DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY	ID: 2F3H Facility ID: 00432			
1. MEDICARE/MEDICAID PROVIDER N (L1) 245562 2.STATE VENDOR OR MEDICAID NO. (L2) 507042200	D.	3. NAME AND ADI (L3) ELDERS HO (L4) SOUTH TOU (L5) NEW YORK	ME INC JSLEY, PO BOX 1		(L6) 56567	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On Sin Visit 9. Othera			
5. EFFECTIVE DATE CHANGE OF OWN (L9)	IERSHIP	7. PROVIDER/SUP 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 01/22/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30			
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 	51 (L18) 51 (L17)	B. Not in Com	ce With quirements	/aivers:	And/Or Approved Waivers Of The2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF)5. Life Safety Code * Code: A* 15. FACILITY MEETS	Following Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)			
18 SNF 18/19 SNF 51 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		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: Mat. Meeth, Enforcement Specialist 02/13/2015 (L20)				
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	L OFFICE OR SINGLE STAT	E AGENCY			
 DETERMINATION OF ELIGIBILITY X1. Facility is Eligible to Part 2. Facility is not Eligible 	icipate (L21)		PLIANCE WITH CI ITS ACT:	VIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREEMI BEGINNING		4. LTC AGREEMEN ENDING DATE		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00	(L30) INVOLUNTARY			
06/01/1991 (L24)	(L41)		(L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer	05-Fail to Meet Health/Safety at 06-Fail to Meet Agreement			
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active			
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)	-				
31. RO RECEIPT OF CMS-1539		. DETERMINATION C 01/20/2015	OF APPROVAL DAT						
	(L32)			(L33)	DETERMINATION APPRO	VAL			



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 Weath

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 Department of Health - Health Regulation Division • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us *An equal opportunity employer*



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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist

Elders Home Inc January 27, 2015 Page 2 Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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 245562	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/22/2015
Name	e of Facility		Street Address, City, State, Zip Code	
EL	DERS HOME INC		SOUTH TOUSLEY, PO BOX 18 NEW YORK MILLS, MN 56567	8

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)	ltem		(Y5)	Date
ID Prefix	F0253	C	Correction Completed 1/05/2015	ID Prefix	F0431		Correction Completed 01/07/2015		ID Prefix	F0441		Correction Completed 01/07/2015
	483.15(h)(2)			Reg. # LSC	483.60(b), (d), (e)				Reg. # LSC	483.65		
ID Prefix Reg. # LSC		C	Correction Completed	Reg. #			Correction Completed					
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			
ID Prefix Reg. # LSC			Correction Completed	Reg. #					D //			
Reviewed E	By Re	eviewed E	Зу	Date:	Signature o	of Surv	veyor:				Date:	
State Agen	cy GA	A/KFD		01/28/20	15			1/22/2015				
Reviewed E CMS RO	3y Re	eviewed E	Зу	Date:	Signature o	of Sur	veyor:				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				



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,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> 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 00432	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/22/2015
Name	e of Facility		Street Address, City, State, Zip Code	
EL	DERS HOME INC		SOUTH TOUSLEY, PO BOX 18 NEW YORK MILLS, MN 56567	8

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	(Y:	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction Completed			Correction Completed			Correction Completed
ID Prefix	20302	01/05/2015	ID Prefix		01/07/2015	ID Prefix	21615	01/07/2015
Reg. # LSC	MN State Statute 144.	_		MN Rule 4658.0800 Sub			MN Rule 4658.1340	
	21695 MN Rule 4658.1415 Su		ID Prefix Reg. #		Correction Completed	ID Prefix		Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed	ID Prefix Reg. # LSC		
ID Prefix Reg. # LSC			Reg. #			Rea. #		
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed	Reg. #		
Reviewed E State Agene	cy GA/K	TFD	Date: 01/27/201		326	00	Date	01/22/2015
Reviewed E CMS RO	3y Reviewe	d By	Date:	Signature of Sur	veyor:		Date	:
Followup t	o Survey Completed o 12/4/2014 M: REVISIT REPORT (Check for any Unco Uncorrected Defic Page 1 of 1				

