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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 40EW
Facility ID: 00432

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

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

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

4. TYPE OF ACTION: 7 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/21/2015** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA
02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF
03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC
04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

X 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** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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):

CCN: 24-5562

Reduction in the number of certified SNF/NF beds from 48 beds to 45 beds, effective December 1, 2015, in accordance with a change in licensure. Due to three beds being placed in lay away status (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective December 1, 2015, all 45 facility beds are certified SNF/NF.

17. SURVEYOR SIGNATURE Date :
Sherri Softing, HPR Dietian 01/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/28/2015** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245562

January 12, 2016

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 December 18, 2015 the above facility is certified for:

45   Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 10, 2016

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

RE: Project Number S5562025

Dear Mr. Anderson:

On November 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 6, 2015. 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 December 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 23, 2015 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 November 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 6, 2015, effective December 18, 2015 and therefore remedies outlined in our letter to you dated November 23, 2015, 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.

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

Sincerely,

Mark Meath

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

An equal opportunity employer

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245562	A. Building B. Wing	12/21/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	12/18/2015	ID Prefix F0314 Reg. # 483.25(c) LSC	12/18/2015	ID Prefix F0465 Reg. # 483.70(h) LSC	12/18/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/mm	01/06/2016	34982	12/21/2015
CMS RO				

Followup to Survey Completed on: 11/6/2015

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

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245562	01 - 01 MAIN BUILDING	12/23/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0022	12/15/2015	ID Prefix Reg. # NFPA 101 LSC K0025	12/15/2015	ID Prefix Reg. # NFPA 101 LSC K0029	12/15/2015
ID Prefix Reg. # NFPA 101 LSC K0062	12/15/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	01/10/2016	36536	12/23/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/3/2015

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 40EW
Facility ID: 00432

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/06/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **48** (L18)

13. Total Certified Beds **48** (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: * Code: **B*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 12/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/28/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 23, 2015

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

RE: Project Number S5562025

Dear Mr. Anderson:

On November 6, 2015, 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. In addition, at the time of the November 6, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number .

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. In addition, at the time of the November 6, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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>Electronic 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
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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 December 16, 2015, 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 December 16, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 February 6, 2016 (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 May 6, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245562	A. BUILDING ______ B. WING ______	11/06/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in electronic POC (ePOC), your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the ePOC will be used as verification of compliance. Upon receipt of an acceptable ePOC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the plan of care related to pressure relieving devices for 1 of 2 resident (R6) reviewed for pressure ulcers. Findings include: R6's current care plan dated 9/22/15, identified R6 had a history of ulcers, poor hygiene and spent the majority of the day lying in bed reading. R6 ' s care plan instructed staff to apply heel	F 282	The facility does provide and arrange services by qualified persons for each resident’s plan of care. Staff will assure resident R6 has her heel boots applied when she is in bed, and staff will assist to hover her heels with a pillow to assure her heels are off the bed. All resident care plans will be reviewed for the use of heel boots, or other pressure reducing appliances. All residents found to be care planned to use these pressure reducing devices will be audited for their	12/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 12/02/2015

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.

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	245562	A. BUILDING ______ B. WING ______	11/06/2015

