medications were stored in the portable green tackle box: hydrocodone apap 10-325 mg-34 whole tablets hydrocodone apap 5-325 mg-12 half tablets hydrocodone apap 5-325 mg 50 tabs fentanyl Duragesic (a narcotic pain patch)patches 25 mcg-3 patches Morphine Sulfate (narcotic pain medication) 20 mg/ml solution opened bottle-29.5 ml Morphine Sulfate20 mg/ml solution unopened bottle, 30 ml milliliters) On 12/3/14, at 11:50 a.m. the locked emergency kit (e-kit) in medication room #44 was observed secured with a red, plastic, numbered band. The number 170 was printed in white on the red plastic band. However, the narcotic medication log identified the e-kit had last been secured with band number 137. Registered nurse (RN)-A, who was present for the observation, confirmed the log did not reflect the accurate lock number. She indicated she was not aware when the lock had been changed and confirmed documentation on the log should reflect when a new lock had been applied. RN-A stated the usual facility practice was for staff to apply a new numbered lock on the e-kit when the previous lock had been removed in order to access medications stored in the e-kit. RN-A further stated the staff member who changed the lock should of entered the new number on the e-kit log. Review of the facility form titled Narcotic Medication Count for the month of December	F 431	**Maintenance staff, permanently affixed the locked narcotic boxes, to the medication carts, on Dec. 31st.** **The correction will be monitored by the Director of Nursing, or in her absence, the Asst. Director of Nursing** **Jan. 7, 2015**	

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F 431	Continued From page 5 2014 listed ER(emergency) kit, med room and #137, 12/1/14 and an area for signature on the 6:00 a.m., 2:30 p.m. and 10:30 p.m. shift each day of the month. Each shift had two sets of initials documented daily from 12/1/14 to 12/3/14. During interview on 12/3/14, at 11:54 a.m. RN-B and LPN-A both confirmed the scheduled II narcotics were stored in the portable tackle box in the central medication cart. They indicated storing schedule II narcotics in the portable tackle box has been the usual facility practice for a long time. During interview on 12/3/14, at 1:16 p.m. the director of nursing (DON) confirmed staff were expected to document the e-kit lock number on the e-kit log every time after attaching a new lock to ensure medication security and integrity of the e-kit supplies for emergency use in the facility. The DON stated the facility had always stored schedule II narcotics in removable boxes in the locked medication carts. The DON confirmed both of the boxes the facility were using to store the scheduled II narcotics were not permanently affixed to the medication carts. The DON reported the facility's consulting pharmacy group had not identified the scheduled II narcotics were improperly stored. The DON further stated the consultant pharmacists did not routinely look in the medication carts, or at current narcotics, and confirmed the pharmacy consultant only observed the medication rooms and reviewed the storage of discontinued narcotics. Review of the pharmacist's consultant quarterly report, dated July 2014 indicated storage of medications in the facility had been audited during visit and identified no concerns at that	F 431		

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F 431	Continued From page 6 time. Review of the facility's Physician Drug Emergency Supply policy, dated 5/14, directed staff to lock the emergency kit with a tamper proof lock that is marked with a number to identify it. Further, the policy identified Morphine may be stored in the kit, and the narcotic medication would be counted by checking to make sure the lock remained unchanged. A facility policy regarding storage of Scheduled narcotic medications was requested, but not provided.	F 431		
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 - (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.	F 441		

