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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2RK9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00195

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E152**
2.STATE VENDOR OR MEDICAID NO.
(L2) **926219900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELLIOT CARE HOME INC**
(L4) **1500 ELLIOT AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **03/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (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)
12/31

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

12.Total Facility Beds **15** (L18)

13.Total Certified Beds 15 (L17)

0. 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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A,3,4,8 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		15		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 06/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1976
(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.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-E152

On 03/05/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on 03/13/14, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 01/23/14 standard survey, effective 02/12/14. Refer to the CMS 2567B for both health and life safety code survey results.

The facility's request for a continuing waiver involving the Health deficiencicies cited under tags F353, F354 and F458 are approved. The facility's request for a continuing waiver involving the Life Safety Code (LSC) deficiencies cited under tags K12, K33, and K40 at the time of the 01/23/14 standard survey has been forwarded to CMS for their review and determination. The facility's compliance is based on pending CMS approval of your request for waiver.

Effective 02/12/14, the facility is certified for 15 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-E152

April 14, 2014

Mr. Mark Jefferis, Administrator
Elliot Care Home Inc
1500 Elliot Avenue South
Minneapolis, Minnesota 55404

Dear Mr. Jefferis:

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 February 12, 2014 the above facility is certified for:

15 - Nursing Facility Beds

Your request for waiver of F353, F354 and F458 has been approved based on the submitted documentation.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K12, K33, and K40.

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 provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 7, 2014: Electronically delivered

Mr. Mark Jefferis, Administrator
Elliot Care Home Inc
1500 Elliot Avenue South
Minneapolis, Minnesota 55404

RE: Project Number SE152023

Dear Mr. Jefferis:

On January 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 23, 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 March 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 13, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 12, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 23, 2014, effective February 12, 2014 and therefore remedies outlined in our letter to you dated January 29, 2014, will not be imposed.

Your request for a continuing waiver involving the Health deficiency(ies) cited under F353 and F458 are approved. Your request for a continuing waiver involving the Life Safety Code (LSC) deficiency(ies) cited under K12, K33, and K40 at the time of the January 23, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E152	A. Building B. Wing	3/5/2014

Name of Facility	Street Address, City, State, Zip Code
ELLIOT CARE HOME INC	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **02/12/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/12/2014**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **02/12/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GD/AK	**Date:** 06/16/2014	**Signature of Surveyor:** 30951	**Date:** 03/05/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/23/2014	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E152	A. Building / B. Wing: 01 - MAIN BUILDING 01	3/13/2014

Name of Facility	Street Address, City, State, Zip Code
ELLIOT CARE HOME INC	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0012	Correction Completed 02/07/2014	ID Prefix Reg. # NFPA 101 LSC K0033	Correction Completed 02/07/2014	ID Prefix Reg. # NFPA 101 LSC K0040	Correction Completed 02/07/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	06/16/2014	28120	03/13/2014
CMS RO				

Followup to Survey Completed on: 1/23/2014

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: 2RK9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00195

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E152**

2.STATE VENDOR OR MEDICAID NO.
(L2) **926219900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELLIOT CARE HOME INC**
(L4) **1500 ELLIOT AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **01/23/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **10** (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)
12/31

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

12.Total Facility Beds **15** (L18)

13.Total Certified Beds **15** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
X 3. 24 Hour RN
X 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
X 8. Patient Room Size
__ 9. Beds/Room

* Code: **B 3, 4, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		15		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sandra Nelson, HFE NEII 02/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/21/2014 (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
04/01/1976
(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.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-E152

At the time of the standard survey completed 01/23/14, the facility was not in substantial compliance and the most serious deficiencies in your facility to be widespread deficiencies thatconstitute 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.The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

The facility request and this Department accepted the following health waivers:

- F458 CFR 483.70 (d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT
- F353 CFR 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS
- F354 CFR 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON

The Life Safety Code (LSC) deficiencies cited at K12, K33 and K40 were evaluated and accepted under the Fire Safety Evaluation System" (FSES) Refer to the CMD 2786T for details of this visit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8378

January 30, 2014

Mr. Mark Jefferis, Administrator
Elliot Care Home Inc
1500 Elliot Avenue South
Minneapolis, Minnesota 55404

RE: Project Number SE152023

Dear Mr. Jefferis:

On January 23, 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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3792
Fax: (651) 201-3790

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 March 4, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 4, 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 April 23, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 23, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

3 Waivers have been requested

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

PRINTED: 01/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E152	A. BUILDING _____ B. WING _____	01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOT CARE HOME INC	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404

(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 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 ONSITE 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	RECEIVED FEB 18 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334	Accepted 2/18/14 Lynn Day	

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

Administrator 2/12/2014

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

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F 334	Continued From page 1 the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative	F 334		