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

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F 282	Continued From page 1 boots to R6's feet when in bed and to assist R6 to hover heels with a pillow to ensure R6's heels were off the bed. Further, R6 ' s care plan directed staff to monitor R6 as she would tend to scoot self down in bed and place heels onto footboard, causing risk for breakdown. In addition, R6's care plan directed staff complete treatments as ordered by the medical doctor (MD) regarding R6's ulcer treatment and to measure the ulcer weekly until healed. R6's undated Nurse Aid Care Plan, identified R6 utilized a total body mechanical lift, and was incontinent. However, R6 ' s care plan lacked directions to apply heel boots to R6's feet and to hover R6's heels with a pillow to prevent the heels from touching the bed and did not identify a repositioning schedule for R6. During observation on 11/4/15, from 6:44 p.m. to 7:17 p.m. nursing assistant (NA)-A and NA-B assisted R6 to transfer from the wheelchair to the bed with a mechanical lift. R6 was assisted to lie down in bed where NA-B proceeded to assist R6 with night time cares. NA-B removed R6's white socks from both feet. R6's left heel was observed to have a area, bright shiny pink in color which measured approximately 2.5 cm x 2.5 cm and had dry, flaky skin which surrounded the outer edges of the left heel. NA-B placed blue gripper socks on both of R6's feet and placed R6's feet directly on the mattress of the bed. NA-B assisted to cover R6 up with a blanket and lowered R6's bed to the floor. On 11/4/15 at 7:17 p.m. and 7:55 p.m., R6 was observed lying in bed, with both heels resting directly on the mattress. R6 was not observed to wear heel boots, or have heels floated off of the	F 282	proper use according to the resident's plan of care. The facility will make the following changes to assure the deficient practice will not recur. For R6 Nursing assistant documentation on Point of Care has been updated to include the placing of the heel boots on when the resident is in bed. A list of residents with pressure reducing appliances will be developed and available for all staff to reference. These residents will also be added to the Point of care documentation system as applicable. The Director of Nursing or designee including the ADNS, or facility charge nurse will monitor R6 each shift for the next 2 weeks to assure that the heel boots are on when the resident is in bed, and that she has been assisted to hover her heels with a pillow to assure the heels are off the bed. All other residents using pressure reducing devices will also be audited daily for two weeks to assure the plan of care is being followed. After the initial two weeks of auditing, all residents with pressure reducing devises will be audited weekly by the Director of Nursing or designee as listed above. Audits will be reviewed at QA&A for effectiveness of the process and to address and necessary modifications that need to be made.	

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F 282	Continued From page 2 mattress during the entire observation time. During observation on 11/5/15, at 9:58 a.m. to 10:02 a.m. NA-C and another staff member transferred R6 from her wheelchair to her bed using a mechanical lift. NA-C asked R6 if she wanted her shoes off, which R6 agreed. NA-C removed R6's sandals from her feet and placed R6's heels directly on the mattress. After facility staff completed cares, R6 ' s heels remained resting directly on the mattress of the bed. On 11/5/15 at 11:01 a.m. NA-C stated R6 was supposed to have heel boots on when in bed and confirmed she had not applied the heel protectors to R6's feet when she assisted R6 to bed. NA-C stated she " forgot. " NA-C verified the heel guards and pillow should be on R6's heels at all times when R6 was in bed. On 11/5/15 at 10:20 a.m. RN-A confirmed R6's current care plan and stated the facility staff used to apply heel boots to R6's feet, but staff were, at present still expected to float R6's heels when in bed. RN-A verified she expected staff to float R6's heel off the bed at all times when she was in bed and confirmed R6's heel was prone to breakdown. RN-A stated in the past she had reminded staff several times to make sure R6's heels were floated over the bed. On 11/5/15, at 10:30 a.m. RN-A entered R6's room and placed a pillow under R6's lower legs to float the heels off the bed. R6's was not wearing heel boots, nor did RN-A apply heel boots to R6's feet. R6's left heel had shiny, pink coloring in the middle of the area which measured approximately 2.5 cm x 2.5 cm and had dry, flaky skin surrounding the outer edges of the ulcer.	F 282		

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F 282	Continued From page 3 On 11/5/15 at 10:31 a.m. director of nursing (DON) confirmed R6's care plan and verified staff were to be floating R6's heels off the bed. She confirmed R6 should have been wearing heel boots when she was in bed. The DON stated she expected staff to follow R6's care plan to keep heels off of the bed.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the necessary care and treatments were implemented to promote healing and prevent the development of further pressure ulcers for 1 of 2 resident (R6) reviewed for pressure ulcers. Findings include: R6's significant change Minimum Data Set (MDS) dated 9/30/15, indicated R6 had diagnoses which included: diabetes, memory loss and delusional disorder. The MDS also identified R6 had moderate cognitive impairment, required	F 314	The facility does assure that residents having pressure sores receive necessary treatment and services to promote healing, and prevent new sores from developing. Staff will assure resident R6 has her heel boots applied when she is in bed, and staff will assist to hover her heels with a pillow to assure her heels are off the bed. All resident care plans will be reviewed for the use of heel boots, or other pressure reducing appliances. All residents found to be care planned to use these pressure reducing devices will be audited for their	12/15/15