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F 441	Continued From page 7 (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 infection control program which included ongoing surveillance of resident infections which included specific infecting organisms and analysis of surveillance data to establish possible trends or patterns in the facility. This had the potential to affect all 42 residents who resided in the facility. Findings include: Review of the monthly facility forms titled Infection Surveillance Log, August 14, through November 14, listed various data for each resident which included date of onset, signs and symptoms (s/s), infection site of infection. However, the logs lacked documentation of specific pathogens for UTI's, whether the infection was treated with antibiotics, and whether interventions were effective and if training was provided.	F 441	**F441** **The policy and procedures for the Infections Prevention and Control Program, was reviewed and revised on Dec. 23rd.** **Included in the review, was the infection surveillance procedures, with the infection control logs, which include data regarding resident location in the facility, symptoms of possible infection, identified pathogen, antibiotic treatment/dosage for residents.** **An additional review of the previous items, will also apply to staff illnesses.** **The ICN (Infection Control Nurse) will update the infection control tracking log at a minimum on a weekly basis. Weekly tracking review and analysis of documentation will be completed by the ICN. Any noted trends will be brought to the DON immediately.**	

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F 441	Continued From page 8 Review of the facility forms titled Monthly Infection Report for All Nursing Units, May 14, through June 14, listed for each nursing unit in the facility, the total number the following types of infections: UTI's, skin, upper respiratory infection, lower respiratory infection, gastrointestinal (GI), surgical wound infections, IV site or blood, other and a comments section. However, the forms lacked documentation of specific organisms and analysis of the infections for possible trends. On 12/04/14, at 2:03 p.m., the director of nursing (DON) confirmed the facility infection surveillance logs lacked consistent documentation of specific pathogens as well as follow up of interventions and if training was provided to facility staff for the months of May 14, to November 14. The DON confirmed the current facility policy and confirmed the facility monthly infection report lacked analysis of the findings which was needed to monitor for trends for the months of May to June 14. The DON stated each nursing unit had a 3 ring binder which held infection surveillance logs. The DON stated she expected the nurses to enter all the information onto the logs when a resident was suspected of having an infection. The DON stated she expected all areas on the form to be filled out which included identifying specific pathogens, when treatment was initiated, whether the infection was resolved and any education provided to facility staff. She stated the pathogens were important aspect of the infection control program to help "pin point" potential root cause, guide training and education as well as to stop or decrease the spread of infection. The DON stated she was unable to locate the facilities monthly infection reports for the nursing units for the months of July, August, September, October	F 441	**On Jan. 7, 2015, a mandatory in-service for all licensed nurses and TMA's, will be conducted to review the concerns, listed above. In addition, education will be provided on the P&P for handling Lab results. Staff nurses will be responsible to copy original results sent to the facility. Copies will be placed into a labeled folder, "Lab Results for Infection Control Nurse" and the original lab result, placed in the resident chart.** **Lab results will be documented and followed up only, by the Infection Control Nurse (ICN), or in her absence, by the Director of Nursing (DON).** **The ICN, will update the infection control tracking log at a minimum on a weekly basis.** **Corrections made to the policies listed above, will be monitored by the ICN, or in her absence, by the DON.** **Jan 7, 2015**	

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F 441	Continued From page 9 and November. The DON stated her expectation would have been for the infection control nurse to have the information for the infection control program accessible, however, the nurse was no longer working at the facility. The DON verified the facilities current infection control program lacked comprehensive surveillance, analysis and monitoring for patterns. Review of the facility policy titled, Infection Prevention and Control Program, dated 4/10, revealed the infection control professional (ICP) would conduct a surveillance program that included: assessing the population, selecting outcome measures, collecting surveillance data on a daily basis, analyzing and reporting the surveillance as necessary. The policy directed the ICP to routinely review the surveillance data to analyze clusters or trends, changes in prevalent organisms, or increase in rate of infection in a timely manner and to bring the results to the infection control team members. The policy also directed the facility ICP to monitor antibiotic use to prevent unnecessary use.	F 441		

Addendum to Plan of Correction for Survey exited 12-4-2014:

TAG: F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

1. **Reoccurrence will be prevented by:**

    a. Original lab results will be photocopied by staff nurses and filed in resident chart.
    b. Copies of lab results will be placed by staff nurses in labeled folder "LAB RESULTS FOR INFECTION CONTROL NURSE" which will be kept at Central Nursing Station.
    c. ICN will be notified upon receipt of infection results via nurse communication book and resident "black book" that ICN checks daily.
    d. Lab results will be documented and followed up on only by Infection Control Nurse (ICN) and DON (in times of absence of ICN).
    e. The Infection Control Tracking Log was revised implementing an area to indicate the type of pathogen and an area to indicate what antibiotic was used to treat the resident.
    f. The ICN will complete Infection Control Tracking Log and analyze results on a weekly basis and prn.
    g. Audits on Infection Control Tracking will be completed two times per week for 90 days by ICN or DON.
    h. Audit results will be presented to the Quality Assurance Committee for recommendations on any need for further audits.