DEPARTMENT ()F HEALTH				~		CDICARE & MEDICAI			
						AND TRANSMITTAL FE SURVEY AGENCY		2F3H		
1. MEDICARE/MEDIC			3. NAME AND A			IE SURVET AGENCI	4. TYPE OF ACTION:	ility ID: 00432		
(L1) 245562	AIDTROVIDER	NO.	(L3) ELDERS H				4. TITE OF ACTION.			
2.STATE VENDOR OR			(L4) SOUTH TO	USLEY, PO B	BOX 188		3. Termination	 Recertification CHOW 		
(L2) 507042200			(L5) NEW YORK MILLS, MN			(L6) 56567	5. Validation 6. Complaint 7. On-Site Visit 9. Other			
5. EFFECTIVE DATE	CHANGE OF OW	VNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey After Co			
(L9)	12/04	2014 (I 24)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	13 PTIP 22 CLIA				
 6. DATE OF SURVEY 8. ACCREDITATION S 		2014 (L34) (L10)	02 SNF/NF/Duai 03 SNF/NF/Distinct	00 F K I F 07 X-Ray	10 NF 11 ICF/III	14 CORF D 15 ASC	FISCAL YEAR ENDING	DATE: (L35)		
0 Unaccredited	1 TJC	(====)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30			
2 AOA	3 Other									
11LTC PERIOD OF C	ERTIFICATION		10.THE FACILITY		AS:					
From (a):			A. In Complia Program R	ance With Requirements		And/Or Approved Waivers O 2. Technical Personne	Of The Following Requirements el6. Scope of Servic			
To (b) :				ce Based On:		3. 24 Hour RN	7. Medical Directo	or		
12. Total Facility Beds		51 (L18)	1. A	acceptable POC		4. 7-Day RN (Rural S 5. Life Safety Code	SNF)8. Patient Room Si 9. Beds/Room	ize		
13.Total Certified Beds		51 (L17)	X B. Not in Cor	npliance with Pro	gram		9. Beds/Room			
15. Total Continue Dous		51 ()	Requirem	ents and/or Appl	ied Waivers:	* Code: B *	(L12)			
14. LTC CERTIFIED BI	ED BREAKDOW	N				15. FACILITY MEETS				
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
	51									
(L37)	(L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY A	GENCY REMAR	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):					
17. SURVEYOR SIGN	ATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:		
Christina Mar	tinson, HFE	NE II	(01/08/2015		Anne Kleppe, Enforce	ement Specialist	01/14/0015		
	,			51/08/2013	(L19)					
	PART	TII - TO BE	COMPLETED	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE	STATE AGENCY			
19. DETERMINATION	OF ELIGIBILIT	Y		APLIANCE WIT	H CIVIL					
1. Facility	is Eligible to Part	ticipate	RIGI	HTS ACT:		 Ownership/Cont Both of the Abov 	trol Interest Disclosure Stmt (HC ve :	CFA-1513)		
2. Facilit	y is not Eligible	(L21)								
		(121)								
22. ORIGINAL DATE		23. LTC AGREE	MENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION	N: (L30	0)		
OF PARTICIPATIC	DN	BEGINNINC	6 DATE	ENDING DA	TE		<u>INVOLUNTA</u>			
06/01/1991						01-Merger, Closure 02-Dissatisfaction W/ Reimbur		et Health/Safety		
(L24)	DATE	(L41)	VE CANCELONG	(L25)		03-Risk of Involuntary Terminat	tion	t refeement		
25. LTC EXTENSION	DATE:		VE SANCTIONS			04-Other Reason for Withdrawa	l <u>OTHER</u> 1 07-Provider S	tatus Change		
	(1.27)			(L44)			00-Active			
	(L27)	B. Rescind St	spension Date:							
				(L45)				_		
28. TERMINATION D	ATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS				
			03001							
		(L28)			(L31)					
31. RO RECEIPT OF C	MS-1539	30	. DETERMINATION	N OF APPROVAL	L DATE					
		(L32)			(L33)	DETERMINATION APP	PROVAL			



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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

PRINTED: 12/18/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245562	B. WING		12/04/2014
	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION TE APPROPRIATE DATE
F 000	INITIAL COMMEN	TS	F 00	00	
	as your allegation of Department's acceleration of the first provide the bottom of the first provide used as verificated by the used as verificated by the used as verificated by the used as the used	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance. acceptable POC an on-site ty may be conducted to			
F 253	regulations has be your verification. 483.15(h)(2) HOU	antial compliance with the en attained in accordance with SEKEEPING &	F 2	53 F253	
SS=E	The facility must p maintenance servi	ERVICES rovide housekeeping and ces necessary to maintain a nd comfortable interior.		The following repairs h be made:	nave been/ will
		١		Room for R24: Wall was repainted on	Dec. 31 st .
	by: Based on observa review, the facility homelike environn	NT is not met as evidenced ation, interview and document failed to ensure a sanitary and nent was maintained in resident		Bathroom for R42: Dave's Floor Covering will replace the floor o	
	R37, R45) reviewe tour.	residents (R24, R42, R6, R29, ed during the environmental		Room for R6: Heat registers were pa Dec. 10 th	ainted on
	the facility was co and maintenance	0 p.m. an environmental tour of nducted with the administrator supervisor (MS) present on the rator and MS confirmed the	2	Bathroom for R29: Dave's Floor Covering will replace the floor o	
		veral large black scuff marks			offer
ABORATOR	RY DIRECTOR'S OR PROV	TPER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00432

JAN 0 5 2015 f continuation sheet Page 1 of 10

MN Dept of Health Fergus Falls

		AND HUMAN SERVICES			FORM	12/18/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245562	B. WING		12/	04/2014	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				DUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 253	the bed side rail. In R42's bathroom was observed arou In addition, the tiles were discolored wi In R6's room, seve from the heat regis bathroom and the In R29's bathroom tiles with gray/blac behind the toilet. In R37's bathroom were observed on and a large area o observed on the til register. In R45's bathroom scuff marks were bathroom, with set the bathroom doot bedroom. On 12/2/14, at 3:1 indicated resident and housekeeping responsible for pan needed to be door wall in R37's bath stated "take out th wearing out." At 3	age 1 the wall above the bed, near , a dark brown/black substance and the entire base of the toilet. s on the wall behind the toilet th a gray/black substance. eral areas with paint missing sters was observed in the register in the bed room. , a large section of discolored k substance were observed , sections of dark rust spots the tile walls next to the toilet f dark brown spots were les below the bathroom and he had areas of large black observed on the walls in the veral areas of paint missing on r jam facing out into the 0 p.m. the administrator rooms were cleaned weekly, g and maintenance were inting and cleaning that e in the facility. He verified the room would be a "quick fix" and the tile and put new in where it is c12 p.m. MS confirmed he does m audits and indicated he only		53	Bathroom for R37: Tiled were cleaned and tile walls were painted on Dec. 31 st . Bathroom for R45: Walls and door jam, were painted on Dec. 15 th On Dec. 30 th , a mandatory in-service was conducted for all staff in Housekeeping, Laundry and Maintena 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 requess 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 supervis is responsible to, make sure that Maintenance staff, is completing the requested repairs, in a timely manner.	ance, I	
	fixes what he is to						