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F 334	Continued From page 2 refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R1, R12, R13) were offered a Pneumococcal vaccination and 2 of 5 residents (R12, R14) were offered the Influenza vaccination or had documentation of a contraindication or refusal. In addition, the facility failed to develop policies and procedures that ensured residents were being offered the Pneumococcal and Influenza vaccinations and that the administration, contraindication or refusal was documented in the medical record. Findings include: Review of R1's medical records lacked documentation if a Pneumococcal vaccination had been received, was contraindicated or refused. Review of R12's medical records lacked documentation if a Pneumococcal or Influenza vaccination had been received, was contraindicated or refused. Review of R13's medical records lacked documentation if a Pneumococcal vaccination had been received, was contraindicated or refused. Review of R14's medical records lacked documentation if an Influenza vaccination had been received, was contraindicated or refused.	F 334	**F334** **483.25(n) Influenza and Pneumococcal Immunizations** ..... The Elliot Care Home recognises the importance of immunizations. Influenza: The nursing staff will continue the practise of meeting with each resident between October 1 and March 31 to offer by scheduling influenza vaccinations with their doctor. We will do patient teachings and education using the "Vaccine Information Statement" from the Center for Disease Control. To ensure the health of our residents, we have updated our influenza policy and procedure. We have made changes to our Immunization Record to include the steps we have completed for compliance, any contraindication and refusals. We will continue our current practise of recording immunizations in the "Nurses Notes" section in resident's charts. Documentation for R14 now shows that education was provided and the influenza vaccine is currently scheduled to be given by the doctor. Documentation for R12 now shows that education was provided and the resident refused due to the resident's stated egg allergy. Continued on following page number 4.....	

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F 334	Continued From page 3 When interviewed on 1/22/14, at 2:20 p.m. licensed practical nurse (LPN)-A/program director verified R1 had not received a Pneumococcal vaccination. LPN-A stated R12 had refused to be vaccinated. LPN-A was unable to provide documentation of R12's education of the risks and benefits of vaccination or refusal to be vaccinated. LPN-A stated she had requested Pneumococcal vaccination information for R13 and was unable to provide the documentation. In addition, LPN-A stated because of difficulty finding a primary care physician due to an insurance change, R14 had not been offered an Influenza vaccination. Upon interview at 1/22/14, at 2:25 p.m. LPN-A verified the facility did not have policies and procedures for Pneumococcal and Influenza vaccinations. The director of nursing (DON) was interviewed on 1/22/14, at 2:38 p.m. and stated she was not involved in the infection control policy and procedure and the administrator and LPN-A wrote all of the policies. The facility Infection Control Policy and Procedure dated 10/2013, was reviewed and lacked direction regarding Pneumococcal and Influenza vaccinations.	F 334	F334 483.25(n) Influenza and Pneumococcal Immunizations Continued: Pneumococcal: The Elliot Care Home immunization policy and procedures for pneumococcal vaccinations has been updated to reflect the following: Prior to the resident's annual physical, the Elliot Care Home will provide the resident with education on pneumococcal vaccines. The "Pneumococcal Polysaccharide Vaccine" information sheet per the Center for Disease Control will be used. At this time, the resident's interest in the vaccine or refusal will be passed on to the resident's physician in preparation for their annual physical appointment. In turn, the determination of the doctor to provide the vaccine or that it is contraindicated will be received back from the doctor post physical and entered into the resident's chart "Immunization Record". The Elliot Care Home has done a current review to gain documentation showing which residents received the pneumococcal vaccine within the last five years. Based on this review, one resident has been provided education and an appointment with the doctor has been scheduled for the vaccination. Other resident's education and doctor appointments will be coordinated with their next annual physical. The D.O.N. and Program Director will monitor the compliance. **Completion 2-12-14**	
F 353 SS=C	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as	F 353		

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F 353	Continued From page 4 determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide licensed nursing coverage as required for each shift. This had the potential to affect all 15 residents in the facility at the time of the survey. Findings include: The facility did not staff all shifts with a licensed nurse. Each residents' medical record contained a statement signed by the physician, stating the resident was not in need of 24-hour nursing care. The facility had a waiver for provision of care without licensed nursing staff on each shift. During interview with all 15 residents, no complaints were offered regarding their health	F 353	**F353 483.30 (a) Sufficient 24 HR Nursing Staff Per Care Plans** Waiver Requested ~~2-7-2014~~ Each resident's primary physician has signed a statement stating that in his/her opinion, it is not necessary to require 24 hours of licensed nursing care, but minimal supervision for ADL's due to each resident's ambulatory status and capability of self preservation. Also, the program director, DON, administrator, and owner are all available by cell phones with pagers. This waiver request seeks to included the use of a Trained Medication Aide (TMA) on the 11:00 PM to 7:00 AM shift, the 3:00 PM top 11:00 PM shift and the 7:00 AM to 3:00 PM shift only when necessary.	