2. **The Correction will be monitored by:**
    a. Infection Control Nurse
    b. Director of Nursing (if Infection Control Nurse is absent from facility)

Elders Home Inc.
P.O. Box 188
New York Mills, MN 56567

JAN - 7 2015

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Elders Home was found 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. 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. The facility has a capacity of 51 beds and had a census of 41 at the time of the survey.	K 000		

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

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 requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2491

December 18, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5562024

Dear Mr. Anderson:

The above facility was surveyed on December 1, 2014 through December 4, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: Gail.anderson@state.mn.us

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at the number or email above.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

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
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 5562s15lic

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00432	A. BUILDING: _____ B. WING _____	12/04/2014

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/1/2014 to 12/4/2014 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Received Via mail 1/7/15 Lo

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health Gail Anderson, Unit Supervisor, 1505 Pebble Lake Road, Suite 300, Fergus Falls, 56537	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		

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2 302	Continued From page 2 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide consumers in written or electronic form, information regarding facility staff training for Alzheimer's disease and related disorders. Findings include: During interview on 12/04/14, at 10:14 a.m. the social services designee (SS)-A indicated she was not aware of the requirement regarding provision of written or electronic information to facility consumers, of staff training for care of residents with Alzheimer's disease and related disorders. The SS-A stated "no nothing in writing" had been provided to family or residents explaining the dementia training topics, who is trained or frequency of the training with the current facility admission package or any other	2 302		

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2 302	Continued From page 3 information provided to consumers. During an interview on 12/4/14 10:56 a.m. the director of nursing (DON) verified the facility had not provided consumers in writing or electronic form, the details of Alzheimer training regarding what training is provided, what staff were trained or the frequency of training. The DON indicated this information could be provided in the future to the consumer by including in the facility admission package. Review of the facility's current admission package folders revealed no written, or access to electronic information, of facility staff training on caring for residents with Alzheimer's disease and related disorders was included in the admission information. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet for consumer information. The DON or designee could educate staff and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases;	21390		

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21390	Continued From page 4 C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included ongoing surveillance of resident infections which included specific infecting organisms and analysis of surveillance data to establish possible trends or patterns in the facility. This had the potential to affect all 42 residents who resided in the facility. Findings include: Review of the monthly facility forms titled Infection Surveillance Log, August 14, through November 14, listed various data for each resident which included date of onset, signs and symptoms (s/s), infection site of infection.	21390		

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21390	Continued From page 5	21390		

However, the logs lacked documentation of specific pathogens for UTI's, whether the infection was treated with antibiotics, and whether interventions were effective and if training was provided.

Review of the facility forms titled Monthly Infection Report for All Nursing Units, May 14, through June 14, listed for each nursing unit in the facility, the total number the following types of infections: UTI's, skin, upper respiratory infection, lower respiratory infection, gastrointestinal (GI), surgical wound infections, IV site or blood, other and a comments section. However, the forms lacked documentation of specific organisms and analysis of the infections for possible trends.