Facility ID: 00432

If continuation sheet Page 2 of 10

		AND HUMAN SERVICES			FORMA	12/18/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245562	B. WING		12/0	04/2014
NAME OF F	ROVIDER 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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		JLD BE	(X5) COMPLETION DATE
F 253 F 431 SS=D	issues that are wro nurses station and aware of the areas environmental tour with fixing things all A facility maintenan the administrator in have a policy to add the facility. Review of facility p revised 11/27/2000 maintenance and / supervisor. The por request was to be was to be sent to t 483.60(b), (d), (e) LABEL/STORE DF The facility must e a licensed pharma of records of receil controlled drugs in accurate reconciliar reconds are in order controlled drugs is reconciled. Drugs and biologic labeled in accordar professional princi appropriate access instructions, and th applicable.	1 a.m. MS confirmed he fixes te in the log book up at the MS indicated he was not		 The Housekeeping/Laundry Supervisor, is also responsi make random room inspect to verify that the resident re are in a safe and clean cond Supervisor will make these inspections for three months and report her findings to th QA Committee at their next quarterly meeti 	ions, ooms lition. s ne ng.	an. 5, 2015
		- Ohaalala	11	Eccliby ID: 00420	linuation above	t Page 3 of 10
FORM CMS-2	567(02-99) Previous Versior	ns Obsolete Event ID: 2F3H		Facility ID: 00432 If cont	inuation shee	et Page 3 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/18/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMF	SURVEY
		245562	B, WING			12/0	4/2014
	PROVIDER OR SUPPLIER			so	IREET ADDRESS, CITY, STATE, ZIP CODE OUTH TOUSLEY, PO BOX 188		
ELDEKO				N	EW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	locked compartment controls, and permit have access to the The facility must pr permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distr	Il drugs and biologicals in hts under proper temperature it only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and b and other drugs subject to n the facility uses single unit ibution systems in which the ninimal and a missing dose can	F 4	31	 F431 The policy and procedures for the following items of concern, were reviewed and revised on December 29th and 30th: Controlled Drugs / Count Medications. Physician's Emergency Drug Supply. (E-kit) Narcotic Medication Verification 	e 1ber	
	by: Based on observa review, the facility (medications that h controlled medicati permanently affixe medication carts. ensure the integrity 1 of 1 emergency f Findings include: On 12/1/14, at 6:21 (LPN)-B unlocked opened the bottom green tackle box w medication cart. L which contained se medications, and p hydrocodone apap	NT is not met as evidenced tion, interview and document failed to store schedule II have a high potential for abuse) ons (narcotics) in a d compartment for 1 of 3 In addition, the facility failed to y of emergency medications in kits utilized in the facility. 7 p.m. licensed practical nurse the central medication cart, drawer and retrieved a locked which she set on the top of the PN-B unlocked the tackle box everal different schedule II prepared one tablet of 325 mg (a narcotic pain LPN-B locked the green			A mandatory in-service for all li Nurses and TMA's , discussing review and revisions of the pol procedures, will be held on Jan. 7, 2015. Bi-weekly audits will be conduct days on: documentation of cont medications, locked storage or medications, compliance of stat controlled medications and e-k maintenance and documentati The results of the audits will be reported to the next Quat Assurance Committee, quarter	the icies an trolled n contro iff relate it ion.	90 Iled ed to

Facility ID: 00432

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CON	E SURVEY IPLETED 104/2014
	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	3
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 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 50 tabs fentanyl Duragesic (a narcotic pain patch)patches 25 mg-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 am. 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 (R)-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 applied, RN-A 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 	tion he

Facility ID: 00432

If continuation sheet Page 5 of 10

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

PRINTED: 12/18/2014 FORM APPROVED OMB NO. 0938-0391

		& WEDICAID SERVICES				T NO.	0000-0001
STATEMENT OF DE AND PLAN OF CORI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245562	B. WING			12/0)4/2014
NAME OF PROVID	der or supplier			s	IREET ADDRESS, CITY, STATE, ZIP CODE OUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567		
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
2014 #137 6:00 day initia Duri and narc the o sche has time Duri direc expe the o to er e-kit The sche lock both the s sche has time e-kit The sche to er e-kit The sche to er e-kit The sche to er e-kit The sche to er e-kit the o sche to er e-kit the o sche sche the o sche the o sche the o sche sche the o sche sche the o sche sche the o sche the o sche sche sche sche sche sche sche sche	7, 12/1/14 and a o a.m., 2:30 p.m of the month. E als documented ing interview or LPN-A both co- cotics were stor central medicate edule II narcotic been the usual been the usual edule II narcotic been the usual e-kit log every nsure medicate t supplies for en DON stated the edule II narcotic t supplies for en DON stated the edule II narcotic t scheduled II narcotic t sche	ergency) kit, med room and an area for signature on the h, and 10:30 p.m. shift each Each shift had two sets of I daily from 12/1/14 to 12/3/14. In 12/3/14, at 11:54 a.m. RN-B nfirmed the scheduled II red in the portable tackle box in tion cart. They indicated storing cs in the portable tackle box I facility practice for a long In 12/3/14, at 1:16 p.m. the (DON) confirmed staff were hent the e-kit lock number on time after attaching a new lock on security and integrity of the mergency use in the facility. The facility had always stored cs in removable boxes in the carts. The DON confirmed he facility were using to store arcotics were not permanently cation carts. The DON r's consulting pharmacy group the scheduled II narcotics were The DON further stated the cists did not routinely look in ts, or at current narcotics, and rmacy consultant only observed ons and reviewed the storage		431			

