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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: B4L8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00375

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245494**
2.STATE VENDOR OR MEDICAID NO.
(L2) **615342900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME**
(L4) **701 FIRST STREET**
(L5) **PRINCETON, MN** (L6) **55371**

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 11/06/2013 (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 **113** (L18)

13.Total Certified Beds **113** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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
	113			
(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 :
Karen Aldinger, HFE, NEII 11/6/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 01/17/2014 (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
08/01/1987
(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
11/25/2013
(L33)

DETERMINATION APPROVAL

CCN: 24-5494

On August 15, 2013 an Opportunity to Correct Survey was completed at this facility. The most serious deficiency was issued at a scope and severity (S/S) level of E.

On September 13, 2013, a Federal Monitoring Survey (FMS) was completed at this facility. The most serious deficiency was issued at a S/S level of F. As a result of the survey findings, CMS imposed the following remedy:

Mandatory Denial of Payment New Admissions (DOPNA), effective November 15, 2013

The facility was subject to a two year loss of Nursing Assistant Training Competency Evaluation Program (NATCEP) beginning November 15, 2013.

On November 6, 2013, a Post Certification Revisit (PCR) was completed to verify correction of deficiencies from our standard survey and the FMS survey. The PCR verified correction of all deficiencies. As a result of this PCR, this Department recommended the following to the CMS RO:

Mandatory DOPNA, effective November 15, 2013, be rescinded.

Since DOPNA did not go into effect, the facility would not be subject to a loss of NATCEP for two years.

Please refer to the CMS 2567B. Effective November 6, 2013, the facility is certified for 113 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5494 January 17, 2014

Mr. Todd Lundeen, Administrator
Elim Home
701 First Street
Princeton, Minnesota 55371

Dear Mr. Lundeen:

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 November 6, 2013 the above facility is certified for:

113 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 113 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.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 6, 2014

Mr. Todd Lundeen, Administrator
Elim Home
701 First Street
Princeton, Minnesota 55371

RE: Project Number S5494022 and S5494024

Dear Mr. Lundeen:

On September 3, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 15, 2013. The survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

In addition, on September 13, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Health Comparative Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required.

On September 19, 2013,CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 15, 2013. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of September 19, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 15, 2013.

On November 6, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey complete on a August 15, 2013 and an FMS completed on September 13, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 14, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 6, 2013 and the FMS completed on September 13, 2013, as of November 6, 2013.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of their letter of September 19, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 15, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 15, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 15, 2013, is to be rescinded.

In addition, CMS Region V Office notified you in their letter of September 19, 2013 that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 15, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 6, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245494	A. Building B. Wing	11/6/2013

Name of Facility	Street Address, City, State, Zip Code
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/24/2013**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/24/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/24/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **09/24/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **09/24/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/24/2013**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/BF	01/06/2014	29245	11/06/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245494	A. Building B. Wing	11/6/2013

Name of Facility	Street Address, City, State, Zip Code
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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 **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **09/24/2013**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/BF	01/06/2014	29245	11/06/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/15/2013

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00375	A. Building B. Wing	11/6/2013

Name of Facility	Street Address, City, State, Zip Code
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	**09/24/2013**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**09/24/2013**	ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp. 1** LSC	**09/24/2013**
ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp. 2.B** LSC	**09/24/2013**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	**09/24/2013**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	**09/24/2013**
ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	**09/24/2013**	ID Prefix **20960** Reg. # **MN Rule 4658.0600 Subp. 1** LSC	**09/24/2013**	ID Prefix **21405** Reg. # **MN Rule 4658.0810 Subp. 2** LSC	**09/24/2013**
ID Prefix **21410** Reg. # **MN Rule 4658.0815 Subp. 1** LSC	**09/24/2013**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	**09/24/2013**	ID Prefix **21810** Reg. # **MN St. Statute 144.651 Subd. 6** LSC	**09/24/2013**
ID Prefix **21980** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	**09/24/2013**	ID Prefix **21985** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	**09/24/2013**	ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/BF	01/06/2014	29245	11/06/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/15/2013

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

FMS

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
245494	A. Building B. Wing	11/6/2013

Name of Facility	Street Address, City, State, Zip Code
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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 **F0224** Reg. # **483.13(c)** LSC	Correction Completed **11/06/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **11/06/2013**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **11/06/2013**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/06/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **11/06/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/06/2013**
ID Prefix **F0328** Reg. # **483.25(k)** LSC	Correction Completed **11/06/2013**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **11/06/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **11/06/2013**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **11/06/2013**	ID Prefix **F0490** Reg. # **483.75** LSC	Correction Completed **11/06/2013**	ID Prefix **F0518** Reg. # **483.75(m)(2)** LSC	Correction Completed **11/06/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/BF	01/06/2014	29245	11/06/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/13/2013			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 6, 2014

Mr. Todd Lundeen, Administrator
Elim Home
701 First Street
Princeton, Minnesota 55371

Re: Enclosed Reinspection Results - Project Number S5494022

Dear Mr. Lundeen:

On November 6, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 15, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5494r13.rtf

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B4L8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00375

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245494**

2.STATE VENDOR OR MEDICAID NO.
(L2) **615342900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME**
(L4) **701 FIRST STREET**
(L5) **PRINCETON, MN** (L6) **55371**

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 **08/15/2013** (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 **113** (L18)

13.Total Certified Beds **113** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	113			
(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 :
Kathy Sass, HFE NE II — 09/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 11/22/2013 (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
08/01/1987
(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
11/25/2013
(L33)

DETERMINATION APPROVAL

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

At the time of the standard survey completed August 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5018

September 3, 2013

Mr. Todd Lundeen, Administrator
Elim Home
701 First Street
Princeton, Minnesota 55371

RE: Project Number S5494022

Dear Mr. Lundeen:

On August 15, 2013, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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 August 15, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5494013 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>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;

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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

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 September 24, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 November 15, 2013 (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 February 15, 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:

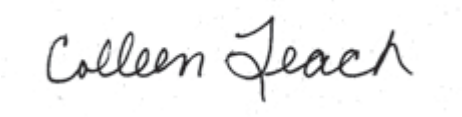
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

(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	F 000		

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.

Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

In addition, a complaint investigation was inititated on August 12, 2013 to investigate complaint #H5494013. The complaint was not substantiated.

RECEIVED
SEP 16 2013
MN Dept of Health
St.Cloud

F 225 SS=D — 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS — F 225

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported

7/23/13 see addendum to POC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9-12-13

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
	245494	A. BUILDING _____ B. WING _____	08/15/2013

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ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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F 225	Continued From page 1 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure resident allegations of neglect and mistreatment were immediately reported to the administrator, state agency and thoroughly investigated for 1 of 5 resident, (R10) allegations reviewed. Findings include: R10 had diagnosis that included left side paralysis. The annual Minimum Data Set (MDS) dated 6/17/13 indicated R10 was cognitively intact, had no behaviors of rejection of care, and was totally dependent upon staff for all activities of daily living (ADL's), except eating. During interview on 8/14/13, at 7:05 a.m. trained	F 225	**F 225** It is the policy of Elim Care and Rehab Center that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. Alleged violations must be thoroughly investigated and a plan in place to prevent further potential abuse/neglect/mistreatment while the investigation is in progress. To assure continued compliance the following plan has been implemented. **Regarding cited resident:** A report was filed with OHFC and sent to the common entry point once notified by surveyors of potential resident mistreatment. An investigation was conducted which included staff and resident interview. The conclusion was that there was no substantiated mistreatment expressed by this resident or neighboring residents regarding the alleged perpetrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 2 medication aide (TMA)-B stated R10 had complained to her regarding nursing assistant (NA)-A being rude and neglectful to the resident. NA-A often tells R10 to have a bowel movement in his pants and will say to the resident, "Now what; I was just in here!" TMA-B stated she had reported this to the director of nursing (DON) and also "other management" within the last several months. During interview on 8/14/13, at 10:35 a.m. R10 stated NA-A will come into the residents room when the call light is on and will say, "What do you want now!" R10 stated NA-A also tells him to "lay off the buzzer!" R10 stated he puts his call light on to use the bed pan to have a bowel movement and NA-A will come into his room, shut the call light off, and say she will come back. R10 stated NA-A never comes back, and he just has to go in his pants, and "sit in it." R10 stated he had talked about NA-A at care conferences and had told "many people" that NA-A is neglectful. R10 stated NA-A works with him on a regular basis and stated nothing has changed regardless of who he has complained to about NA-A's treatment. During interview on 8/14/13, at 10:35 a.m. family member (FM)-C stated R10 had complained about NA-A in the past at care conferences. FM-C was unsure if anything had ever been done regarding this complaint. During interview on 8/14/13, at 1:15 p.m. social worker (SW)-A stated no concerns had ever come up regarding NA-A regarding any neglect or maltreatment of R10, or any other resident that they were aware of. SW-A did not remember this being brought up at care conferences.	F 225	Although mistreatment was not substantiated, alleged perpetrator was coached regarding policy. Facility has received a response back from OHFC that no further investigation is required at this time. **Actions taken to identify other potential residents having similar occurrences:** Facility staff is expected to report any suspected occurrence of neglect, abuse, mistreatment, injury or bruise of unknown origin, misappropriation of funds immediately. This is part of new staff orientation and annual All facility Staff training. **Measures put in place to ensure deficient practice does not occur:** In-service training of ALL facility staff on protocol for proper reporting of suspected incidence of mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property is reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures will be conducted. Training took place at several times throughout the day/night	

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F 225	Continued From page 3 During interview on 8/15/13, at 8:50 a.m. DON stated she was not aware of specific allegations regarding NA-A and R10, but she knew NA-A "was big on the radar" from some of the nurses. The DON stated the "nurses" have been watching NA-A regarding "not always getting cares done" such as toileting and repositioning residents. She stated the RN's are working on "time management" with NA-A. During interview on 8/15/13, at 2:10 p.m. RN-B stated she had never heard any concerns regarding NA-A and R10. RN-B stated as far as she knew NA-A was not being monitored for any concerns regarding resident neglect, time management, or not completing cares. Although R10 had complained to NA's and other staff regarding alleged neglect from NA-A, the facility did not investigate the allegation. A facility policy entitled Vulnerable Adult Abuse Prohibition Policy and Procedure, dated November 2012, included under Policy, "Residents are to be treated with respect and kindness at all times. Each employee is responsible to report suspected/alleged violations of resident abuse/neglect immediately to one of the following: Nursing Supervisor, Nurse on Duty, Director of Nursing, or Social Worker. The Administrator will be notified immediately by one of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the state agency and all other agencies as required." Under Resident Protection During Investigation; "1. Provide for the immediate safety of the resident upon	F 225	of September 10 & 11, 2013. In addition random staff interviews will be completed weekly times one month and then monthly and periodically, to ensure understanding of the vulnerable adult reporting processes. This information will be reviewed by CQI Committee. **Effective implementation of actions will be monitored by:** Interdisciplinary team consisting of Social Services, nursing, dietary, activity director, director of nursing and administrator. **Those responsible to maintain compliance will be:** The facility Administrator is responsible for ongoing compliance. **Completion date for certification purposes only is 09-24-2013**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	08/15/2013