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F 353	Continued From page 5 needs while residing in the facility.	F 353		
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was working in the facility eight hours a day, seven days a week. This could potentially affect all 15 residents in the facility at the time of the survey. Findings include: The facility did not meet the requirements for RN coverage for eight hours daily. A review of resident records of the facility showed evidence of a statement by the physician stating residents were not in need of 24-hour nursing care. A waiver was in place at the time of the survey for the lack of required RN coverage eight	F 354	**F354** **483.30 (b) Waiver-RN 8 Hrs 7 Days/Wk, Full-Time DON** Waiver requested. ~~2-7-2014~~ At the present time, with the residents currently residing at Elliot, the lack of an RN on the premises 8 hours per day will not jeopardize the care of the residents. All of the residents' primary care physicians have indicated that the residents are capable of self-preservation with the DON monitoring their care 8 hours per week and in conjunction with some scheduled RN's.	

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F 354	Continued From page 6 hours a day, seven days per week. During interview with all 15 residents, no complaints were offered regarding their health needs while residing in the facility.	F 354		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide 80 square feet of living space for each resident in three multiple occupancy bedrooms. This had the potential to affect 9 of 9 residents residing in those rooms. Findings include: Rooms 101, 102, and 202 each accommodated three residents. The three resident rooms in the facility did not meet the space requirements. The total square footage in room 101 measured 227.5 square feet, providing each individual with 75.8 square feet of living space. Room 102 measured 216 square feet, providing each individual with 72 square feet of living space. Room 202 measured 196 square feet, providing each individual with 65 square feet of living space. Residents residing in the rooms were interviewed and did not offer complaints or a desire to change rooms. A room-size waiver was in place at the time of the survey.	F 458	**F 458** **483.70 (d)(1)(ii) Bedrooms measure at least 80 sq ft / resident** Waiver requested ~~2-7-2014~~ Residents involved in the indicated rooms have been interviewed by the owner. Each resident expressed no dissatisfaction with their own personal space in their rooms. Granting this waiver will not adversely affect the health and safety of the resident.	
F 465	483.70(h)	F 465		

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F 465 SS=E	Continued From page 7 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure privacy curtains were maintain in a clean and sanitary manner for 1 of 1 common bathroom which had the potential to affect 12 of 15 residents that used the bathroom/shower room. Findings include: On 1/21/14, at 11:15 a.m. during the initial facility tour on the second floor bathroom two privacy curtains hanging up around the toilet and shower area were observed to have brown stains on them. On 1/22/14, at 11:00 a.m. a trained medication aide (TMA)-A was observed going in and out of the shower room assisting a resident with a shower. Both curtains were pulled and the stains were visible from standing in the hallway when the door was opened. On 1/22/14, at 3:20 p.m. the privacy curtains were still observed to have the brown stains. On 1/23/14, at 9:39 a.m. during the environmental tour, the maintenance directors verified the privacy curtains were stained and not clean. Stated the curtains are changed every Friday and	F 465	**F 465** **483.70 (h) Safe/Functional/Sanitary/Comfortable Environment** The Elliot Care Home maintains policies and procedures in order to provide for a clean & sanitary environment for the residents. The procedures have been adjusted to include specifically the privacy curtain. The observed curtain did not have any active soil on it but it did have a darkened stain in the bottom corner. The curtain has been discarded. The remaining curtains were inspected and are in good condition and stain free. Elliot Care Home housekeeping procedures now include the privacy curtains along with written cleaning schedules to show that the privacy curtain is changed weekly and as needed. All staff have been reminded that a soiled curtain at any time should be changed. Privacy curtains that may become soiled will be cleaned and sanitized. Any stained privacy curtains will be discarded. The Program Director & Maintenance Director will check this daily to ensure compliance. Completion 2-12-2014	

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F 465	Continued From page 8 as needed and would be changing them as soon as the tour was completed. He further stated because he was in-charge of the building there was no cleaning policy. The maintenance director further stated he was not keeping any documentation or logs when the privacy curtains were being changed as indicated weekly. On 1/23/14, at 9:44 a.m. the program manager overheard the conversation and stated the facility had a cleaning policy and would provide it and that the staff had a cleaning schedule and documented when any cleaning was done at the facility. Review of the Elliot Care Home Cleaning Schedule for January 2014, revealed the bathrooms was cleaned every shift but the Cleaning Schedule did not address checking the privacy curtains and ensuring they were maintained in a clean and sanitary manner. The Housekeeping Policies dated 9/04, directed "The entire facility, including walls, floors, ceilings, registers, fixtures, equipment and furnishing shall be maintained in a clean, sanitary and orderly condition ..." In addition, the Housekeeping Procedures indicated bathroom windows and curtains were to be cleaned semi-annually or as needed. The policy lacked to information that was responsible to oversee the privacy curtains were maintained in a clean and sanitary manner.	F 465		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		