Facility ID: 00432

If continuation sheet Page 6 of 10

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		AND HUMAN SERVICES				FORM A	12/18/2014 PPROVED)938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMP	SURVEY
		245562	B. WING			12/04	4/2014
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOMEINC				UTH TOUSLEY, PO BOX 188 W YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa time.	age 6	F۷	131			
	Supply policy, date the emergency kit marked with a num policy identified Mo kit, and the narcoti	ty's Physician Drug Emergency of 5/14, directed staff to lock with a tamper proof lock that is ober to identify it. Further, the prphine may be stored in the c medication would be counted ke sure the lock remained					
F 441 SS=F	narcotic medicatio provided. 483.65 INFECTIO	arding storage of Scheduled ns was requested, but not N CONTROL, PREVENT	F	441			
	Infection Control F safe, sanitary and	establish and maintain an Program designed to provide a comfortable environment and e development and transmissior ection.	ו			·	
	Program under wi (1) Investigates, c in the facility; (2) Decides what should be applied	establish an Infection Control hich it - controls, and prevents infections procedures, such as isolation, to an individual resident, and cord of incidents and corrective					
	determines that a	ction Control Program resident needs isolation to ad of infection, the facility must					
FORM CMS	2567(02-99) Previous Versio	ons Obsolete Event ID: 2F31		Fa	acility ID: 00432 If contir	uation she	et Page 7 of 10

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245562	B. WING				04/2014
ELDERS	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	SOU NEV	EET ADDRESS, CITY, STATE, ZIP CODE JTH TOUSLEY, PO BOX 188 W YORK MILLS, MN 56567 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	CTION OULD BE	(X5) COMPLETION DATE
F 441	Continued From pa (2) The facility mus communicable dise from direct contact direct contact will t (3) The facility mus hands after each o hand washing is in professional practi (c) Linens Personnel must ha transport linens so infection. This REQUIREME by: Based on intervie facility failed to es	age 7 age 7 ast prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. at require staff to wash their lirect resident contact for which idicated by accepted ce. andle, store, process and b as to prevent the spread of ENT is not met as evidenced ew and document review, the tablish an infection control	F 4		CROSS-REFERENCED TO THE APP DEFICIENCY) F441 The policy and procedures Infections Prevention and C Program, was reviewed an on Dec. 23 rd . Included in the review, wa surveillance procedures, wa control logs, which include resident location in the fac of possible infection, ident antibiotic treatment/dosag An additional review of the will also apply to staff illne The ICN (Infection Control	PROPRIATE of or the Control d revised with the infect with the infect of ata rega cility, symp tified patho ge for resid e previous esses.	DATE DATE DATE DECTION Arding toms ogen, lents.
	resident infections infecting organism data to establish y facility. This had t residents who res Findings include: Review of the mo Infection Surveilla November 14, list resident which int symptoms (s/s), i However, the log specific pathoger infection was treat	cluded ongoing surveillance of s which included specific hs and analysis of surveillance bossible trends or patterns in the he potential to affect all 42 sided in the facility. onthly facility forms titled ance Log, August 14, through ted various data for each cluded date of onset, signs and infection site of infection. s lacked documentation of hs for UTI's, whether the ated with antibiotics, and whether re effective and if training was	er		will update the infection control tracking log at a n a weekly basis. Weekly tra and analysis of document completed by the ICN. An will be brought to the DO	acking revi tation will b iy noted tre	iew ends tely.