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F 225	Continued From page 4 identification abuse, neglect, mistreatment...The resident involved is removed from the suspected perpetrator's care and reassigned to another caregiver..." Under Investigation, "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to implement their abuse prohibition policy which required immediate notification to the administrator, state agency and a thorough investigation of any alleged abuse and neglect for 1 of 5 resident (R10) allegations reviewed. Findings include: A facility policy entitled Vulnerable Adult Abuse Prohibition Policy and Procedure, dated November 2012, included under Policy, "Residents are to be treated with respect and kindness at all times. Each employee is responsible to report suspected/alleged violations of resident abuse/neglect immediately to one of the following: Nursing Supervisor, Nurse on Duty, Director of Nursing, or Social Worker. The Administrator will be notified immediately by one	F 226	**F 226** **Staff Treatment of Residents:** It is the practice at Elim Care & Rehab Center – Princeton for staff to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. All staff is trained on these policies and protocols for reporting suspected mistreatment, neglect and abuse of residents and misappropriation of resident property. Per regulatory guidelines a policy has been developed and training regarding proper implementation of policies and procedures occurs with new staff orientation and on at least an annual basis.	

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F 226	Continued From page 5 of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the state agency and all other agencies as required." Under Resident Protection During Investigation; "1. Provide for the immediate safety of the resident upon identification abuse, neglect, mistreatment...The resident involved is removed from the suspected perpetrator's care and reassigned to another caregiver..." Under Investigation, "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated." R10 diagnosis that included left side paralysis. The annual Minimum Data Set (MDS) dated 6/17/13 indicated R10 was cognitively intact, had no behaviors of rejection of care, and was totally dependent on staff for all activities of daily living (ADL's) except eating. During interview on 8/14/13, at 7:05 a.m. trained medication aide (TMA)-B stated R10 had complained to her regarding nursing assistant (NA)-A being rude and neglectful to the resident and tells R10 to have a bowel movement in his pants and will say to the resident, "Now what; I was just in here!" TMA-B stated she had reported this to the director of nursing (DON) and also "other management" within the last several months. During interview on 8/14/13, at 10:35 a.m. R10 stated NA-A will come into the residents room when the call light is on and will say, "What do you want now!" R10 stated NA-A also tells him to "lay off the buzzer!" R10 stated he puts his call light on to use the bed pan to have a bowel	F 226	**Regarding cited resident:** A report was filed with OHFC and sent to the common entry point once notified by surveyors of potential resident neglect. An investigation was conducted which included staff and resident interview. The conclusion was that there was no substantiated neglect expressed by this resident or neighboring residents regarding the alleged perpetrator **Actions taken to identify other potential residents having similar occurrences:** All staff is expected to report any suspected occurrence of neglect, abuse, injury or bruise of unknown origin, misappropriation of funds or mistreatment immediately. This is included in staff orientation and annual All Facility Staff training. **Measures put in place to ensure deficient practice does not occur:** In-service training of All facility staff on facility procedure regarding proper implementation of Elim's Vulnerable Adult policies and procedures was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 6 movement and NA-A will come into his room, shut the call light off, and say she will come back. R10 stated NA-A never comes back, and he just has to go in his pants, and "sit in it." R10 stated he had talked about NA-A at care conferences and has told "many people" that NA-A is neglectful. R10 stated NA-A works with him on a regular basis and stated nothing had changed regardless of who he has complained to. During interview on 8/14/13, at 10:35 a.m. family member (FM)-C stated R10 had complained about NA-A in the past at care conferences. FM-C was unsure if anything had ever been done regarding this complaint. During interview on 8/14/13, at 1:15 p.m. social worker (SW)-A stated no concerns had ever come up regarding NA-A regarding any neglect or maltreatment of R10 or any other resident that they were aware of. SW-A did not remember this being brought up at care conferences. During interview on 8/15/13, at 8:50 a.m. DON stated she was not aware of specific allegations regarding NA-A and R10, but she knew NA-A "was big on the radar" from some of the nurses. DON stated the "nurses" have been watching her regarding "not always getting cares done" such as toileting and repositioning residents. She stated the RN's are working on "time management" with NA-A. DON verified the accusations of staff neglect by NA-A to R10 had not been investigated or reported. During interview on 8/15/13, at 2:10 p.m. RN-B stated she had never heard any concerns regarding NA-A and R10. RN-B stated as far as she knew NA-A was not being monitored for any	F 226	conducted. Training will take place at several times throughout the day/night of September 10 & 11, 2013. In addition random staff interviews will be completed weekly times one month and periodically, to ensure understanding of the vulnerable adult policies and procedures. This information will be reviewed at quarterly CQI Committee. **Effective implementation of actions will be monitored by:** Interdisciplinary team consisting of Social Services, nursing, director of nursing and administrator. **Those responsible to maintain compliance will be:** The facility Administrator is responsible for ongoing compliance. **Completion date for certification purposes only is 09-24-2013**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 7 concerns regarding resident neglect, time management, or not completing cares. Although R10 had complained to NA's and other staff regarding neglect from NA-A, the facility did not report or investigate the allegation per facility policy.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident received toileting assistance in a dignified manner, when they had to wait extended periods of time for assistance, for 5 of 5 residents (R34, R12, R105, R5, and R10) interviewed who required assistance with toileting. Findings include: R34 did not receive timely assistance to the bathroom, causing urinary incontinence and distress for her. R34's diagnoses included osteoarthrits and kidney disease. The annual Minimum Data Set (MDS) dated 5/23/13, indicated R34 was cognitively intact, required extensive assistance for toileting, received a diuretic (water pill that causes urinary urgency and frequency) daily, and	F 241	**F 241** It is the policy of Elim Care and Rehab care to provide care for our residents in a manner that enhances their dignity and respect in recognition of their individuality. **Regarding cited residents:** Residents R34, R12, R105, R5, and R10 call light reports have been reviewed. RN Unit managers and Night Supervisors have interviewed residents regarding strategies for staff to meet their needs in a satisfactory period of time. Care plan was updated if appropriate. Effectiveness of strategies will continued to be monitored.	

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F 241	Continued From page 8 was frequently incontinent of urine. R34's Activities of Daily Living (ADL's) Care Area Assessment (CAA) dated 5/23/13 indicated she required extensive staff assistance and needed a ceiling lift for transfers/toileting. R34's care plan dated 6/28/13, included; "Elimination: Alteration in bowel and bladder status d/t [due to] impaired mobility, hx [history] uti [urinary tract infection] kidney disease, pain, diuretic, cathartic..." Staff were directed to: "Prompt to toilet upon rising, before meals @ [at] hs [bedtime] and per her request." The care plan did not identify when R34 received a diuretic, or the urgent need to void that this medication may cause. R34 was interviewed on 8/14/13, at 1:35 p.m. and stated she had to wait extensive periods of time to be assisted to the toilet, or the bed pan. "You have to wait and wait and wait; an hour, nearly two sometimes. It is often at least 45 minutes. They will come in and say they will be right back to help me, and shut off my call light, then they don't come back, or if they do it is at least 45 minutes. I get wet because of the wait." What happens at night is that I have to use the bed pan, I will put on my call light and wait, sometimes they will come fairly quickly, shut off my light and then leave saying they will be back, then they just don't come back. I have to stay awake because I have to urinate, if I have wait too long, I will wet my pad. Then I have to force myself to stay awake while I wait for them to come and change my pad and clean me up. This makes me not feel very good during the day, because I am awake so much at night. If they would just come right away, I could use the bed pan and go back to sleep. "I would feel a lot better, my life would	F 241	**Actions taken to identify other potential residents having similar occurrences:** Call light reports are being reviewed for all residents with greater than 10 minute response time. Evaluating for trends related to call time use and response times. **Measures put in place to ensure deficient practice does not occur:** In-service training of caregiver staff regarding expectations related to call light response was reviewed at Sept. 10th & 11th All Staff meetings with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Daily call light response times will be audited and reviewed with focus on response greater than 10 minutes – daily x's 2 weeks (Mon – Friday) than weekly alternating days of week so alternating teams are audited x's 3 months and then periodically. Results to be reviewed by CQI (continuous	

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F 241	Continued From page 9 be a lot better." R34 went on to say she was very dependent upon staff to use the bathroom and it is upsetting to her when she has "wet myself." R34's call light audit sheet from 8/1/13 through 8/15/13 showed an average call light wait time of 7.5 minutes. However, R34 also had extensive wait times documented as follows: Between 10-15 minutes 26 times. Between 15-20 minutes 15 times. Between 20-25 minutes seven times. Between 25- 30 minutes twice. There was also one recording showing a 52.5 minute wait time for R34. R12 had to wait an extended periods of time for staff to empty his urinal causing him "fear of spilling it", and needing to be cleaned up. R12's diagnoses included a stroke and right sided hemiplegia [weakness on one side]. R12's MDS dated 5/16/13, included he was cognitively intact, and required extensive assistance with toileting and hygiene. R12 was continent of urine. R12's Urinary Incontinence CAA dated 2/7/13, indicated he was continent of urine, but required staff to empty his urinal. R12's care plan dated 5/16/13 indicated he required staff assistance with emptying his urinal. R12 was interviewed on 8/12/13, at 3:19 p.m. and stated he is capable of placing the urinal to void in it after he is in bed. However, he is unable to remove the urinal without spilling it and has to wait for staff to come and do this. R12 stated he often has to wait 15-20 minutes, but sometimes an hour for someone to come, remove and empty his urinal. During this time he has to remain very	F 241	quality improvement) team. Administration of Lasix times to be adjusted to 8:00 a.m. and 2:00 p.m. for all residents unless ordered differently by physician. Diuretic use to be added to 'risk for incontinence' of bladder care plans. Care plan audits to be conducted by RN unit manager or designee – 6 per week x's 1 month, then 1 per week x's 3 months. CQI Committee to review results and determine pattern for continued audits. **Those responsible to maintain compliance will be:** Administrator/Director of Nursing will oversee continuing compliance **Completion date for certification purposes only is 09-24-2013**	

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still, or the urinal will spill, and his bed gets wet, and then staff have to clean it up which involves staff having to roll him back and forth in bed. R12 stated this was particularity disturbing at night time because it disrupts his sleep when he can not go back to sleep until staff comes. R12 stated this causes some day time sleepiness, not allowing him to go do the activities he loves to do. R12 also stated the wait causes some genital discomfort for him. "If they were smart, they would just come empty my urinal, if they wait, they also have to roll me around to change my bed clothes."