On 12/04/14, at 2:03 p.m., the director of nursing (DON) confirmed the facility infection surveillance logs lacked consistent documentation of specific pathogens as well as follow up of interventions and if training was provided to facility staff for the months of May 14, to November 14. The DON confirmed the current facility policy and confirmed the facility monthly infection report lacked analysis of the findings which was needed to monitor for trends for the months of May to June 14. The DON stated each nursing unit had a 3 ring binder which held infection surveillance logs. The DON stated she expected the nurses to enter all the information onto the logs when a resident was suspected of having an infection. The DON stated she expected all areas on the form to be filled out which included identifying specific pathogens, when treatment was initiated, whether the infection was resolved and any education provided to facility staff. She stated the pathogens were important aspect of the infection control program to help "pin point" potential root cause, guide training and education as well as to

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21390	Continued From page 6 stop or decrease the spread of infection. The DON stated she was unable to locate the facilities monthly infection reports for the nursing units for the months of July, August, September, October and November. The DON stated her expectation would have been for the infection control nurse to have the information for the infection control program accessible, however, the nurse was no longer working at the facility. The DON verified the facilities current infection control program lacked comprehensive surveillance, analysis and monitoring for patterns. Review of the facility policy titled, Infection Prevention and Control Program, dated 4/10, revealed the infection control professional (ICP) would conduct a surveillance program that included: assessing the population, selecting outcome measures, collecting surveillance data on a daily basis, analyzing and reporting the surveillance as necessary. The policy directed the ICP to routinely review the surveillance data to analyze clusters or trends, changes in prevalent organisms, or increase in rate of infection in a timely manner and to bring the results to the infection control team members. The policy also directed the facility ICP to monitor antibiotic use to prevent unnecessary use. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure resident infections with spcific organisms were tracks, and analyzed for any patterns or trends in the facility. Facility staff could be re-educated and an auditing system developed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one	21390		

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21390	Continued From page 7 (21) days.	21390		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to store schedule II (medications that have a high potential for abuse) controlled medications (narcotics) in a permanently affixed compartment for 1 of 3 medication carts. In addition, the facility failed to ensure the integrity of emergency medications in 1 of 1 emergency kits utilized in the facility. Findings include: On 12/1/14, at 6:27 p.m. licensed practical nurse (LPN)-B unlocked the central medication cart, opened the bottom drawer and retrieved a locked green tackle box which she set on the top of the medication cart. LPN-B unlocked the tackle box which contained several different schedule II medications, and prepared one tablet of hydrocodone apap 325 mg (a narcotic pain medication) for R5. LPN-B locked the green tackle box, returned the box to the bottom drawer of the central medication cart. The following medications were stored in the	21615		

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21615	Continued From page 8 portable green tackle box: hydrocodone apap 10-325 mg-34 whole tablets hydrocodone apap 5-325 mg-12 half tablets hydrocodone apap 5-325 mg 50 tabs fentanyl Duragesic (a narcotic pain patch)patches 25 mcg-3 patches Morphine Sulfate (narcotic pain medication) 20 mg/ml solution opened bottle-29.5 ml Morphine Sulfate20 mg/ml solution unopened bottle, 30 ml milliliters) On 12/3/14, at 11:50 a.m. the locked emergency kit (e-kit) in medication room #44 was observed secured with a red, plastic, numbered band. The number 170 was printed in white on the red plastic band. However, the narcotic medication log identified the e-kit had last been secured with band number 137. Registered nurse (RN)-A, who was present for the observation, confirmed the log did not reflect the accurate lock number. She indicated she was not aware when the lock had been changed and confirmed documentation on the log should reflect when a new lock had been applied. RN-A stated the usual facility practice was for staff to apply a new numbered lock on the e-kit when the previous lock had been removed in order to access medications stored in the e-kit. RN-A further stated the staff member who changed the lock should of entered the new number on the e-kit log. Review of the facility form titled Narcotic Medication Count for the month of December 2014 listed ER(emergency) kit, med room and #137, 12/1/14 and an area for signature on the 6:00 a.m., 2:30 p.m. and 10:30 p.m. shift each day of the month. Each shift had two sets of initials documented daily from 12/1/14 to 12/3/14.	21615		