1.1

If continuation sheet Page 8 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/18/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING			12/0	04/2014
	ROVIDER OR SUPPLIER	L		SO	REET ADDRESS, CITY, STATE, ZIP CODE UTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Report for All Nurs June 14, listed for the total number th UTI's, skin, upper respiratory infection wound infections, comments section documentation of analysis of the infe On 12/04/14, at 2: (DON) confirmed logs lacked consis pathogens as well and if training was months of May 14 confirmed the cur the facility monthly analysis of the fin- monitor for trends 14. The DON stated s enter all the inforr resident was susp The DON stated s enter all the inforr resident was susp The DON stated s form to be filled o specific pathogen whether the infec education provide pathogens were if control program t cause, guide train stop or decrease DON stated she monthly infection	ity forms titled Monthly Infection ing Units, May 14, through each nursing unit in the facility, he following types of infections: respiratory infection, lower in, gastrointestinal (GI), surgical V site or blood, other and a . However, the forms lacked specific organisms and ections for possible trends. 03 p.m., the director of nursing the facility infection surveillance stent documentation of specific as follow up of interventions a provided to facility staff for the to November 14. The DON rent facility policy and confirmed y infection report lacked dings which was needed to for the months of May to June ed each nursing unit had a 3 held infection surveillance logs. she expected the nurses to mation onto the logs when a bected of having an infection. she expected all areas on the ut which included identifying is, when treatment was initiated tion was resolved and any ed to facility staff. She stated the mportant aspect of the infection o help "pin point" potential root hing and education as well as to the spread of infection. The was unable to locate the facilitie reports for the nursing units for ly, August, September, October	s	441 Fa	On Jan. 7, 2015, a mandatory for all licensed nurses and TM conducted to review the cond above. In addition, education provided on the P&P for ham results. Staff nurses will be to copy original results sent Copies will be placed into a f "Lab Results for Infection Co and the original lab result, pl resident chart. Lab results will be documentu up only, by the Infection Cond or in her absence, by the Dir (DON). The ICN, will update the infect tracking log at a minimum or Corrections made to the polit will be monitored by the ICN, by the DON.	MA's, will berns, lis will be dling La respons to the fa abeled f ntrol Nu aced in f ed and for rol Nurs ector of tion com a week or in he	I be sted b ible cility. older, rse" the bllowed e (ICN), Nursing trol ly basis.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	PPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE : COMPI	SURVEY
•		245562	B. WING	·		12/04	4/2014
NAME OF F	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 441	and November. Th would have been for have the informatic program accessible longer working at th the facilities curren lacked comprehen monitoring for patte Review of the facili Prevention and Co revealed the infect would conduct a se included: assessin outcome measures on a daily basis, an surveillance as nee ICP to routinely re- analyze clusters o organisms, or incr- timely manner and infection control te	e DON stated her expectation or the infection control nurse to on for the infection control e, however, the nurse was no he facility. The DON verified t infection control program sive surveillance, analysis and erns. Ity policy titled, Infection ntrol Program, dated 4/10, ion control professional (ICP) urveillance program that g the population, selecting s, collecting surveillance data halyzing and reporting the cessary. The policy directed the view the surveillance data to r trends, changes in prevalent ease in rate of infection in a to bring the results to the am members. The policy also r ICP to monitor antibiotic use		441			
FORM CMS-	2567(02-99) Previous Version	ns Obsolete Event ID: 2F3H	11	F	acility ID: 00432 If contin	uation sheet	Page 10 of 10

Facility ID: 00432

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PRINTED: 12/18/2014

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

TAG: F 441483.65 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

CA

	MENT OF HEALTH				562024	FORM	12/09/2014 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1 · ·	PLE CONSTRUCTIÓN G 01 - 01 MAIN BUILDING	(X3) DATE S COMPLE	
		245562		B. WING		12/0	5/2014
	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
ELDERS	HOME INC				Y. PO BOX 188 .S, MN 56567		
(X4) ID PREFIX	SUMMARY STA (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL		(X5) COMPLETION
TAG		NTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
K 000	INITIAL COMMENT	S		K 000			
	FIRE SAFETY						
	A Life Safety Code	Survey was conduct	ed by the				
		ent of Public Safety. Elders Home was fou					
	substantial compliant	nce with the requirer	nents for				
		icare/Medicaid at 42 Life Safety from Fire					
	2000 edition of Nati	onal Fire Protection					
		Standard 101, Life er 19 Existing Health					
	Elders Home is a 1-	-story building with a	partial				
	basement. The orig	inal building was cor	structed				
		termined to be of Ty 3, an addition was a					
	the south that was o	determined to be of T	Гуре II				
		ldition was added on e west which is Type					
	The building is divid	ed into 4 smoke zon e and 90 minute fire	es				
		sprinkler protected in					
		PA 13 Standard for the Natic Sprinkler Syste					
	edition. The facility h	has a manual fire ala	rm				
		detection in the corri corridor that is monit					
	automatic fire depar	tment notification, in	stalled in				
		PA 72 "The National dition. Other hazard					
		tic fire detectors that					
		n in accordance with					
	Minnesota State Fire sleeping rooms have						
	are battery operated	÷					
	The facility has a ca		d had a				
	census of 41 at the	time of the survey.					
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGN	ATURE	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.

	MENT OF HEALTH					FOR	: 12/09/2014 MAPPROVED). 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA //BER:	1 · ·	PLE CONSTRUCTION G 01 - 01 MAIN BUILDING	(X3) DATE S COMPL	URVEY
		245562		B. WING		12/0	5/2014
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE SOUTH TOUSLEY. PO BOX 188 NEW YORK MILLS, MN 56567			Y. PO BOX 188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	ige 1		K 000			
	The requirement at MET.	42 CFR, Subpart 48	3.70(a) is				
			÷.				
	÷						
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If continuation sheet Page 2 of 2



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 <u>only a suggestion</u> 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.