R12's call light audit report from August 1-15, 2013 indicated call wait times of 10-15 minutes four times, 15-20 minutes twice, and over 20 minutes three times.

R105 had to wait an extended amount of time to be toileted, causing her to feel uncomfortable and "like a number."

R105's diagnoses included a stroke and diabetes. R105's quarterly MDS dated 5/21/13, included she was cognitively intact, required extensive assistance to the toile,t and was occasionally incontinent of urine. The Urinary Incontinence CAA dated 11/13/12, included occasional urinary incontinence. "Staff assist her to the toilet per the residents request, 2-3 times an hour, or up to 3 hours as needed."

R105's care plan dated 5/22/13, included a need for assistance to the toilet due to lower extremity paralysis, and to toilet her upon request.

R105 was interviewed on 8/14/13, at 12:00 p.m. and stated, "They don't have enough help, I will

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turn on my call light, they will come in and turn it off saying they have to get another helper." I need two people to help me to the bathroom. The problem is, they don't come back. I get terribly uncomfortable, "I try not to beg for help, it makes me feel like a number." R105 stated she had turned on her call light at 10:00 a.m. today, someone came in and shut off her call light, said they would be right back, but she was still waiting at 12:00 p.m. She had just turned her call light back on. R105 stated this happens every day. Nursing assistant (NA)-H was asked by the surveyor to assist R105.

During interview on 8/14/13 at 1:08 p.m. NA-H stated she was not aware someone had turned off R105's call light. NA-H stated they do have trouble getting to call lights timely and if someone needs two assistants, she has to go find someone to help, often from a different unit.

R105's call light audit forms from 8/1/13 through 8/15/13, showed wait times: 10-15 minutes 21 times. 15-20 minutes 17 times. Over 20 minutes 13 times, including twice over 30 minutes.

R5 did not receive timely assistance to the bathroom, causing urinary incontinence, which she felt embarrassed about.

R5's diagnoses included diabetes and heart failure. R5's quarterly MDS dated 7/29/13, indicated she had cognitive impairment, required extensive assistance to toilet, and took a diuretic daily. R5 was occasionally incontinent of urine. R5's Urinary Incontinence CAA dated 3/4/13, included, "She was occasionally incontinent prior to the hospitalization related to lasix

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found embarrassing. In addition,

R10 had to wait extended periods of time to use the bed pan, causing bowel incontinence, and having to sit in the stool, which felt "horrible."

R10 had diagnosis including left side paralysis. The annual MDS dated 6/17/13, indicated the resident was cognitively intact and was totally dependent on staff for all ADL's.

During interview on 8/13/13, at 10:40 a.m. R10 stated the facility is short staffed and at times he has to wait over an hour for help to get on the bedpan to have a bowel movement. The resident stated he turns the call light on for assistance, and staff will come in and turn it off and say they are coming back, but they don't come back to help him. R10 stated he will then have a bowel movement in his pants because he can't wait any longer and has to "sit in it for an hour" which is "horrible!"

During interview on 8/14/1, at 10:15 a.m. family (F)-C stated concerns regarding R10 not being toileted timely had been brought to the "staffs" attention.

During interview on 8/12/13, at 7:45 p.m. trained medication aide (TMA)-D stated nurse aides ask her to assist them with transferring residents to the toilet all the time. She does help them, but if she is in the middle of a medication pass, she can not help until she is done. TMA-D stated that sometimes residents have to wait a long time to get to the bathroom.

During interview on 8/12/13, at 8:00 p.m. NA-I

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[diuretic-water pill] use and she states that urine just comes quickly."

R5's Physician Order Report dated 2/15/2013 - 8/15/2013 included: Lasix 20 mg [milligrams] 1/2 tablet twice a day at 8:00 a.m. and 12:00 p.m.

R5's care plan dated 1/28/13, included "cognition has fluctuated past several months," scoring between moderate cognitive impairment to cognitively intact. The Elimination care plan dated 7/26/13, included; "One assist for toileting. Prompt to toilet every two hours while awake and every three hours at night." The care plan did not address when R5 took a diuretic, or the need to assist her to the toilet shortly thereafter to prevent incontinence.

R5 was interviewed on 8/12/13, at 2:55 p.m. and stated she waits 10 to 30 minutes each time she needs to urinate, she takes a water pill and needs to go as soon as she feels the need. If she has to wait too long she becomes incontinent of urine. "This is embarrassing for me; I wouldn't wet, if they would help me in a reasonable amount of time."

R5's call light audit sheet dated 8/1/13 through 8/15/13, included and average wait time of six minutes after R5 would put on call light for assistance. The audit showed extended wait times of waiting over 10 minutes five times; over 15 minutes once; and over 30 minutes once in the 15 day period.

Even though the facility was aware R5 received a diuretic and had urinary urgency, she often had to wait for assistance with toileting for over 10 minutes, causing urinary incontinence, which R5

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F 241	Continued From page 14 stated, "Residents call to go to the bathroom, we don't have time and the nurses won't help. We are often in the groups by ourselves and the residents just have to wait until we can get someone to help." During interview with NA-W on 8/14/13, at 8:34 a.m. she stated, "I get called to help out other groups all the time, then I can't answer call lights in my own group. Residents have to wait a long time." NA-W stated they often shut off call lights if someone needs two assist to help them to the toilet. They will have to wait until another aide is available to help them. This often takes a long time, 30-60 minutes.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident choices about bathing preferences were honored for 3 of 19 residents (R79, R5, and R150) interviewed about bathing preferences. Findings include: R79 had expressed it was important to her to	F 242	**F 242** **Self-Determination- Right to make Choices** the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care. It is the practice at Elim Care & Rehab Center – Princeton for staff to encourage and assist residents in making choices about aspects of their life in the facility that are significant to the resident including preferred bathing method. **Regarding cited residents:** Residents R150, R5 and R79 have been interviewed regarding their preferred bathing style. This information will be added to the ADL care plan and caregiver group sheets.	

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F 242	Continued From page 15 choose between a tub bath or shower, but the facility did not have a system in place to ensure their preference was being honored. R79's diagnosis included osteoarthritis. R79's annual Minimum Data Set (MDS) dated 8/27/12, indicated she was cognitively intact and required physical assist from staff for bathing. The MDS also indicated it was somewhat important to R79 to choose between a tub bath, shower, bed bath, or sponge bath. The Psychosocial Well-Being Care Area Assessment (CAA) dated 8/27/12, indicated the facility care plan was consistent with resident's prior lifestyle, preferences and routines. R79's care plan dated 6/4/13, included one assistant to bathe but did not include a bathing preference of a tub bath or shower for R79. During interview with R79 on 8/12/13, at 3:35 p.m. she stated she use to take a shower at home, "but here we don't have any choice, we just get into the whirlpool tub. I use to ask to take a shower, but they told me we only have a tub here, so I haven't asked again." R5 had expressed it was important for her to choose between a tub bath or shower, but the facility did not have a system in place to ensure this preference was honored. R5's diagnosis included diabetes. R5's quarterly MDS dated 7/29/13, indicated moderate cognitive impairment and required extensive assistance with bathing. R5's annual MDS section F, dated 3/4/13, indicated it was very important to her to choose between a tub bath, shower, bed bath, or sponge bath.	F 242	**Actions taken to identify other potential residents having similar occurrences:** Current residents Preference Sheets will be reviewed and bathing style will be added to care plan and group sheets. On admission and during care conferences, nursing or activity dept. will interview resident regarding bathing preferences. This information will be added to the caregivers group sheets. Residents will be asked prior to providing services if this is their current preference. **Measures put in place to ensure deficient practice does not occur:** Training on September 10 & 11, 2013 will include review of resident right to choose preferred bathing style. Staff will be informed of additional information added to the resident care group sheets. Staff will also be instructed to offer resident choices when providing cares as a residents choice on a given day may be different than the stated/care planned preference. Resident preference for bathing style will be addressed upon admission and as needed. Unit manager will be responsible to oversee	

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R5's care plan dated 7/26/13 included one assist for bathing, however did not include a bathing preference.

During interview on 8/12/13, at 2:55 p.m. R5 stated she does not have a bathing choice, they only have a tub here, she would prefer a shower. She had told staff at one point, but was told they only have a big tub. R5 had not asked recently if she could take a shower.

During interview on 8/15/13, at 8:45 a.m. registered nurse (RN)-D stated she had never heard either R79 or R5 preferred a shower over a tub bath. A shower was not available on this unit and resident's would have to go off the unit to shower. RN-D did not think either resident would want to do that but had not asked them. RN-D stated she does not fill out the section of the MDS indicating bathing preferences, the activity director does.

During interview on 8/15/13, at 9:11 a.m. the activity director (AD) stated she fills out the section of the MDS which indicates resident bathing preferences. If a resident has a preference, she would tell a nurse aide on the unit and would expect this nurse aide to report it to a nurse. The nurse should report this information to the unit manager to ensure the preference were followed. The AD does not add this information to the care plan, nursing would be responsible for this.

During interview on 8/15/13, at 9:20 a.m. trained medication aide (TMA)-C stated the tub on this unit has a shower adapter, all they would need to do is get in the tub, shut the door and use the

resident choices are offered and care plan preferences in addition put on group sheet. Information will be confirmed and/or updated at scheduled care conferences and as needed. Auditing will be completed by IDT weekly on new admissions for 3 months, and/or at least 5 random resident charts monthly. Audit results will be sent to CQI Committee for review and determination of need for ongoing audits.