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21615	Continued From page 9 During interview on 12/3/14, at 11:54 a.m. RN-B and LPN-A both confirmed the scheduled II narcotics were stored in the portable tackle box in the central medication cart. They indicated storing schedule II narcotics in the portable tackle box has been the usual facility practice for a long time. During interview on 12/3/14, at 1:16 p.m. the director of nursing (DON) confirmed staff were expected to document the e-kit lock number on the e-kit log every time after attaching a new lock to ensure medication security and integrity of the e-kit supplies for emergency use in the facility. The DON stated the facility had always stored schedule II narcotics in removable boxes in the locked medication carts. The DON confirmed both of the boxes the facility were using to store the scheduled II narcotics were not permanently affixed to the medication carts. The DON reported the facility's consulting pharmacy group had not identified the scheduled II narcotics were improperly stored. The DON further stated the consultant pharmacists did not routinely look in the medication carts, or at current narcotics, and confirmed the pharmacy consultant only observed the medication rooms and reviewed the storage of discontinued narcotics. Review of the pharmacist's consultant quarterly report, dated July 2014 indicated storage of medications in the facility had been audited during visit and identified no concerns at that time. Review of the facility's Physician Drug Emergency Supply policy, dated 5/14, directed staff to lock the emergency kit with a tamper proof lock that is marked with a number to identify it. Further, the	21615		

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21615	Continued From page 10 policy identified Morphine may be stored in the kit, and the narcotic medication would be counted by checking to make sure the lock remained unchanged. A facility policy regarding storage of Scheduled narcotic medications was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure controlled medications were securely double locked. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21615		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a sanitary and homelike environment was maintained in resident	21695		

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21695	Continued From page 11 rooms for 6 of 30 residents (R24, R42, R6, R29, R37, R45) reviewed during the environmental tour. Findings include: On 12/2/14, at 3:00 p.m. an environmental tour of the facility was conducted with the administrator and maintenance supervisor (MS) present on the tour. The administrator and MS confirmed the following findings: In R24's room, several large black scuff marks were observed on the wall above the bed, near the bed side rail. In R42's bathroom, a dark brown/black substance was observed around the entire base of the toilet. In addition, the tiles on the wall behind the toilet were discolored with a gray/black substance. In R6's room, several areas with paint missing from the heat registers was observed in the bathroom and the register in the bed room. In R29's bathroom, a large section of discolored tiles with gray/black substance were observed behind the toilet. In R37's bathroom, sections of dark rust spots were observed on the tile walls next to the toilet and a large area of dark brown spots were observed on the tiles below the bathroom register. In R45's bathroom, an large area of large black scuff marks were observed on the walls in the bathroom, with several areas of paint missing on the bathroom door jam facing out into the bedroom.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00432	A. BUILDING: _____ B. WING _____	12/04/2014

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21695	Continued From page 12 On 12/2/14, at 3:10 p.m. the administrator indicated resident rooms were cleaned weekly, and housekeeping and maintenance were responsible for painting and cleaning that needed to be done in the facility. He verified the wall in R37's bathroom would be a "quick fix" and stated "take out the tile and put new in where it is wearing out." At 3:12 p.m. MS confirmed he does not do routine room audits and indicated he only fixes what he is told to fix. On 12/3/14, at 11:11 a.m. MS confirmed he fixes issues that are wrote in the log book up at the nurses station and MS indicated he was not aware of the areas observed on the environmental tour. MS stated "we can do better with fixing things and looking at the rooms." A facility maintenance policy was requested, and the administrator indicated the facility did not have a policy to address routine maintenance in the facility. Review of facility policy titled, Housekeeper, revised 11/27/2000 directed staff to report to maintenance and /or safety concerns to supervisor. The policy indicated a maintenance request was to be completed for repair needs and was to be sent to the maintenance department. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to report timely environmental concerns so they can be addressed timely to provide a safe and sanitary environment for the residents, staff and visitors. TIME PERIOD FOR CORRECTION: Twenty One	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21695	Continued From page 13 (21) days.	21695		