Minnesota Department of Health • Compliance Monitoring • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us *An equal opportunity employer*

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

	ta Department of He		(VO) 111 2101 -	CONSTRUCTION	(X3) DATE SURVEY
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · /	CONSTRUCTION	COMPLETED
	C. 501112511011		A. DOLDING.		
		00432	B. WING		12/04/2014
		<u> </u>		TATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		DUSLEY, PO		
ELDERS	HOME INC		K MILLS, M		
(VA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
(X4) ID PREFIX	(FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	LD BE COMPLETE DPRIATE DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
			2 000		
2 000	Initial Comments		2 000		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	In accordance with	n Minnesota Statute, section			
	144A.10, this corre	ection order has been issued			
	pursuant to a surv	ey. If, upon reinspection, it is			
	found that the defi	ciency or deficiencies cited			
	herein are not corr	rected, a fine for each violation I be assessed in accordance			
		fines promulgated by rule of			
	the Minnesota De	partment of Health.			
		vhether a violation has been			
	corrected requires	compliance with all rule provided at the tag			
	number and MN F	Rule number indicated below.			
	When a rule conta	ains several items, failure to			
	comply with any o	f the items will be considered			
	lack of compliance	e. Lack of compliance upon			
	re-inspection with	any item of multi-part rule will ssment of a fine even if the item			
	that was violated	during the initial inspection was			
	corrected.				
	You may request	a hearing on any assessments			
	inat may result fro	om non-compliance with these nat a written request is made to			1
	the Department w	rithin 15 days of receipt of a			
		nent for non-compliance.			
				Minnesota Department of Healt	h is
	Department's stat	12/4/2014 surveyors of this ff visited the above provider and		documenting the State Licensin	
	the following licer	ising orders were issued. When	n	Correction Orders using federa	l software.
	corrections are co	ompleted, please sign and date		Tag numbers have been assign	
	on the bottom of	the first page in the line marked		Minnesota state statutes/rules f	or Nursing
	with "Laboratory I	Director's or Provider/Supplier		Homes.	
		signature." Make a copy of		1	
Minnesota	Department of Health	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE
LADORATO	NT DIRECTORS OR FRO	Sell K.	9 dillema	ada	JAN - 7 2015
STATE FO	RM	17 yours	6899	2F3H11	If continuation sheet 1 of 1
SIALEFU	I NIVE				

Portinuation sheet 1 of 14 Portugal Add Port

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00432	B. WING		12/04/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ELDERS H	IOME INC	SOUTH	TOUSLEY, PO BO	K 188		
		NEW YC	ORK MILLS, MN 56	567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	
2 000	Initial Comments		2 000			
	*****ATTEN	ITION*****				
1	NH LICENSING C	ORRECTION 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					
	re-inspection with an result in the assessm	Lack of compliance upon y item of multi-part rule will lent of a fine even if the item ing the initial inspection was				
	that may result from orders provided that	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.				
	Department's staff vis the following licensin corrections are comp on the bottom of the with "Laboratory Dire	S: 4/2014 surveyors of this sited the above provider and g orders were issued. When eleted, please sign and date first page in the line marked ctor's or Provider/Supplier nature." Make a copy of		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	software. I to	

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			B. WING			
	ROVIDER OR SUPPLIER	00432	ADDRESS, CITY, ST		12/04/2014	
			TOUSLEY, PO E			
LDERSF	IOME INC	NEW YC	ORK MILLS, MN	56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	
2 000	Continued From page	e 1	2 000			
	original to the addres Minnesota Departme Gail Anderson, Unit S	nt of Health		The assigned tag number appear far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state stat out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Com portion of the correction order. T column also includes the finding are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sur findings are the Suggested Metho Correction and the Time Period F Correction. PLEASE DISREGARD THE HEA THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OI CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA S STATUTES/RULES.	Tag." Tag." the atute/rule ties" nply" his s which e after the as rveyors od of or DING OF F TO . THIS TO ON FOR	
2 302	MN State Statute 144 or related disorder tra	1.6503 Alzheimer's disease ain	2 302			
	ALZHEIMER'S DISE DISORDER TRAININ MN St. Statute 144.6	IG:				
	(a) If a nursing facility Alzheimer's disease or related dis segregated or genera					

STATE FORM

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00432	B. WING		12	/04/2014		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE				
ELDERS H	IOME INC		TOUSLEY, PO BOX RK MILLS, MN 56					
(X4) ID								
PRÉFIX TAG	(ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				COMPLET DATE		
2 302	Continued From page	e 2	2 302					
	care staff and their supervisors care.	must be trained in dementia						
	 (b) Areas of required training inc. (1) an explanation of Alzheimer's related disorders; (2) assistance with activities of d. (3) problem solving with challeng and 	Alzheimer's disease and ctivities of daily living;						
	written or electronic f training program, the trained, the frequenc topics covered.	kills. provide to consumers in form a description of the categories of employees y of training, and the basic document compliance with						
	by: Based on interview a facility failed to provid electronic form, inform training for Alzheimen disorders. Findings include: During interview on 1 social services desig was not aware of the provision of written o facility consumers, of residents with Alzheim	-						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:			
		00432	B. WING		12	2/04/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
ELDERS H	IOME INC		TOUSLEY, PO BOX ORK MILLS, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From page	e 3	2 302			
	information provided	to consumers.				
	director of nursing (D not provided consum form, the details of Al what training is provid or the frequency of tra	on 12/4/14 10:56 a.m. the ON) verified the facility had ers in writing or electronic zheimer training regarding ded, what staff were trained aining. The DON indicated I be provided in the future to uding in the facility				
	folders revealed no w electronic information caring for residents w	s current admission package vritten, or access to n, of facility staff training on vith Alzheimer's disease and s included in the admission				
	DON or designee coustaff training to the reconsumer information	OD OF CORRECTION: The uld add information regarding esident admission packet for n. The DON or designee nd conduct audits to ensure				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			
	control program must procedures which pro A. surveillance b collection to identify r residents;	ovide for the following: ased on systematic data nosocomial infections in letection, investigation, and				