Effective implementation of actions will be monitored by:
Interdisciplinary team consisting of Social Services, nursing, recreation therapy and administrator and director of nursing.

Those responsible to maintain compliance will be:
The facility RN Unit managers are responsible for ongoing compliance.

Completion date for certification purposes only is 9/24/13

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shower attachment versus filling the tub. The tub was observed at this time and had a shower option available.

During interview on 8/15/13, at 9:23 a.m. nursing assistant (NA)-D stated she has used the tub as a shower for other residents, but had not heard R79 or R5 had a preference for using a shower.

R150 had expressed it was important to her to choose between a tub bath or shower, but the facility did not have a system in place to ensure this preference was honored.

R150 diagnoses included anxiety and depression. R150 admission MDS dated 5/20/13, indicated she was cognitively intact and required physical assist from staff for bathing. The MDS also indicated it was very important for R150 to choose between a tub bath, shower, bed bath, or sponge bath.

During interview on 8/13/13, at 6:00 p.m. R150 stated she prefers a tub bath, but only gets showers and has not been offered a tub bath. R150 further stated she does not think that they have a tub in the rehab unit.

During interview 8/15/13, at 2:03 p.m., NA-K stated residents on the rehab unit only receive showers since they don't have a tub.

During interview on 8/15/13, at 2:15pm, trained medication aide (TMA)- F stated there are tub rooms on other floors, and they could give a tub bath on the other floors if a resident requested, but did not think anyone on the rehab unit had been receiving tub baths.

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F 242	Continued From page 18 During interview on 8/15/13, at 2:06 p.m., LPN-D stated everyone on the rehab unit takes a shower. LPN-D further stated if they request a tub bath, "we could give them a bath on a different floor." This had not been offered to R150 even though she had expressed it was important for her to choose.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R10) who were reviewed for bathing concerns, was provided the necessary equipment to ensure the resident was able to take a bath or a shower. Findings include: R10's diagnoses included hemiplegia (one sided paralysis) and morbid obesity. The annual Minimum Data Set (MDS) dated 6/17/13, identified R10 was cognitively intact, was totally dependent on staff for all activities of daily living (ADL's), and indicated it was very important for the resident to chose between a bath, shower, and a bed bath.	F 246	**F 246: Reasonable Accommodation of needs/ Preferences** It is the policy of Elim Care and Rehab Center that residents receive reasonable accommodations of their individual needs and preferences. To assure continued compliance the following plan has been implemented. **Regarding cited residents: Resident R10** has been re-approached by nursing regarding his preference for a shower. In the past resident has refused offered attempts to shower using the equipment purchased by facility. The process was explained to resident regarding special bariatric shower chair that was purchased for resident to be able to shower. Resident has refused this in the past but was now agreeable to explained method for	

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F 246	Continued From page 19 During interview on 8/13/13, at 10:40 a.m. R10 stated he received a bed bath and had not received a bath or a shower since being admitted to the facility which was "about a year ago." R10 stated because of his large size, staff can't get his wheelchair into the shower or tub room. He stated "several months" ago the facility had purchased a chair they thought would possibly fit, to get him into the tub room, but the chair would not support his weight. R10 stated he never feels clean, and was used to taking a shower everyday before being admitted to the facility. R10's care plan dated 8/14/13, indicated R10 was unable to independently perform self cares and needed three staff assist with a bath weekly, and PRN (as needed). The care plan did not identify how R10 was bathed. Review of R10's Resident Progress Notes revealed the following: 2/27/13- R10's wife was contacted regarding "the status of assessing [R10] for appropriateness of using the shower chair/commode for a bowel movement... she was notified that staff attempted to evaluate seating on the shower chair however, [R10] refused..." 2/28/13- "Staff attempted to assess [R10] seating on the shower chair today as previously discussed with [R10 and wife]. The chair was structurally sound during the process and would be useful in that respect, however, due to the curve of his back and his inability to sit with his back and legs at a 90 degree angle he slid forward on the chair. He began to complain of discomfort so he was immediately assisted back to bed per his request. He stated that he did not	F 246	showering. To date resident has been showered three times using the assistance of 3 – 4 staff. Resident has stated he doesn't want to shower any longer however, staff will offer, encourage and approach resident weekly to offer shower. Interdisciplinary team, resident and resident's spouse reviewed plan of care. Strategies for providing a shower were implemented and care plan updated. Effectiveness of accommodations will be monitored for efficacy by Unit Manager. **Actions taken to identify other potential residents having similar occurrences:** All residents' bathing style preferences will be reviewed. **Measures put in place to ensure deficient practice does not occur:** In-service training of all care giver staff on facility procedure for honoring	

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F 246	Continued From page 20 want to do that again." 4/16/13- "Tested if wheelchair would fit into tub rooms. Was able to fit through PCL's [Pine Cone Lane] tub room door. Resident was not in wheelchair at the time and would have to take into consideration that his body extends approximately 6 inch's past wheelchair width, which is 35 inch's wide, making the width needed a minimum of approximately 45 inch's [sic]. Inside measurement of tub on PCL measured 28 inch's [sic] wide. Measured tub on RRP [Rum River Place] which measured 26 inch's wide, although I do not believe we would be able to maneuver wheelchair into that spa room. At this time will continue to give weekly bed baths, wash hair in bed and cleanse daily with cares." During interview on 8/14/13, at 7:05 a.m. trained medication aide (TMA)-B stated R10 only gets bed baths because he is to big to fit into the shower or bath at the facility. She stated if she has time she tries to bring R10 down to the beauty shop to wash his hair in the sink. During interview on 8/14/13, at 8:45 a.m. nursing assistant (NA)-B stated R10 gets a bed bath and had never been brought into the shower or bath. NA-B stated the resident does not fit into the bath or shower room. During interview on 8/14/13, at 10:15 a.m. R10's family (F)-C stated R10 has not had a bath or shower since being admitted to the facility over a year ago and only receives bed baths. F-C stated he took a shower everyday at home before coming to the facility. The facility told the family they had tried different chairs, and the chairs were too wide to fit through the door. They ordered a special chair, but it wasn't strong	F 246	choices and accommodating resident preferences was conducted September 10th and 11, 2013 with follow-up training as indicated. **Effective implementation of actions will be monitored by:** RN Unit Managers will monitor resident bathing style preferences and assure care plan and group sheets are updated as needed. **Those responsible to maintain compliance will be:** RN Unit Managers will monitor ongoing compliance. Director of Nursing will oversee continuing compliance **Completion date for certification purposes only is 09-24-2013**	

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enough to hold his weight, and nothing has been done since.

During interview on 8/14/13, at 11:10 a.m. registered nurse (RN)-C stated R10 is unable to take a shower or a bath because of his large size. RN-C stated the facility ordered a special shower chair for the resident, but that shower chair would also not fit through any shower or bath door in the facility. RN-C stated she had a long talk with the resident and his family and explained the chair didn't fit through the doors and R10 and family were in agreement a bed bath would be "fine."

During interview on 8/14/13, at 11:00 a.m. RN-B stated R10 is unable to shower in the facility because the chair does not fit through the door of the shower or the tub room. RN-B stated the facility had bought him a bariatric chair for the shower/commode and he would not sit in it because he said it was too uncomfortable. RN-B stated she thought social services had been working closely with the family to try to figure out how R10 can receive a shower or bath.

During interview on 8/14/13, at 11:15 p.m. social worker (SW)-B stated nursing was working with R10 regarding getting a chair for him when he first arrive in the facility over a year ago. Social services was not involved in ordering or finding special equipment for R10 to take a shower or a bath.

During interview on 8/15/13, at 8:50 a.m. the director of nursing (DON) stated when R10 was admitted the facility purchased a special chair which was a commode and a shower chair combined. The DON stated the resident refused the chair because it was uncomfortable. She also

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F 246	Continued From page 22 stated the facility had offered to bring the resident into the shower in his wheelchair, but he refused. During observation on 8/15/13, at 10:45 a.m. the facility had a bariatric shower chair/ commode, which RN-B stated they had purchased for R10 to use for taking a shower or a bath. The chair was observed being able to fit through the door going into the shower room. RN-B stated the resident just didn't want to sit in it and thought it was "too uncomfortable." RN-B was unsure the last time the chair was attempted to be used with R10, nor was RN-B aware if any adjustments had been attempted with R10's input to try to make the chair more comfortable for him. During another interview on 8/15/13, at 12:40 a.m. R10 stated he remembered staff bringing that (shower/ commode) chair into his room "months ago" for him to use to have a bowel movement. R10 stated he didn't know that it could be used for the shower, and was told by staff that was for him to sit up and have a bowel movement on; which he did not want to do. R10 stated he was "willing" and "excited" to try the chair to see if he can use it to take a shower. R10 stated he had some concerns with the chair because (unknown) staff had told him several months ago, they did not think the chair would support his weight. Although the facility was aware R10 wanted to take a shower or a bath, the facility did not ensure all accommodations were attempted, provided, and/or explained to R10 to ensure the resident got the care required. A policy was requested, but not provided by the	F 246		

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F 246	Continued From page 23 facility.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop comprehensive care plans for 1 of 3 residents (R7) reviewed who were at risk for pressure ulcers, and for 1 of 1 residents (R131) who received hospice care from an outside agency. Findings include: R7's diagnoses included congestive heart failure	F 279	F 279 It is the policy of Elim Care and Rehab Center that each resident have a comprehensive plan of care developed that includes measurable objectives and timetables to meet their medical, nursing, and mental and psychosocial needs as identified in their comprehensive assessment. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** **Re: R131 (deceased)** **Re: R7** Interdisciplinary team reviewed available data, including repeat Tissue Tolerance, Skin Assessment tools and staff interviews. Strategies for appropriate positioning needs including pressure ulcer history and positioning frequencies were identified and implemented. Care plan was updated to include repositioning in wheelchair. Effectiveness of positioning strategies will continue to be monitored.	