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F 314	Continued From page 4 extensive assistance of 1 staff with bed mobility, dressing, toileting and was totally dependent on 2 staff for transfers. The MDS identified R6 was at risk for developing pressure ulcers, and had a stage one pressure ulcer (intact skin with non-blanchable redness of a localized area.) The MDS further identified R6 used a pressure relieving device on the bed and chair. R49's Braden Scale For Predicting Pressure Sore Risk (tool used to determine the risk for development of pressure ulcers) dated 6/30/16, identified R6 was at risk for the development of pressure ulcers. R6's current care plan dated 9/22/15, identified R6 had a history of ulcers, poor hygiene and spent the majority of the day lying in bed reading. R6 ' s care plan instructed staff to apply heel boots to R6's feet when in bed and to assist R6 to hover heels with a pillow to ensure R6's heels were off the bed. Further, R6 ' s care plan directed staff to monitor R6 as she would tend to scoot self down in bed and place heels onto footboard, causing risk for breakdown. In addition, R6's care plan directed staff complete treatments as ordered by the medical doctor (MD) regarding R6's ulcer treatment and to measure the ulcer weekly until healed. R6's undated Nurse Aid Care Plan, identified R6 utilized a total body mechanical lift, and was incontinent. However, R6 ' s care plan lacked directions to apply heel boots to R6's feet and to hover R6's heels with a pillow to prevent the heels from touching the bed and did not identify a repositioning schedule for R6. Review of R6's Nursing Home Notes dated	F 314	proper use according to the residents' plan of care. The facility will make the following changes to assure the deficient practice will not recur. For R6 Nursing assistant documentation on Point of Care has been updated to include the placing of the heel boots on when the resident is in bed. A list of residents with pressure reducing appliances will be developed and available for all staff to reference. These residents will also be added to the Point of care documentation system as applicable. The Director of Nursing or designee including the ADNS, or facility charge nurse will monitor R6 each shift for the next 2 weeks to assure that the heel boots are on when the resident is in bed, and that she has been assisted to hover her heels with a pillow to assure the heels are off the bed. All other residents using pressure reducing devices will also be audited daily for two weeks to assure the plan of care is being followed. After the initial two weeks of auditing, all residents with pressure reducing devises will be audited weekly by the Director of Nursing or designee as listed above. Audits will be reviewed at QA&A for effectiveness of the process and to address and necessary modifications that need to be made.	

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Continued From page 5
9/14/15, revealed a note from the MD which indicated: registered nurse (RN)-A reported a quarter to fifty cent piece sized black spot on R6's heel, possible due to pressure from cam walker (rigid immobilizer) boot. The MD directed facility staff to relieve pressure to R6's heel, keep area padded and monitor closely.

Review of R6's Weekly Wound Progress Report dated 9/21/15, identified R6 had a 2.6 centimeter (cm) by 1.8 cm black, semi-hard area on the left heel and work a cam boot on the left foot. The report included a handwritten note from the MD which directed facility staff to remove R6's boot at night and to place pressure relieving pads while R6 wore the boot.

Review of R6's Referral Form dated 9/23/125, revealed a note from the MD which identified R6 had a pressure ulcer to the left heel and would likely improve since the boot was removed. The MD directed facility staff to keep the left heel padded and if the ulcer did not improve or if R6 complained of pain, the facility staff were to notify the physician by 9/30/15.

Review of R6's Elders Home Fax Transmission dated 11/4/15, revealed a note to R6's MD which identified R6's pressure ulcer to left heel was healed, the skin was firm, pink and was without scabbing. The note identified R6's issue was resolved and the MD discontinued the order for a nutritional supplement at that time.

During observation on 11/4/15, from 6:44 p.m. to 7:17 p.m. nursing assistant (NA)-A and NA-B assisted R6 to transfer from the wheelchair to the bed with a mechanical lift. R6 was assisted to lie down in bed where NA-B proceeded to assist R6

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F 314	Continued From page 6	F 314		

with night time cares. NA-B removed R6's white socks from both feet. R6's left heel was observed to have a area, bright shiny pink in color which measured approximately 2.5 cm x 2.5 cm and had dry, flaky skin which surrounded the outer edges of the left heel. NA-B placed blue gripper socks on both of R6's feet and placed R6's feet directly on the mattress of the bed. NA-B assisted to cover R6 up with a blanket and lowered R6's bed to the floor.

On 11/4/15 at 7:17 p.m. and 7:55 p.m., R6 was observed lying in bed, with both heels resting directly on the mattress. R6 was not observed to wear heel boots, or have heels floated off of the mattress during the entire observation time.

During observation on 11/5/15, at 9:58 a.m. to 10:02 a.m. NA-C and another staff member transferred R6 from her wheelchair to her bed using a mechanical lift. NA-C asked R6 if she wanted her shoes off, which R6 agreed. NA-C removed R6's sandals from her feet and placed R6's heels directly on the mattress. After facility staff completed cares, R6 ' s heels remained resting directly on the mattress of the bed.