	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00432	B. WING		12	2/04/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ELDERS H	HOME INC		TOUSLEY, PO BOX ORK MILLS, MN 565			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	COMPLET
21390	21390 Continued From page 4		21390			
	C isolation and r	precautions systems to				
		ission of infectious agents;				
		cation in infection				
	prevention and control					
		lth program including an				
		n, a tuberculosis program as				
		0810, and policies and				
	-	nt care practices to assist in				
	the prevention and tre	eatment of infections;				
	F. the developme	ent and implementation of				
		cies and infection control				
		tuberculosis program as				
	defined in part 4658.0					
		eviewing antibiotic use;				
	-	eview and evaluation of				
	•	infection control, such as				
	disinfectants, antisep	-				
	incontinence products					
		aintaining awareness of				
	current standards of	practice in infection control.				
	This MN Requiremen	t is not met as evidenced				
	by:					
		nd document review, the				
		lish an infection control				
		ed ongoing surveillance of				
	resident infections wh	•				
		nd analysis of surveillance				
	-	sible trends or patterns in the				
		potential to affect all 42				
	residents who resided	a in the facility.				
	Findings include:					
	Review of the monthl	y facility forms titled				
	Infection Surveillance	Log, August 14, through				
	November 14, listed					
		ed date of onset, signs and				
	symptoms (s/s), infect	Allow with a set to far attain	1			1

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00432	B. WING		1:	2/04/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
	HOME INC	SOUTH	TOUSLEY, PO BOX	(188		
		NEW YO	ORK MILLS, MN 56	567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page	e 5	21390			
	specific pathogens for infection was treated	cked documentation of r UTI's, whether the with antibiotics, and whether fective and if training was				
	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.					
	(DON) confirmed the logs lacked consister pathogens as well as and if training was pr months of May 14, to confirmed the current the facility monthly in analysis of the finding monitor for trends for 14. The DON stated for 14. The DON stated she enter all the informati resident was suspect The DON stated she form to be filled out w specific pathogens, w whether the infection education provided to pathogens were import	p.m., the director of nursing facility infection surveillance at documentation of specific follow up of interventions ovided to facility staff for the November 14. The DON t facility policy and confirmed fection report lacked gs which was needed to the months of May to June each nursing unit had a 3 d infection surveillance logs. expected the nurses to on onto the logs when a ed of having an infection. expected all areas on the which included identifying when treatment was initiated, was resolved and any o facility staff. She stated the ortant aspect of the infection elp "pin point" potential root				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00432	B. WING		12/04/2014	
NAME OF PROVIDER OR SUPPLIER			DDRESS, CITY, STATE,	, ZIP CODE	12	/04/2014
ELDERS H		SOUTH	TOUSLEY, PO BOX	188		
ELDERS F		NEW YO	ORK MILLS, MN 565	567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page	e 6	21390			
	DON stated she was monthly infection report the months of July, A and November. The I would have been for have the information program accessible, I longer working at the the facilities current in lacked comprehensive monitoring for pattern Review of the facility Prevention and Contr revealed the infection would conduct a surv included: assessing to outcome measures, c on a daily basis, anali- surveillance as necess ICP to routinely review analyze clusters or the organisms, or increass timely manner and to infection control team directed the facility IC to prevent unnecessa SUGGESTED METH The administrator or opolicies and procedur	policy titled, Infection rol Program, dated 4/10, a control professional (ICP) eillance program that he population, selecting collecting surveillance data yzing and reporting the ssary. The policy directed the w the surveillance data to ends, changes in prevalent se in rate of infection in a bring the results to the members. The policy also CP to monitor antibiotic use ary use. OD OF CORRECTION: designee could review res to ensure resident				
	infections with spcific analyzed for any pattern	organisms were tracks, and erns or trends in the facility. re-educated and an auditing				
	TIME PERIOD FOR	CORRECTION: Twenty one				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00432	B. WING		12	2/04/2014
AME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
LDERS H	IOME INC		TOUSLEY, PO BOX ORK MILLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page	e 7	21390			
	(21) days.					
21615	MN Rule 4658.1340 Preparation Area;Sch	Subp. 2 MedicineCabinet & neduleII	21615			
	nursing home must p compartments, perm physical plant or med	lication cart for storage of ed in Minnesota Statutes,				
	by: Based on observation review, the facility fai (medications that hav controlled medication permanently affixed of medication carts. In ensure the integrity of	It is not met as evidenced n, interview and document led to store schedule II ve a high potential for abuse) is (narcotics) in a compartment for 1 of 3 addition, the facility failed to f emergency medications in is utilized in the facility.				
	Findings include:					
	(LPN)-B unlocked the opened the bottom di green tackle box white medication cart. LPN which contained sever medications, and pre hydrocodone apap 3 medication) for R5. L	25 mg (a narcotic pain PN-B locked the green he box to the bottom drawer				
	The following medica	tions were stored in the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00432	B. WING		12	/04/2014
NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE,		12	/04/2014
	IOME INC		TOUSLEY, PO BOX			
			ORK MILLS, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21615	Continued From pag	je 8	21615			
	portable green tackle box:					
	hydrocodone apap 5 hydrocodone apap 5 fentanyl Duragesic (25 mcg-3 patches Morphine Sulfate (na mg/ml solution open	a narcotic pain patch)patches arcotic pain medication) 20 ed bottle-29.5 ml mg/ml solution unopened				
	kit (e-kit) in medicati secured with a red, p number 170 was prin plastic band. Howev log identified the e-k band number 137. R was present for the c log did not reflect the indicated she was no been changed and c the log should reflec applied. RN-A stated was for staff to apply e-kit when the previo order to access med RN-A further stated	a.m. the locked emergency on room #44 was observed olastic, numbered band. The need in white on the red er, the narcotic medication it had last been secured with Registered nurse (RN)-A, who observation, confirmed the e accurate lock number. She of aware when the lock had confirmed documentation on t when a new lock had been d the usual facility practice y a new numbered lock on the pus lock had been removed in lications stored in the e-kit. the staff member who ould of entered the new log.				
	2014 listed ER(emer #137, 12/1/14 and a 6:00 a.m., 2:30 p.m.	r the month of December rgency) kit, med room and n area for signature on the and 10:30 p.m. shift each ach shift had two sets of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00432	B. WING		12	2/04/2014
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ELDERS H	IOME INC		TOUSLEY, PO BOX ORK MILLS, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21615	Continued From page	9	21615			
	and LPN-A both confinancotics were stored the central medicatio schedule II narcotics has been the usual fa- time. During interview on 1 director of nursing (D expected to document the e-kit log every time to ensure medication e-kit supplies for eme The DON stated the schedule II narcotics locked medication ca- both of the boxes the the scheduled II narco- affixed to the medication reported the facility's had not identified the improperly stored. The consultant pharmacis the medication room of discontinued narco- Review of the pharma- report, dated July 20	consulting pharmacy group e scheduled II narcotics were le DON further stated the sts did not routinely look in or at current narcotics, and acy consultant only observed s and reviewed the storage				
	time. Review of the facility' Supply policy, dated	fied no concerns at that s Physician Drug Emergency 5/14, directed staff to lock th a tamper proof lock that is				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00432	B. WING		10	2/04/2014
NAME OF PI	NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	14	///////////////////////////////////////
ELDERS H	IOME INC		TOUSLEY, PO BOX ORK MILLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21615	Continued From page	e 10	21615			
	kit, and the narcotic r	policy identified Morphine may be stored in the kit, and the narcotic medication would be counted by checking to make sure the lock remained				
	A facility policy regarding storage of Scheduled narcotic medications was requested, but not provided.					
	The director of nursin policies and procedur medications were see director of nursing or appropriate staff men	OD OF CORRECTION: ag or designee could develop res to ensure controlled curely double locked. The designee could educate all nbers on the processes. The designee could develop o ensure ongoing				
	TIME PERIOD FOR days.	CORRECTION: Seven (7)				
21695	MN Rule 4658.1415 Housekeeping, Opera		21695			
	provide housekeepin necessary to maintain comfortable interior, i	bing. A nursing home must g and maintenance services n a clean, orderly, and ncluding walls, floors, tures, equipment, lighting,				
	by: Based on observation review, the facility fail	It is not met as evidenced n, interview and document led to ensure a sanitary and nt was maintained in resident				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00432	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	12	2/04/2014
ELDERS H	HOME INC		TOUSLEY, PO BOX ORK MILLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From page	e 11	21695			
		idents (R24, R42, R6, R29, during the environmental				
	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:					
		al large black scuff marks e wall above the bed, near				
	was observed around In addition, the tiles o	dark brown/black substance d the entire base of the toilet. on the wall behind the toilet a gray/black substance.				
	from the heat registe	l areas with paint missing rs was observed in the gister in the bed room.				
		large section of discolored substance were observed				
	were observed on the	ections of dark rust spots e tile walls next to the toilet ark brown spots were below the bathroom				
	scuff marks were obs	n large area of large black served on the walls in the ral areas of paint missing on m facing out into the				