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F 279	Continued From page 24 and dementia. R7's quarterly Minimum Data Set (MDS) dated 5/25/13, indicated severe cognitive impairment, required extensive assistance with bed mobility, and transfers. R7 was at risk for pressure ulcers and was on a turning and repositioning program. The Pressure Ulcers care area assessment (CAA) dated 2/15/13, included risk factors for pressure ulcer development: needs special mattress or set cushion to reduce or relieve pressure; requires regular schedule of turning; immobility; cognitive loss; incontinence; and poor nutrition. A summary included; "Risks for impaired skin include impaired mobility and cognition, occasional incontinence, edema with Ted socks in place, depression, independent with w/c [wheel chair] mobility..." The CAA did not address how often R7 required assistance with repositioning. R7's care plan dated 7/25/13, included; "Skin: Potential for altered skin integrity related to: occasional incontinence, impaired mobility...Pressure/friction areas to bilateral inner knees noted 5/29/13-closed-7/1/12. Open blister near right hip noted 6/1/12- closed- 7/8/13..." The approaches staff were instructed to use included; "Has history of stage two pressure sore to the left ischium. Reposition resident off of left side when in bed q [every] 2 hours." The care plan failed to include how often R7 required assistance to reposition when in wheel chair. R7's nurse aide worksheets entitled PB Group 2; included; "Side to side reposition every two hours when in bed." The worksheet did not instruct staff on when to reposition R7 when he was in the wheel chair. During interview on 8/15/13 at 8:55 a.m.	F 279	**Actions taken to identify other potential residents having similar occurrences:** **Re: Repositioning needs** - RN unit managers will review residents quarterly and prn to assure comprehensive care plans are in place. **Re: Coordinating of Hospice Care** - RN Unit Managers will review residents receiving hospice benefits to assure care plan indicates methods for coordination of hospice and facility interventions. Those found needing care plan updates will be modified to reflect a coordinated plan of care. **Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff responsible for care plan development, revision and review; and implementation of care plan interventions will be conducted prior tp 9/24/13, with follow-up training as indicated. Resident care plans will be reviewed quarterly and prn. End of Life – Hospice Policy implemented and staff trained on policy.	

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F 279	Continued From page 25 registered nurse (RN)-D was unable to find an assessment or care planning on what R7's needs were for repositioning while in the wheel chair. RN-D stated R7 can not reposition himself in the wheel chair, was at risk for pressure ulcers, and would need repositioning by staff at least every 2 hours. R131's care plan did not identify when hospices was coming, nor what type of services they were providing for R131. R131 diagnoses included terminal lymphoma, anxiety and depression. R131's quarterly MDS dated 7/17/13, indicated R131 was cognitively intact. R131's care plan dated 6/23/13, indicated she was on hospice and received a hospice nurse one to three times a week and a hospice aide visit once a week. The care plan failed to include what services would be provided by the hospice aide, and when each discipline would be available to assist R131. During interview on 8/12/13, at 7:00 p.m. R131 stated, The hospice aides make me nervous, they are "too perky. I don't even know what they are suppose to do with me," they come in and ask me what I want, and I don't know what to tell them because I don't know what they are suppose to do. "I never know when they are coming either, if they tell me, they don't tell me loud enough so I can hear them." When interviewed on 8/14/13, at 9:00 a.m. registered nurse (RN)-C stated, "hospice is supposed to call the day before to let us know they are coming we than put it in the calendar at	F 279	**Effective implementation of actions will be monitored by:** ADON/DON will conduct 6 monthly audits for complete and accurate care plan development, revision, review and implementation. Results will be reported to CQI Committee for review and determination of need for continued audits. **Those responsible to maintain compliance will be:** RN Unit Managers will monitor ongoing compliance. Director of Nursing will oversee continuing compliance. **Completion date for certification purposes only is 09-24-2013**	

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F 279	Continued From page 26 the desk so staff are aware when they are coming." RN-C further stated usually they have a calendar in the medical record stating when they are coming and verified the last date listed was 7/16/13 and did not know why the calendar was further filled out. When interviewed on 8/14/13, at 11:30 a.m., RN-B stated "hospice should have a calendar letting us know when they are coming," and further stated the calendar had no dates past 7/16/13 and did not know when hospice would be seeing R131 again. When interviewed on 8/14/13, at 11:42 a.m., nursing assistant (NA)-J stated "hospice is suppose to call us ahead of time and the nurses write it in the calendar." NA-J then stated there has been no recent documentation in the calendar as to when hospice would be available for R131. The facilities hospice service agreement dated 12/07/08, indicated "combined plan of care" means a written care plan established, maintained , reviewed , and modified, in collaboration between Hospice and the Nursing Facility that includes (a) an assessment of each patient's needs, (b) an identification of the Hospice Services, including management of discomfort and symptom relief needed to meet such patient's needs and related needs of the Hospice Patient's family, and (c) details concerning the scope and frequency of such Hospice Services.	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 27 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 provide timely assistance with toileting, as directed by the care plan, for 1 of 3 residents (R7) reviewed for urinary incontinence; and 5 of 6 residents (R130, R24 R46, R10, R139) who recieved nursing restorative care, as directed by their current plan of care. Findings include: R7's diagnoses included congestive heart failure and dementia. R7's quarterly Minimum Data Set (MDS) dated 5/25/13, indicated R7 had severe cognitive impairment, required extensive assistance to toilet, was on a toileting program, and was frequently incontinent of urine. R7's care plan dated 5/15/13 included; "Bowel and Bladder: Alteration in elimination R/T [related to] resisting cares, impaired cognition, and mobility, visual impairments, pain BPH [benign prostatic hypertorphy, enlarged prostate], depression, and use of antidepressant and antipsychotic meds." Staff were instructed to; "Toilet upon rising, but before 1030 [10:30 a.m.] 1000 [10:00 a.m.], 1400-1500 [2:00 p.m. to 3:00 p.m.], and 1800-1900 [6:00 p.m. to 7:00 p.m.] and per request with 2 assist."	F 282	**F 282** It is the policy of Elim Care and Rehab Center to provide qualified staff to provide cares to resident's based on their written plan of care. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** **Re: R24:** is in hospital; will be assessed upon return **Re: R46:** revised ROM to a.m. and p.m. cares **Re: R10:** revised to a.m. and p.m. care **Re: R130:** ambulation program revised **Re:R139:**(deceased) Interdisciplinary team reviewed plan of care revisions as required. Effectiveness for restorative program care plan implementation will continue to be monitored for completeness and appropriateness of programs **Actions taken to identify other potential residents having similar occurrences:** All restorative programs will be reviewed by RN Unit Manager and revised as appropriate prior to 9/24/13. Referrals to therapy as needed (i.e. decline in ADL's, improvement, refusal).	

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F 282	Continued From page 28 R7 was observed on 8/12/13, from 5:10 p.m. until 8:35 p.m. in the dining room, and then moved to a day room without being assisted to the toilet or repositioned during this time. At 8:35 p.m. nursing assistant (NA)-I stated R7 was last toileted and repositioned around 4:00 p.m. At 8:48 p.m. NA-I and NA-G asisted R7 to the toilet. His incontinent brief was dry and he did not void in the toilet. R7 buttocks were pink and creased. NA-I stated R7 should have been toileted and repositioned by now, but they did not have time. During interview on 8/15/13 at 8:55 a.m. registered nurse (RN)-D stated R7 should have been toileted between 6:00 p.m. and 7:00 p.m. and repositioned as directed by the care plan. R130 had diagnoses including backache and Alzheimer's disease. The annual Minimum Data Set (MDS) dated 6/19/13 identified R130 had severe cognitive impairment and needed extensive assitance of two persons for walking. R130 was observed on 8/12/13 at 5:05 p.m. being pushed in a wheelchair to the dining room and was assited with eating. On 8/13/13 at 9:00 a.m. R130 was observed sitting in the dayroom in front of the television. On 8/13/13 at 12:15 p.m. R130 was sitting in her wheelchair in the dining room being assisted with eating. On 8/14/13 at 9:00 a.m. R130 was sitting in te dayroom in her wheelchair; at 9:20 a.m. the resident was pushed to an activity in her wheelchair. R130's current plan of care dated 6/27/13 instructed staff to do a nursing restorative program for resident to maintain lower extremity	F 282	**Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff responsible for care plan development, revision and review; and implementation of care plan interventions will be conducted before 9/24/13, with follow-up training as indicated. All Staff meetings were held Sept. 10th and 11th to include instruction and clarification related to proper charting of restorative programming and what/when to report to nurse. Clarification to day and night staff regarding completion of twice a day range of motion programs to be completed with a.m. and p.m. cares. **Effective implementation of actions will be monitored by:** RN Unit Managers, night supervisor and/or nurse designee will complete 1 observation audit per shift for one month to assure restorative programs are being completed as written and revised as appropriate. Audit results will be sent to CQI Committee for review and determination of need for ongoing audits.	

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strength for safe transferring and mobility. R130 was to ambulate twice a day with one staff assist on each side and one staff to follow with wheelchair with the goal of ambulating 100 feet.

Review of R130's Resident Progress Notes dated 6/2/13 indicated, "Resident does participate in walking program but requires assist of three to do the program. Resident is resistive initially but once she is standing and walks a couple feet she walks better. Per staff interview, the program isn't always followed. This is due to difficulties in having three staff members available and also whether the unit is busy."

Review of the Nursing Rehab Time Logs for R130 from May through July 2013, identified dates, minutes ambulated, progress, and how the ambulation was tolerated. May 2013 identified R130 ambulated 4 times out of 62 opportunity's; June 2013 ambulated 7 times out of 60 opportunity's, and in July 2013 ambulated 5 times out of 62 opportunity's.

Although R130's plan of care indicated the resident was suppose to walk twice daily, this was not being completed.

R24 had diagnoses including osteoarthritis and fatigue. The Quarterly MDS dated 7/23/13 indicated the resident had no cognitive impairment and needed extensive assistance with walking.

R24 was observed walking with two staff members to breakfast on 8/15/13 at 8:25 a.m.