On 11/5/15 at 11:01 a.m. NA-C stated R6 was supposed to have heel boots on when in bed and confirmed she had not applied the heel protectors to R6's feet when she assisted R6 to bed.NA-C stated she " forgot. " NA-C verified the heel guards and pillow should be on R6's heels at all times when R6 was in bed.

On 11/5/15 at 10:20 a.m. RN-A confirmed R6's current care plan and stated the facility staff used to apply heel boots to R6's feet, but staff were, at present still expected to float R6's heels when in

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bed. RN-A verified she expected staff to float R6's heel off the bed at all times when she was in bed and confirmed R6's heel was prone to breakdown. RN-A stated in the past she had reminded staff several times to make sure R6's heels were floated over the bed.

On 11/5/15, at 10:30 a.m. RN-A entered R6's room and placed a pillow under R6's lower legs to float the heels off the bed. R6's was not wearing heel boots, nor did RN-A apply heel boots to R6's feet. R6's left heel had shiny, pink coloring in the middle of the area which measured approximately 2.5 cm x 2.5 cm and had dry, flaky skin surrounding the outer edges of the ulcer.

Review of R6's November 2015, treatment administration record (TAR), revealed an order which directed staff to relieve pressure to left heel, keep padded, inspect each shift, update MD as needed, assess and measure black area to left heel, make nurses note and a wound progress assessment.

Review of R6's Weekly Wound Progress Reports from 9/14/15 to 10/26/15 revealed to following measurements of R6's pressure ulcer;

- 9/14/15, R6's left heel wound measured 2.5 cm x 1.8 cm, blackened area, R6's MD was notified of area and listed interventions to keep heels off of bed with a pillow and R6's cam boot was to be loosened while in bed to help with pressure. The wound assessment did not identify what type of wound R6 had on the left heel.

-9/22/15, R6's left heel wound measured 1.7 cm x 2.7 cm, blackened area. Preventative measures in place were to keep R6's heels elevated off the

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bed with pillows and cam boot was to be removed when in bed.

-9/28/15, R6's left heel wound measured 2 cm x 1.25 cm, scabbed. Preventative measures in place were pressure relieving pads/dressing.

-10/5/15, R6's left heel wound measured 3 cm x 3 cm, scabbed. Preventative measures in place were pressure relieving pads/dressing and high protein supplements.

-10/12/15, R6's left heel wound measured 3 cm x 3 cm, scabbed.

-10/19/15, R6's left heel wound measured 3 cm x 2 cm, large scab was no longer present. Heel area continued to be bright pink area, with two small scabs, one about the size of a pin head and the other pencil size tip.

-10/26/15, R6's heel wound measured 0.2 cm x 0.1 cm scab. One small scab still present to left heel, surrounding skin intact light pink in color and blanchable, no pain noted at site. Elevate heels when in bed, cam boot discontinued and Arginaid (supplement used to promote skin healing) supplement added.

Review of R6's Progress Notes from 9/14/15 to 11/4/14 revealed the following:

-9/14/15, staff noted a black area to R6's left heel were the cam boot rested. R6 also had small reddened areas on the top of the left foot. R6's MD was notified of the area. Interventions to loosen cam boot when in bed and to keep R6's heels elevated with a pillow when in bed.

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F 314	Continued From page 9 -9/18/15, R6's left heel was checked, sheepskin was placed in R6's cam boot for protection and cam boot was left off while R6 was in bed. A dietary note revealed a request was faxed to R6's MD requesting Arginaid to promote healing. -9/23/15, R6 was seen by the MD and the following changes were made; cam boot was discontinued and the MD indicated R6's heel would likely heal once the cam boot was not in use. The MD was to be notified of any pain to the left heel pressure ulcer by 9/30/15. -10/5/15, R6's left heel scab and skin were intact, no signs or symptoms of infection were noted. -10/26/15, R6's left heel had one small scab, surrounding skin intact, light pink in color, and blanchable. The note revealed R6 did not have pain at the site and R6 was to continue to have heels elevated when in bed and to continue to monitor the site weekly until the scab was resolved. -11/3/15, R6's left heel was re-evaluated by an RN and was healed and did not have any scabbing. The note revealed R6's left heel ulcer was resolved. -11/4/15, R6's MD was notified R6's heel ulcer was healed and requested to have Arginaid discontinued. On 11/5/15 at 10:31 a.m. director of nursing (DON) confirmed R6's care plan and verified staff were to be floating R6's heels off the bed. She confirmed R6 should have been wearing heel boots when she was in bed. The DON stated she	F 314		