STATE FORM

6899

00432 B. WING 12/04/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12/04/201 ELDERS HOME INC SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567 10 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (COM		FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
Image: construction of the second state of the second s			00422				
NEW YORK MILLS, MN 56567 (K4) 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) COM 21695 Continued From page 12 21695 Continued From page 12 21695 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	NAME OF PROVIDER OR SUPPLIER					12	04/2014
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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.		indicated resident roo and housekeeping ar responsible for painti needed to be done in wall in R37's bathroo stated "take out the ti wearing out." At 3:12 not do routine room a fixes what he is told t On 12/3/14, at 11:11 issues that are wrote nurses station and M aware of the areas of environmental tour. I with fixing things and A facility maintenance the administrator indi have a policy to addr the facility. Review of facility poli revised 11/27/2000 d maintenance and /or supervisor. The polic request was to be co was to be sent to the SUGGESTED METH administrator could in to report timely enviro can be addressed tim sanitary environment	oms were cleaned weekly, and maintenance were ing and cleaning that in the facility. He verified the im would be a "quick fix" and ile and put new in where it is p.m. MS confirmed he does audits and indicated he only to fix. a.m. MS confirmed he fixes in the log book up at the IS indicated he was not beserved on the MS stated "we can do better I looking at the rooms." e policy was requested, and icated the facility did not ess routine maintenance in it cy titled, Housekeeper, lirected staff to report to safety concerns to y indicated a maintenance mpleted for repair needs and maintenance department.				

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		00432	B. WING		12/04/2014	
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21695	Continued From page	e 13	21695			
	(21) days.					