The residents current plan of care dated 8/13/13

Those responsible to maintain compliance will be:
RN Unit Managers/Night supervisor will monitor ongoing compliance. Director of Nursing/ADON will oversee continuing compliance.
Completion date for certification purposes only is 09-24-2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

(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 282	Continued From page 30 indicated R24 received restorative nursing program and staff was to ambulate the resident to all meals with her walker and a transfer belt. A Resident Progress Note dated 8/6/13 indicated R24's family (F)-Z called the facility with multiple concerns; one being "that she [R24] is not being walked everyday." The progress note indicated there would be "reminders to staff to follow care plan for resident and document in a timely manner." The restorative nursing ambulation program was initiated on 7/24/13. The documentation in the Point of Care history which reflects the number of times R24 was walked according to the restorative nursing program from 7/24/13 to 8/14/13 was 29 times out of 66 opportunity's. During interview on 8/12/13 at 7:15 p.m. registered nurse (RN)-A stated staff had complained they don't have time to walk R24 because she walks so slow and it takes to much time to walk her to and from every meal. During interview on 8/13/13 at 3:15 p.m. R24 stated her F-Z had spoken with staff about a week ago regarding the resident not being walked to and from meals. R24 stated she doesn't like to "bug" staff about walking but she would like to walk more often then she had been. R24 stated she had not walked in a week, but once her F-Z complained to the facility, the staff had been "trying more often." Although R24's plan of care indicated the resident was suppose to walk twice daily, this was not being completed.	F 282		

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F 282	Continued From page 31	F 282		

R46 had diagnoses including hemiplegia and healing after a traumatic hip fracture. The quarterly Minimum Data Set (MDS) dated 7/19/13 identified the resident had severe cognitive impairment and was an extensive assist with all activities of daily living (ADL's).

On 8/12/13 at 5:00 p.m. R46 was observed wheeling his wheelchair to the dining room using his feet and arms to propel himself.

R46's current plan of care dated 7/23/13 indicated the resident was on a nursing restorative program to maintain range of motion (ROM). Staff was instructed to do passive ROM to left upper extremity's, 10 repetitions (reps) twice a day and active assistive ROM to all right upper extremity's and left upper extremity's 10 reps twice a day.

Review of R46's Point of Care History which records the residents range of motion participation indicated the following:

In June 2013 R46 received active ROM 23 times out of 60 opportunity's and received passive ROM 24 times out of 60 opportunity's.
In July 2013 R46 received active ROM 27 times out of 62 opportunity's and received passive ROM 32 times out of 62 opportunity's.

During interview on 8/14/13 at 7:05 a.m. trained medication assistant (TMA)-B stated staff are not able to do R46's ROM because they don't have enough staff to take the time the resident needs to do the restorative nursing ROM. TMA-B stated R46 is very hard of hearing and it is difficult to communicate with him which makes the ROM

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F 282	Continued From page 32	F 282		

take "too much time."

Although R24's plan of care indicated the resident was suppose to receive ROM twice a day, this was not being completed.

R10 had diagnoses including hemiplegia (paralysis). The annual MDS dated 6/17/13 indicated the resident had no cognitive impairment and required total staff assistance with all ADL's.

R10's current plan of care dated 8/14/13 indicated the resident had significant paralysis of the left upper extremity's and was to receiving nursing restorative care twice daily of 10 reps of passive ROM to all extremities; and it noted to be "gentle with left upper extremities."

R10 was observed laying in his bed on 8/13/13 at 10:40 a.m. on his back. On 8/14/13 at 12:45 p.m. R10 was observed sitting up 90 degrees in bed eating lunch. On 8/15/13 at 8:45 a.m. R10 was observed laying in bed watching television.

A Resident Progress Note dated 7/19/13 indicated "Restorative Nursing goal is that resident will have no decline in ROM and develop no contracture. Resident is able to use his left arm to feed himself and use his telephone and call light. Staff report that resident tolerates program at this time with no decline."

During interview on 8/14/13 at 7:05 a.m. trained medication aide (TMA)-B stated R10 does not have his restorative nursing done because staff does not have time to complete it. TMA-B stated most staff just chart it was done if they do cares

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F 282	Continued From page 33 on him such as getting him dressed. During interview on 8/14/13 at 10:10 a.m. R10 stated staff does not do any "exercises" with him. He stated staff does nothing with his legs, and in the morning he needs to raise his arm to put his shirt on, which is all the movement he does with his arms. Review of the Point of Care History R10 received passive ROM in June 2013 23 times out of 60 opportunities, and July 2013 24 times in out of 62 opportunities. Although R10's plan of care indicated the resident was suppose to receive ROM twice a day, this was not being completed. R139 had diagnoses that included dementia with visual hallucinations. The quarterly MDS dated 6/17/13, indicated R139 had severe cognitive impairment and required extensive assistance with transfers. The resident Care Area Assessment (CAA) dated 12/13/12 identified R139 having muscle and generalized weakness, impaired ambulation and frequent falls. R139's current plan of care dated 2/24/13 included nursing restorative program to attain maximum functional potential by ambulating to one meal daily to maintain lower extremity strength. R139 was observed on 8/12/13 at 7:30 p.m., 8/13/13 at 9:48 a.m., 3:07 p.m.; 8/14/13 at 7:05 a.m., 7:41 a.m. either in his wheelchair or bed. R139 was not ambulated during these times.	F 282		

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F 282	Continued From page 34 The nursing rehab time log from 6/1/13 - 8/13/13 idenified ambulation for R139 as follows: June 2013 R139 ambulated 17 out of 30 opportunities, July 2013 ambulated 14 out of 31 opportunities and from August 1 - 13th, 2013, ambulated 7 of 13 opportunities. There was only 7 days of 74 when R139 was reapproached three times to ambulate. During an interview on 8/12/13 at 8:25 p.m., TMA-E stated there was not enough staff on this unit to ambulate R139 and staffing was recently decreased in the past 2 weeks making more difficult to complete ambulation. Although R139's plan of care indicated the resident was supposed to walk to one meal per day, this was not completed. Review of the Elim Care, Inc Restorative Nursing Documentation policy with revision date of January 2010 indicated under Procedure, step 2: "the restorative nursing therapy program is provided by the nurse/trained assistants under the supervision of the registered nurse"....under step 4a and b: "minutes of therapy are documented for each session except for toileting programs"... "if the resident refuses to participate the staff member will document the minutes spent trying to get participation and will document the refusal. The resident will be reapproached at a later time and the staff member will again document the minutes spent to obtain either participation or refusal"	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 35 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to coordinate hospice services and identify what services were being provided for 1 of 1 resident (R131) who was receiving hospice services. Findings include: R131 had diagnosis of lymphoma. R131's quarterly minimum data set (MDS) dated 7/17/13 indicated she was alert and orientated and had diagnoses of cancer, anemia, anxiety and depression. R131's care plan dated 6/23/13 indicated she was on hospice and received a hospice nurse one to three times a week and a hospice aide visit once a week. There was no indication what services would be provided by the hospice aide, and when each discipline assisted R131. During interview on 8/12/13, at 7:00 p.m. R131 stated, The hospice aides make me nervous, they are "too perky. I don't even know what they are suppose to do with me," they come in and ask me what I want, and I don't know what to tell them because I don't know what they are suppose to do. "I never know when they are coming either, if they tell me, they don't tell me	F 309	**F 309 Quality of Care** It is the policy of Elim care and Rehab Center that each resident receive and facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This includes coordination of care with hospice services. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** **Re: R131**- (deceased) **Actions taken to identify other potential residents having similar occurrences:** Strategies for assuring coordination of care with hospice services have been reviewed with DON and Director of Fairview homecare and hospice. Coordination of care with other hospice providers will follow the same notification protocol. All hospice resident calendars and care plans will be reviewed for completeness.	

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F 309	Continued From page 36 loud enough so I can hear them." During interview on 8/13/13 at 1:30 p.m. registered nurse (RN)-A stated the facility does not always know when hospice is coming. RN-A stated she just had a nursing assistant ask her to call the hospice agency to find out when they are coming so R131 does not receive duplicate cares. During interview on 8/14/13 at 9:Pam., with RN-C stated hospice was supposed to call the day before to let us know they are coming then we place it in the calendar at the desk so staff are aware when they are coming. RN-C further stated usually they have a calendar in the medical record stating when they are coming and verified the last date listed was 7/16/13 and was unsure why the calendar was not filled out since 7/16/13. During interview on 8/14/13 at 11:30 a.m., RN-B stated hospice should have a calendar letting us know when they are coming and further stated the calendar has no dates past 7/16/13 and does not know when they are going to see R131. During interview on 8/14/13 at 11:42 a.m., with nursing assistant (NA)-J stated hospice was suppose to call us ahead of time and the nurses write it in the calendar. NA-J then stated there has been no recent documentation in the calendar as to when they are coming. The facilities hospice service agreement dated 12/07/08 indicated, "Combined plan of care" means a written care plan established, maintained , reviewed , and modified, in collaboration between Hospice and the Nursing	F 309	**Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff on facility protocol for coordinating care with hospice were conducted September 10 & 11, 2013. Hospice will provide additional follow-up training as indicated. End of Life – Hospice Policy implemented and staff trained on policy. Revised policy sent to both Fairview and Guardian Angels hospice. **Effective implementation of actions will be monitored by:** RN unit managers will monitor all residents receiving hospice services for coordination of care. Coordination of care will be monitored via audit for completeness with new enrollments x's 3 months and results reviewed by CQI Committee for determination of need for continued audits. **Those responsible to maintain compliance will be:** RN Unit Managers will monitor ongoing compliance. Director of Nursing will oversee continuing compliance **Completion date for certification purposes only is 09-24-2013**	

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F 309	Continued From page 37 Facility that includes (a) an assessment of each patient's needs, (b) an identification of the Hospice Services, including management of discomfort and symptom relief needed to meet such patient's needs and related needs of the Hospice Patient's family, and (c) details concerning the scope and frequency of such Hospice Services.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative nursing services for ambulation were consistently provided for 3 of 5 residents (R130, R24, and R139) who had a walking program. Findings include: R130 had diagnoses including backache and Alzheimer's disease. The annual Minimum Data Set (MDS) dated 6/19/13 identified R130 had severe cognitive impairment and was an extensive two person assist with walking. R130's current plan of care dated 6/27/13 directed staff to complete a nursing restorative program to maintain lower extremity strength for safe transferring and mobility. R130 was to ambulate twice a day with one staff assist on each side and one staff to follow with wheelchair,	F 311	**F 311** It is the policy of Elim Care and Rehab Center that each resident is given the appropriate treatment and services to maintain or improve his or her abilities to ambulate. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** **Re: R139:** deceased **Re: R24:** ambulation program was revised **Re: R130:** ROM was revised to with a.m. and p.m. cares RN Unit Managers and IDT team reviewed ambulation programs for cited residents and program revisions put in place as appropriate. Effectiveness of ambulation programs will be monitored for effectiveness quarterly and prn.	