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F 314	Continued From page 10 expected staff to follow R6's care plan to keep heels off of the bed. Review of facility policy titled Ulcer Prevention revised on 6/3/09, directed facility staff to provide care and services to prevent pressure ulcer development, to promote the healing of pressure ulcers/wounds that were present, and to prevent development of additional pressure ulcers/wounds. Interventions within the assessment would be utilized within the resident ' s plan of care.	F 314		
F 465 SS=D	483.70(h) 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 provide housekeeping and maintenance services necessary to maintain sanitary living conditions for 1 of 1 residents (R1) reviewed for urinary incontinence. Findings include: On 11/03/15, at 2:54 p.m. R1's room was noted to have a strong smell of urine present and the floor of R1 ' s room was noted to be sticky in several areas around the room. On 11/04/15, at 5:08 p.m. the strong, concentrated urine smell was noted inside R1's	F 465	The facility does provide a safe functional sanitary and comfortable environment for residents, staff and the public. The facility has and will continue to maintain a routine cleaning schedule for resident R1's room to provide housekeeping and maintenance services necessary to maintain sanitary living conditions related to urinary incontinence. Facility housekeeping manager will review all residents' rooms, for the presence of urinary odors. Any room identified to have urinary odors will be set up with additional cleaning interventions. The facility will continue to clean R1's	12/15/15

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bedroom which permeated down the hallway from his room.

On 11/05/15, at 9:15 a.m. again, a strong urine smell was noted in the hallway outside R1's bedroom and in his room.

On 11/05/15, at 2:44 p.m. R1's room a strong smell of urine, and sticky floor was again noted in his room. A gray foam mat beside R1 ' s bed had several 1/4" diameter holes to the top of the mat, and the edges of the foam matt were cracked. There was tortilla chip pieces and debris observed on the top of the mat, and a 6" darker gray area on the top right edge of the mat which appeared wet. A 1 inch (") and a 3" smear of dark brown, dried material was observed on R1's fitted bed sheet, R1's quilted white bed pad had a 1" dark brown, dried stain on the lower right corner of the trim, with the rest of the trim covered by his bed pillow. R1 had approximately 20, 1/8" dried pieces of dark brown material which rested on the edge and center of his bed linens.

On 11/06/15, at 7:13 a.m. R1 was in his bed, asleep on his left side. R1 ' s fitted sheet was again observed with the 2 areas of dried brown material on it. R1's floor matt remained soiled, damaged with several holes, cracked areas and tortilla chip pieces and debris. R1's bedroom continued to have a strong, concentrated urine smell throughout the room and the floor sticky.

On 11/06/15, at 8:58 a.m. R1 was observed seated on the edge of his bed eating his breakfast meal. R1 ' s fitted sheets were observed with the same 2 dark brown, dried stains visible.

room daily, and any other rooms identified as having a urinary odor problem. The facility has purchased an herbal odor counteractant and a lemon disinfectant Q.T. for routine cleaning of the rooms with urinary odor problems. R1's bed will be stripped daily so his mattress can be washed. Other resident room identified with urine odors will have their beds stripped daily for cleaning if indicated for odor elimination. R1's floor mat has been replaced, and is washed daily. Any other residents who are noted to urinate on the floor will also have their floor mats washed daily if applicable for the resident. The housekeeping manager will monitor its performance to assure that solutions continue to be working effectively, and that documentation of the cleaning is done daily. Housekeeping staff will report to the housekeeping supervisor any cleaning that was ineffective for odor elimination, so alternate or additional cleaning can be done to assure that all rooms are odor free. Housekeeping manager will do weekly room audits to assure all rooms are odor free. Audits will be reviewed at QA&A for effectiveness of the process and to address and necessary modifications that need to be made.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245562	A. BUILDING ______ B. WING ______	11/06/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 12 On 11/05/15, at 10:16 a.m. ADON stated the urine odor in R1's room and body odor were present all the time and the staff complained about it to her in the past. She stated they had to replace R1's bedroom floor because R1 had been urinating on his floor. She stated R1 would sometimes use a urinal, but continued to also urinate on the floor of his bedroom. She stated housekeeping tried to get into his room and clean when R1 was out of his room and stated she thought they cleaned his room 3-4 times per week. She indicated R1 spent a lot of time in his room sleeping and on sometimes R1 would not leave his room all day. She stated she would expect the nurse aides (NAs) to frequently change his bed linens and use a room deodorizer in the room. The ADON indicated R1 had a history of being soaked with urine and smearing feces on his bed linens. She stated since she was aware R1 ' s urine smell in his room and hallway had been a problem in the past and ongoing. She stated she wished there was a way to cure R1's odor problem. She stated that if other people smelled and noticed R1's urine odor it would affect R1's dignity. She stated if someone were to tell R1 about the urine odor in his room she wasn't sure if he would understand, but felt he would. She stated to help control the urine smell they could give R1 more baths, and talk to the housekeeping director about trying a different cleaning products and more frequent cleaning of R1's room. On 11/06/15, at 7:15 a.m. housekeeper (HK)-A stated R1's room smelled of urine every day. She stated she wasn't sure if maybe R1's body smelled also. She stated housekeeping did not clean R1's room when he was in the room and he was in his room " a lot " She stated she was	F 465		