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F 520	Continued From page 9 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance (QA) committee consisted of the required members. This had the potential to affect all 15 residents who resided in the facility at the time of the survey. Findings include: During review of the QA attendance log, it was noted the facility QA committee met quarterly. The log identified meeting dates which included 3/5/13, 6/18/13, 9/17/13 and 12/9/13. The meeting on 3/5/13 was attended by the licensed	F 520	**F 520** **483.75 (o)(1) QAA Committee-members/Meet quarterly/Plans** The Elliot Care Home convenes quarterly the five person QAA committee to ensure the quality of care and quality of life for residents; albeit, the Elliot Care Home acknowledges the need to improve the D.O.N.'s attendance. The challenge has been to work both with the Medical Director's varied availability and the DON's primary 8 AM to 4 PM full time work schedule at another facility. Steps to ensure overall attendance at QAA committee meetings and specifically that of the D.O.N. will include the following. 1. The Elliot Care Home Medical Director has been asked to schedule meetings in the evening to accommodate the D.O.N. and other member schedules. 2. The Elliot Care Home will contact D.O.N. and Medical Director 3 weeks in advance of the due dates of the meetings to coordinate their schedules. 3. In case of unforeseen scheduling conflicts and issues such as illness, inclement weather, and other emergencies, meetings will be held by teleconference or by recording. Those members having to attend by teleconference or recording will sign and date the QAA committee meeting minutes no later than 5 business days after the convened meeting. Questions and recommendations of QAA committee members attending by recording will be passed on in writing to the Program Director for follow up. These will be included in the QAA committee book. The Administrator, D.O.N., and Program Director will monitor compliance. **Completion 2-12-2014**	

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F 520	Continued From page 10 practical nurse (LPN) program director, a registered nurse (RN) and the medical director. The meeting on 6/18/13, was attended by the LPN program director, a RN, the maintenance director and the medical director. The meeting on 9/17/1,3 was attended by the LPN program director, a RN and the medical director. The meeting on 12/9/13, was attended by the LPN program director and the medical director. Although the QA committee consisted of the director of nursing (DON), the medical director and three other facility staff, the administrator and DON had not attended any of the meetings. When interviewed on 1/22/14, at 1:48 p.m. the administrator stated scheduling conflicts kept him from attending the QA meetings. The administrator also stated he was aware the DON also had not been attending the QA meetings because of scheduling conflicts. When interviewed on 1/22/14, at 2:38 p.m. the DON stated the QA meetings happen during the day and she has another fulltime job which prevents her from attending the QA meetings.	F 520		

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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, Elliot Care Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	K 000	POC ok W/FSES for K 12, 33 + 410 3-10-14 TS	

3-4-14
DC: 1-23-14
EXIT:

RECEIVED
MAR - 7 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Admin Trainee	2/12/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E152	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOT CARE HOME INC	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Elliot Care Home is a 3-story building with a full basement. The building was constructed in 1906 and was determined to be of Type V(111) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 15 beds and had a census of 15 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirements for construction type and height. This deficient practice could affect all residents. Findings include: During a tour of the facility between 9:30 AM and 11:15 AM on 01/23/2014, observation revealed that this 1906, 3-story, fully fire sprinklered building of Type V(111) construction does not meet the minimum construction requirements of the code for type and height. This deficient practice was verified by the	K 012	**K012** **NFPA 101 Life Safety Code Standard** **Elliot Care Home has passed the FSES on 1-23-2014.** 2-7-2014	

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K 012	Continued From page 2 administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012		
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation, the stairway enclosure of this facility does not meet the required one (1) hour fire resistive construction. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:15 AM on 01/23/2014, observation revealed that the wall of the 2 stair enclosures are constructed of plaster on wood lath on wood studs, which does not meet minimum the requirements for this type of facility. This deficient practice was verified by maintenance at the time of the inspection. Note: This deficiency need not be corrected if an	K 033	**K033** **NFPA 101 Life Safety Code Standard** **Elliot Care Home has passed the FSES on 1-23-2014.** 2-7-2014	

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K 033	Continued From page 3 FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 033		
K 040 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by: Based on observation, the resident room doors on the 2nd floor do not meet the 32-inch clear width requirement. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:15 AM on 01/23/2014, observation revealed that the doors to all five (5) resident rooms on the 2nd floor were found to be only 31 inches in clear width. This does not meet the 32-inch requirement for existing exit access doors. This deficient practice was verified by maintenance at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 040	**K040** **NFPA 101 Life Safety Code Standard** **Elliot Care Home has passed the FSES on 1-23-2014.** 2-7-2014	