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F 311	Continued From page 38 with a goal of walking 100 feet. R130 was observed on 8/12/13 at 5:05 p.m. being pushed in a wheelchair to the dining room and was assisted with eating. On 8/13/13 at 9:00 a.m. R130 was observed sitting in the dayroom in front of the television. On 8/13/13 at 12:15 p.m. R130 was sitting in her wheelchair in the dining room being assisted with eating. On 8/14/13 at 9:00 a.m. R130 was sitting in the dayroom in her wheelchair; at 9:20 a.m. the resident was pushed to an activity in her wheelchair. Review of R130's Resident Progress Notes dated 6/2/13 indicated, "Resident does participate in walking program but requires assist of three to do the program. Resident is resistive initially but once she is standing and walks a couple feet she walks better. Per staff interview, the program isn't always followed. This is due to difficulties in having three staff members available and also whether the unit is busy." Review of the Nursing Rehab Time Logs for R130 from May through July 2013, identified dates, minutes ambulated, progress, and how the ambulation was tolerated. May 2013 identified R130 ambulated 4 times out of 62 opportunity's; June 2013 ambulated 7 times out of 60 opportunity's, and in July 2013 ambulated 5 times out of 62 opportunity's. During interview on 8/15/13 at 9:09 a.m. nursing assistant (NA)-J stated R130 needs assist of three staff to ambulate and because they don't have enough staff they are unable to ambulate her and this happens on a daily basis.	F 311	**Actions taken to identify other potential residents having similar occurrences:** All ambulation programs will be reviewed by RN Unit Manager and revised as appropriate prior to 9/24/13. Referrals to therapy as needed (i.e. decline in ADL's, improvement, refusal). **Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff responsible for program development, revision and review; and implementation of programming will be conducted on or before 9/24/13, with follow-up training as indicated. All Staff meetings were held Sept. 10th and 11th to include instruction and clarification related to proper charting of all restorative programming and what/when to report to nurse. **Effective implementation of actions will be monitored by:** RN Unit Managers, night supervisor and/or nurse designee will complete 1 observation audits per F282 to assure restorative programs are being completed as written and revised as appropriate. Audit results will be sent to	

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F 311	Continued From page 39 During interview on 8/15/13 at 10:10 a.m. Physical Therapist (PT)-B stated the physical therapy had not seen R130 in the past and nursing was responsible for ensuring restorative nursing is appropriate and being completed. R24 had diagnoses including osteoarthritis and fatigue. The Quarterly MDS dated 7/23/13 indicated the resident had no cognitive impairment and needed extensive assistance with walking. The residents current plan of care dated 8/13/13 indicated the resident was receiving a restorative nursing program and staff was to ambulate the resident to all meals with her walker and a transfer belt. R24 was observed walking with two staff members to breakfast on 8/15/13 at 8:25 a.m. A Resident Progress Note dated 8/6/13 indicated R24's daughter called the facility with multiple concerns; one being "that she [R24] is not being walked everyday." The progress note indicated there would be "reminders to staff to follow care plan for resident and document in a timely manner." The restorative nursing ambulation program was initiated on 7/24/13. The documentation in the Point of Care history which reflects the number of times R24 was walked according to the restorative nursing program from 7/24/13 to 8/14/13 identified R24 walked 29 times out of 66 opportunity's. During interview on 8/12/13 at 7:15 p.m.	F 311	CQI Committee for review and determination of need for ongoing audits. **Those responsible to maintain compliance will be:** RN Unit Managers/Night supervisor will monitor ongoing compliance. Director of Nursing/ADON will oversee continuing compliance. **Completion date for certification purposes only is 09-24-2013**	

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F 311	Continued From page 40	F 311		

registered nurse (RN)-A stated staff had complained they don't have time to walk R24 because she walks so slow and it takes to much time to walk her to and from every meal.

During interview on 8/13/13 at 3:15 p.m. R24 stated her family (F)-Z had spoken with staff about a week ago regarding the resident not being walked to and from meals. R24 stated she doesn't like to "bug" staff about walking but she would like to walk more often then she had been. R24 stated she had not walked in a week, but once F-Z complained to the facility, the staff had been "trying more often."

During interview on 8/15/13 at 10:10 a.m. PT-B stated staff should be walking R24 to continue to get her strength up as the resident was hoping to go home again.

During interview on 8/14/13 at 10:20 a.m. Registered Nurse (RN)-C stated if the restorative nursing/ walking program is not being completed, the nursing assistants (NA) should be charting why it was not done, and should also be notifying the nurse. RN-C verified the days restorative was not completed as ordered on R139, R130, and R24 there was no charting as to why it was not done, nor was the restorative program being monitored by nursing to ensure it was being done as ordered.

R139 diagnoses included dementia with visual hallucinations. The quarterly MDS dated 6/17/13 indicated R139 had severe cognitive impairment and required extensive assistance with transfers. The resident falls Care Area Assessment (CAA) dated 12/13/12 identified R139 having muscle

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F 311	Continued From page 41 and generalized weakness, impaired ambulation and frequent falls. R139's current plan of care dated 2/24/13 included nursing restorative program to attain maximum functional potential by ambulating to one meal daily to maintain lower extremity strength. R139 was observed on 8/12/13 at 7:30 p.m., 8/13/13 at 9:48 a.m., 3:07 p.m.; 8/14/13 at 7:05 a.m., 7:41 a.m. either in his wheelchair or bed. R139 was no ambulated during these times. The nursing rehab time log from 6/1/13 - 8/13/13 identified ambulation for R139 as follows: June 2013 R139 ambulated 17 out of 30 opportunities, July 2013 ambulated 14 out of 31 opportunities and from August 1 - 13th, 2013, ambulated 7 of 13 opportunities. There was only 7 days of 74 when R139 was reproached three times to ambulate. The restorative progress note dated 6/18-13 identified, "Restorative program in place to ambulate with staff due to impaired mobility. He is able to ambulate 75 feet at a time with one assist..." The 8/10/13 restorative note identified "...restorative program in place to ambulate to one meal with staff assist daily to maintain lower extremity strength...resident participates about half of the time...Staff report resident has become weaker in the legs since the last review. Staff will continue to encourage participation." During an interview on 8/12/13 at 8:25 p.m., TMA-E stated there was not enough staff on this unit to ambulate R139 and staffing was recently	F 311		

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F 311	Continued From page 42 decreased in the past two weeks making more difficult to complete ambulation. During an interview on 8/15/13 at 2:12 p.m., registered nurse (RN)-D stated R139 was walking with assist of one as part of the restorative nursing program. RN-D stated the team lead would make a restorative note every 60 days on his progress and was not aware R139 was becoming "weaker in the legs since last review" on 6/16/13. Review of the Elim Care, Inc Restorative Nursing Documentation policy with revision date of January 2010 indicated under Procedure, step 2: "the restorative nursing therapy program is provided by the nurse/trained assistants under the supervision of the registered nurse"....under step 4a and b: "minutes of therapy are documented for each session except for toileting programs"... "if the resident refuses to participate the staff member will document the minutes spent trying to get participation and will document the refusal. The resident will be reproached at a later time and the staff member will again document the minutes spent to obtain either participation or refusal"	F 311		
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	F 314		

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F 314	Continued From page 43 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 comprehensively assess repositioning needs, or provide assistance with repositioning for an extended period of time for 1 of 3 residents (R7) at risk for pressure ulcers. Findings include: R7's diagnoses included congestive heart failure and dementia. R7's quarterly Minimum Data Set (MDS) dated 5/25/13, indicated R7 had severe cognitive impairment, required extensive assistance with bed mobility, and transfers. R7 was at risk for pressure ulcers and was on a turning and repositioning program. R7's Pressure Ulcers Care Area Assessment (CAA) dated 2/15/13, included risk factors for pressure ulcer development: needs special mattress or set cushion to reduce or relieve pressure; requires regular schedule of turning; immobility; cognitive loss; incontinence; and poor nutrition. A summary included; "Risks for impaired skin include impaired mobility and cognition, occasional incontinence, edema with Ted socks in place, depression, independent with w/c [wheel chair] mobility..." The CAA did not include an assessment of R7's repositioning needs while in the wheel chair. R7 was observed on 8/12/13, from 5:10 p.m. until 8:35 p.m., 3 hours 25 minutes without being repositioned. R7 was seated in a Broda (geri-type	F 314	F 314 It is the policy of Elim Care and Rehab Center that the facility ensures any resident who enters the facility without pressure sores does not develop sores unless the individual's clinical condition demonstrates that they were unavoidable. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** **Re. Resident R7:** Residents R7 has been comprehensively assessed for skin integrity impairment via individualized skin assessment. Care plan was revised and Interdisciplinary team reviewed the plan of care. Bowel and Bladder program reviewed and no revisions deemed necessary or beneficial. Effectiveness of pressure ulcer prevention strategies will continue to be monitored. **Actions taken to identify other potential residents having similar occurrences:** RN Unit Managers will assess residents' Skin upon admission, quarterly and prn. Those needing updated care plans based on data collected will be re-assessed to assure required residents are correctly assessed.	