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F 465	Continued From page 13 aware R1 would urinate on the floor and in his bed. On 11/06/15, at 7:43 a.m. HK-A stated during follow up interview, R1 was supposed to have an air freshener in his room and the staff also utilized a spray to neutralize the urine odor. She stated it was possible that urine got into the holes and cracks of R1's bed mat and also caused an odor. She stated the spray worked pretty good, but only temporarily until he urinated in his bed or on the floor again. She confirmed the urine smell in the hallway outside of R1's room and that his room was the source of the urine odor. On 11/06/15, at 7:25 a.m. HK-B stated R1's bedroom always smelled of urine. She stated he spent a lot of time in his room and she avoided going in R1's room to clean it when he was in the room. She stated urine could get into the gray mat and cause odor. She stated the facility utilized an odor neutralizer spray but indicated R1 ' s room continued to smell of urine and stated nothing seemed to help the odor in R1's room. She said the facility had used an air freshener in R1's room in the past which seemed to help and thought she could ask to use the air freshener again to help with the smell. On 11/06/15, at 7:55 a.m. nursing assistant (NA-D) confirmed R1's room and outside his room into the hallway smelled of urine, and indicated she had been aware of the odor in the past. She stated he had an air freshener in his room in the past to help the smell and indicated she wasn't sure what else they could do to help the smell. During follow up interview on 11/06/15, at 9:02	F 465		

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	245562	A. BUILDING ______ B. WING ______	11/06/2015

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F 465 Continued From page 14 — F 465

a.m. NA-D confirmed she was aware of the tortilla chips and debris on R1 ' s mat yesterday. She confirmed R1's linens had dried feces R1 ' s room smelled of urine. She confirmed R1 ' s sticky floor and stated she wasn't sure why the floor continued to be sticky.

On 11/06/15, at 9:13 a.m. director of nursing (DON) stated the night before R1 had been visually soaked with urine when she checked on him. She stated he had a new floor and continued to urinate all over. She stated she understood housekeeping cleaned R1's room at least daily, and R1 ' s sheets were changed whenever the facility staff could. She stated R1 urinated on his bed mat, and they could look into replacing it to help control the urine odor in R1's room. She stated housekeeping had done everything they could do to help with the urine smell. She stated the urine odor had been and ongoing problem with R1, and felt the facility needed to continue to be proactive to deal with the odor. She said they used a room deodorizer for R1's room, but general cleaning was the most important thing they could do to manage the odor in R1's room. She stated she expected staff to change R1's sheets at least weekly, but R1's sheets could be changed daily.

A group interview was conducted with maintenance supervisor (MS), housekeeping supervisor (HS), DON and the administrator on 11/06/15, at 9:40 a.m. HS and the administrator both agreed the facility had been aware of the strong urine odor problem in R1's room for a long time, and stated the problem had gotten worse over the last 2-3 years. HS stated urine had gotten under R1's mat and could of caused some of the odor. She stated she expected her staff to

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F 465	Continued From page 15	F 465		

clean R1's room daily. She stated housekeeping staff utilized an odor neutralizing spray and seemed to help, but nothing completely removed the urine odor from R1's room. She stated if R1's room was thoroughly cleaned, his bed is stripped, and his mattress cleaned every time feces were removed, she felt it would help with the urine odor in R1's room. HS, MS and the administrator stated in the future the facility would contact their environmental supplier for suggestions of different chemicals to help clean R1's room and control the urine odor in R1's room.

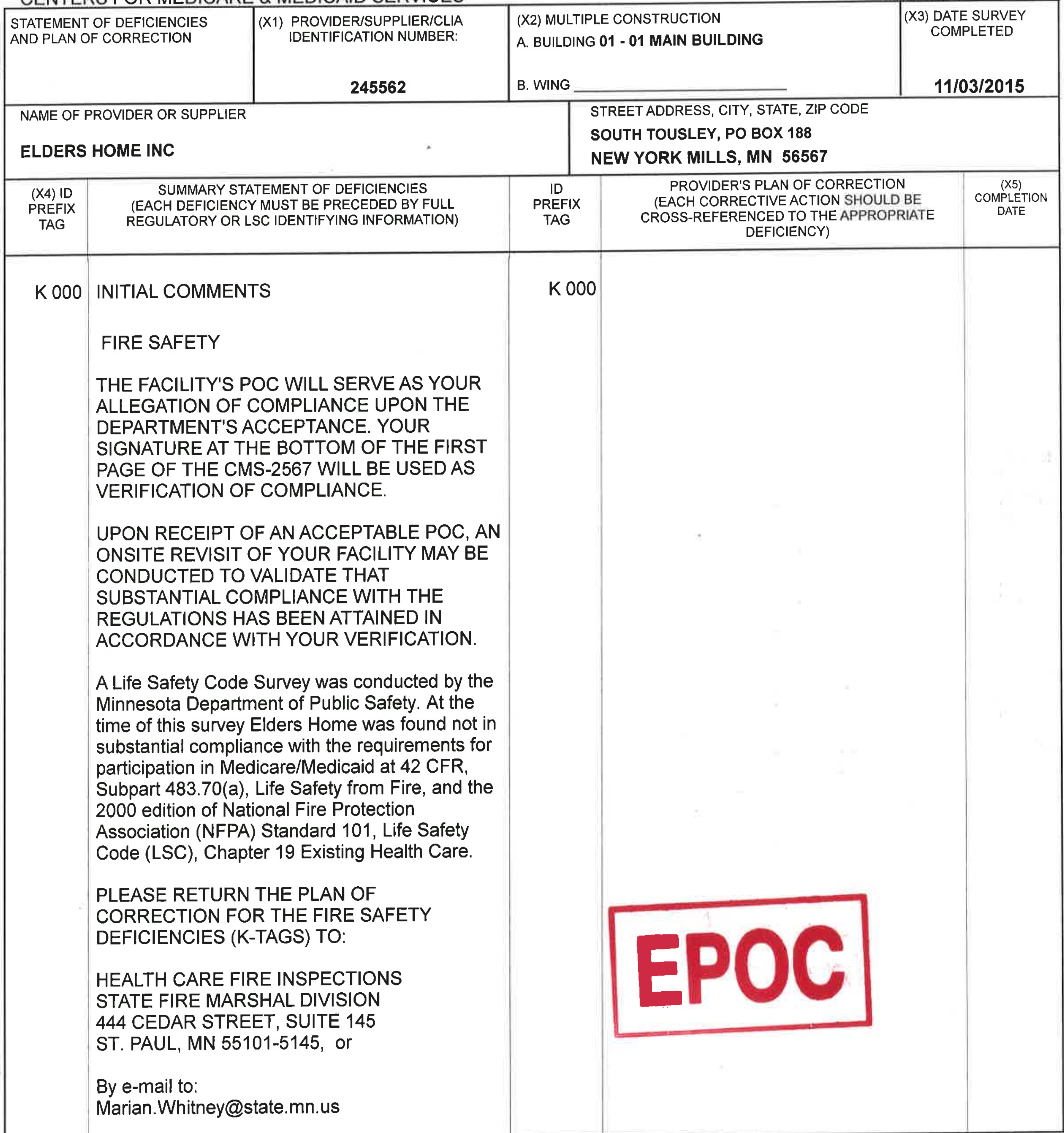
Review of the facility policy Housekeeping Guidelines for Infection Control, undated, identified they would maintain clean and sanitary conditions and follow facility cleaning and decontamination schedules.

Review of the facility policy Housekeeping Policies and Procedures, undated, identified resident rooms would be wet mopped every day and rooms would be examined for any repairs and reported to the maintenance department.

F5562025

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

FORM APPROVED
OMB NO. 0938-0391



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	245562	A. BUILDING 01 - 01 MAIN BUILDING B. WING ______	11/03/2015

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

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/02/2015

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.

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K 000	Continued From page 1	K 000		

Angela.Kappenman@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

Elders Home is a 1-story building with a partial basement. The original building was constructed in 1959 and was determined to be of Type II(111) construction. In 1993, an addition was added to the south that was determined to be of Type II (111). In 1999 an addition was added onto the Dinning Room to the west which is Type V (111). The building is divided into 4 smoke zones divided by 30 minute and 90 minute fire barriers.

The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The

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	245562	A. BUILDING **01 - 01 MAIN BUILDING** B. WING	**11/03/2015**

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ELDERS HOME INC	**SOUTH TOUSLEY, PO BOX 188** **NEW YORK MILLS, MN 56567**

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K 000	Continued From page 2 sleeping rooms have single smoke detectors that are battery operated. The facility has a capacity 48 beds and had a census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation, an exit leading to the exterior was not in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.1.2. This deficient practice could negatively affect residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 2:30 pm and 4:30 pm on November 03, 2015, observations revealed that the exit sign over the exterior door in the dining	K 022	On November 27, 2015, an electrician with Schik Electric, relocated the exit sign, that was located over the exterior door in the dining room, so that it is now located in front of the sprinkler pipe and is no longer an obstruction, to the residents and guests.	12/15/15

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K 022	Continued From page 3 room was blocked by a 3 inch sprinkler pipe. This could affect all residents and guests. This deficient practice was confirmed by the Director of Maintenance and the Administrator at the time of the inspection and during the exit conference.	K 022		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and testing of corridor doors, it was determined that one corridor door did not comply with NFPA 101 "The Life Safety Code" 2000 Edition Section 19.3..7. This deficient practice could allow the products of combustion to spread beyond the room of fire origin and negatively impact all 36 residents, any visitors and staff of this facility. Findings include: During the facility tour on November 03, 2015 between 2:30 PM and 4:30 PM, observations and testing of the corridor doors, revealed that the	K 025	Seven door coordinators have been ordered from Central Door and Hardware, Fargo ND. The Maintenance Supervisor, or his designee, will install the coordinators on the effected corridor doors.	12/15/15

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K 025	Continued From page 4 corridor door from the dining room has a coordinator that did not operate as designed and the corridor doors of the same type did not have coordinators on them. This deficient practice was confirmed by the Director of Maintenance and the Administrator at the time of the inspection and during the exit conference.	K 025		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Observations revealed that one of three smoke barriers were not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 8.3.6. This deficient practice could allow the products of combustion to travel throughout the building by passing through the smoke barrier, which will negatively impact all of the patients, staff and visitors. Findings include: During the facility tour on November 03, 2015,	K 029	The Maintenance Supervisor, or his designee, will place a fire rated Elastomeric sealant on the ceiling areas above the lower level laundry and maintenance area, where there are pipe penetrations that do not have a smoke or fire resistant material filling the annular spaces. The Maintenance Supervisor, will also be responsible to periodically monitor the repair, to ensure that the fire resistant material continues to adhere to the	12/15/15

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K 029	Continued From page 5 between 2:30pm and 4:30 pm, observations revealed that the ceiling areas above the lower level laundry and maintenance area consisted of pipe penetrations that did not have the annular spaces around them filled with a smoke or fire resistant material. This deficient practice was confirmed by the Director of Maintenance and the Administrator at the time of the inspection and during the exit conference.	K 029	annular spaces.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow a delayed activation of the fire sprinkler system and could affect the residents, visitors and staff of the facility. Findings include: On facility tour between 2:30 PM and 4:30PM on 11/03/2015, the following deficient conditions were observed:	K 062	On November 24, 2015 an order was placed with Direct Supply in Milwaukee, WI (Order #21030244) for adjustable wire shelving. The Maintenance Supervisor, or his designees will replace the solid shelving, with the wire shelving. We will also place the top shelving, at a distance from the deflector, that will be in compliance with the NFPA standard.	12/15/15

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K 062	Continued From page 6 1. The sprinkler heads that are in the food storage room 29 are pendants located in the center of the space above solid shelving within 18 inches of the deflector. With the shelves being too close to the deflector and being solid, will obstruct the flow of water from the sprinkler heads.	K 062		