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F 314	Continued From page 44 reclining chair), he was in the dining room at 5:10 p.m. then was brought to the day room and remained seated in the same position until surveyor asked staff at 8:35 p.m. about his positioning needs. Nursing assistant (NA)-I looked in a book at the nurses station and stated R7 had been repositioned last at 4:00 p.m. by the previous shift, which was 4 hours and 35 minutes ago. R7 was assisted to the toilet at 8:48 p.m. with a standing lift by NA-I and NA-G. R7's buttocks was free of redness. NA-I stated R7 should be repositioned while he is in his chair every 2 hours and they should have assisted him sooner. R7's care plan dated 7/25/13, included; "Skin: Potential for altered skin integrity related to: occasional incontinence, impaired mobility...Pressure/friction areas to bilateral inner knees noted 5/29/13-closed-7/1/12. Open blister near right hip noted 6/1/12- closed- 7/8/13..." The approaches staff were instructed to use included; "Has history of stage two pressure sore to the left ischium. Reposition resident off of left side when in bed q [every] 2 hours." The care plan failed to include how often R7 required assistance to reposition when in wheel chair. R7's nurse aide worksheets entitled PB Group 2; included; "Side to side reposition every two hours when in bed." The worksheet did not instruct staff on when to reposition R7 when he was in the wheel chair. R7's Resident Progress Notes dated 8/15/13 included; "[R7's name] spends much time sleeping or sitting in the living room area of his household. He has days when he is more alert, but he is dependent on others to meet care needs	F 314	**Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff responsible for skin assessment will be conducted on facility procedure for proper assessment protocols before 09-24-2013, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** ADON or nurse designee will conduct monthly audits of 6 residents for complete and accurate assessment x's 3 months. Care plans are reviewed at least quarterly and with significant change in status. Audit results will be sent to CQI Committee for review and determination of need for ongoing audits. **Those responsible to maintain compliance will be:** RN Unit Managers will monitor ongoing compliance. Director of Nursing will oversee continuing compliance **Completion date for certification purposes only is 09-24-2013**	

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F 314	Continued From page 45 all of the time." A Resident Progress Notes dated 7/29/13 included; "Blister to mid back scabbed over..." During interview on 8/15/13, at 8:55 a.m. registered nurse (RN)-D was unable to find an assessment or care planning on what R7's needs were for repositioning while in the wheel chair. RN-D stated R7 can not reposition himself in the wheel chair, was at risk for pressure ulcer development and should be repositioned at least every 2 hours. A facility policy was requested, but not received from the facility.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting for 1 of 3 residents (R7) reviewed for urinary incontinence. Findings include:	F 315	F 315 It is the policy of Elim Care and Rehab Center that the facility ensures any resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** **Re. Resident R7:** Resident R7 has been comprehensively assessed for bowel and bladder function. Care plan did not require revisions per Interdisciplinary team review. Effectiveness of bowel and bladder programs will continue to be monitored.	

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F 315	Continued From page 46 R7's diagnoses included congestive heart failure and dementia. R7's quarterly Minimum Data Set (MDS) dated 5/25/13, indicated R7 had severe cognitive impairment, required extensive assistance to toilet, was on a toileting program, and was frequently incontinent of urine. The Urinary Incontinence Care Area Assessment (CAA) dated 2/15/13, included a check list of risk factors including; delirium; pain; restricted mobility; urinary urgency and need for assistance in toileting. Under "Document reason care plan will/will not be developed," was listed only, "on going problem area." A toileting schedule was set up as per the care plan. R7's care plan dated 5/15/13, included; "Bowel and Bladder: Alteration in elimination R/T [related to] resisting cares, impaired cognition, and mobility, visual impairments, pain BPH [benign prostatic hypertorphy, enlarged prostate], depression, and use of antidepressant and antipsychotic meds." Staff were instructed to; "Toilet upon rising, but before 1030 [10:30 a.m.] 1000 [10:00 a.m.], 1400-1500 [2:00 p.m. to 3:00 p.m.], and 1800-1900 [6:00 p.m. to 7:00 p.m.] and per request with 2 assist." R7 was observed on 8/12/13, from 5:10 p.m. until 8:35 p.m., 3 hours and 25 minutes without being toileted. At 5:07 p.m. R7 was in the dining room, and then moved to a day room and was not assied to toilet. At 8:35 p.m. nursing assistant (NA)-I stated R7 was last toileted around 4:00 p.m. by the previous shift. At 8:48 p.m. NA-I and NA-G asisted R7 to the toilet. His incontinent brief was dry and he did not void in the toilet. NA-I stated R7 should have been toileted by now, but they did not have time.	F 315	**Actions taken to identify other potential residents having similar occurrences:** Residents Bladder status will be reviewed quarterly and prn with change in status. **Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff responsible for skin assessment will be conducted on facility procedure for proper assessment protocols before 09-24-2013, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** RN Unit Manager/Team Lead/Night supervisor or nurse designee will place repositioning/toileting stickers on two random residents per household per shift for one month. Audit results will be sent to CQI Committee for review and determination of need for ongoing audits. **compliance will be:** RN Unit Managers/Night Supervisors will monitor ongoing compliance. Director of Nursing will oversee continuing compliance **Completion date for certification purposes only is 09-24-2013**	

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F 315	Continued From page 47 During interview on 8/15/13, at 8:55 a.m. registered nurse (RN)-D stated R7 should have been toileted between 6:00 p.m. and 7:00 p.m. as directed by the care plan.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative nursing services for range of motion was consistently provided for 2 of 3 residents (R46, and R10) reviewed who had a range of motion program. Findings include: R46 had diagnoses including hemiplegia and healing after a traumatic hip fracture. The quarterly Minimum Data Set (MDS) dated 7/19/13 identified the resident had severe cognitive impairment and was an extensive assist with all activities of daily living (ADL's). On 8/12/13 at 5:00 p.m. R46 was observed wheeling his wheelchair to the dining room using his feet and arms to propel himself.	F 318	F 318 It is the policy of Elim Care and Rehab Center to ensure that a resident with a limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** **Re: R46: deceased** **Re: R10: program reviewed and revised** RN Unit Managers reviewed range of motion program for cited resident and program revisions put in place as appropriate. Effectiveness for range of motion programs will continue to be monitored for completeness and appropriateness of program.	

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F 318	Continued From page 48 R46's current plan of care dated 7/23/13 indicated the resident was on a nursing restorative program to maintain range of motion (ROM). Staff was instructed to do passive ROM to left upper extremity's, 10 repetitions (reps) twice a day and active assistive ROM to all right upper extremity's and left upper extremity's 10 reps twice a day. A Resident Progress Note dated 8/4/13 identified R46, was compliant with his restorative program. Review of R46's Point of Care History which records the residents range of motion participation indicated the following: In June 2013 R46 received active ROM 23 times out of 60 opportunity's and received passive ROM 24 times out of 60 opportunity's. In July 2013 R46 received active ROM 27 times out of 62 opportunity's and received passive ROM 32 times out of 62 opportunity's. During interview on 8/14/13 at 7:05 a.m. trained medication assistant (TMA)-B stated staff were not able to complete R46's ROM because they don't have enough staff to take the time the resident needs to do the restorative nursing ROM. TMA-B stated R46 is very hard of hearing and it was difficult to communicate with him which makes the ROM take "too much time." R10 had diagnoses including hemiplegia (paralysis). The annual MDS dated 6/17/13 indicated the resident had no cognitive impairment and required total staff assistance with all ADL's.	F 318	**Actions taken to identify other potential residents having similar occurrences:** All restorative programs will be reviewed by RN Unit Managers and revised as appropriate prior to 9/24/13. Referrals to therapy as needed (i.e. decline in ADL's, improvement, refusal). Care plans and group sheets will be updated as needed. **Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff responsible for program development, revision, review and implementation of programming will be conducted on before 9/24/13, with follow-up training as indicated. Staff meetings were held Sept. 10th and 11th to include instruction and clarification related to proper charting of all restorative programming and what/when to report to nurse. **Effective implementation of actions will be monitored by:** RN Unit Managers, night supervisor and/or nurse designee will complete 1 observation audits per shift for one	

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F 318	Continued From page 49	F 318		

R10's current plan of care updated 8/14/13 indicated the resident had significant paralysis of the left upper extremity's and was to receive nursing restorative care twice daily of 10 reps of passive ROM to all extremities; and it noted to be "gentle with left upper extremities."

R10 was observed laying in his bed on 8/13/13 at 10:40 a.m. on his back. On 8/14/13 at 12:45 p.m. R10 was sitting up 90 degrees in bed eating lunch. On 8/15/13 at 8:45 a.m. R10 was observed laying in bed watching television.

A Resident Progress Note dated 7/19/13 indicated "Restorative Nursing goal is that resident will have no decline in ROM and develop no contracture. Resident is able to use his left arm to feed himself and use his telephone and call light. Staff report that resident tolerates program at this time with no decline."

During interview on 8/14/13 at 7:05 a.m. trained medication aide (TMA)-B stated R10 does not have his restorative nursing done because staff does not have time to complete it. TMA-B stated most staff just chart it was done if they do cares on him such as getting him dressed.

During interview on 8/14/13 at 10:10 a.m. R10 stated staff does not do any "exercises" with him. He stated staff does nothing with his legs, and in the morning he needs to raise his arm to put his shirt on, which is all the movement he does with his arms.

During interview on 8/14/13 at 10:15 a.m. family (F)-C stated she was not aware of any stretching or exercise program they had been doing or are

month to assure restorative programs are being completed as written and revised as appropriate. Audit results will be sent to CQI Committee for review and determination of need for ongoing audits.

Those responsible to maintain compliance will be:
RN Unit Managers/Night supervisor will monitor ongoing compliance. Director of Nursing/ADON will oversee continuing compliance.
Completion date for certification purposes only is 09-24-2013

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F 318	Continued From page 50 doing with R10. Review of the Point of Care History for June and July 2013 indicated that R10 received passive ROM 23 times in June 2013 out of 60 opportunities, and 24 times in July 2013 out of 62 opportunities. During interview on 8/14/13 at 10:20 a.m. Registered Nurse (RN)-C stated if the restorative nursing was not being completed, the nursing assistants (NA) should be charting why it was not completed, and should also be notifying the nurse. RN-C verified the days restorative was not completed as ordered on R46 and R10 there was no charting as to why it was not done, nor was the restorative program being monitored by nursing to ensure it was being completed as ordered.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R7) observed for transfers, was transferred safely; and did not comprehensively evaluate 2 of 3 residents (R139 and R23) with falls to	F 323	F 323 It is the policy of Elim Care and Rehab Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** R7: care plans reviewed and revised regarding transferring of resident. R23: Interdisciplinary team reviewed resident history of falls and adjusted interventions as needed. R139: deceased	

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F 323	Continued From page 51 determine causal factors, and fall prevention interventions. Findings include: R7's diagnosis included dementia. The quarterly Minimum Data Set (MDS) dated 5/25/13, included severe cognitive impairment and required extensive assistance with transfers. R7's care plan dated 8/1/12, included, "Two assist for all transfers with stand up lift." R7 was observed at supper time on 8/12/13 at 5:00 p.m. R7 was assisted with eating, but staff had to keep trying to wake him to take in any food/fluids. R7 was then brought to the day room at 5:10 p.m. where he slept in his wheel chair unil 8:35 p.m. Trained medication aide (TMA)-D stated R7 has been "extra sleepy today", unable to wake him up, "he has days like that." R7 was observed being transferred from his wheel chair to the bathroom at 8:48 p.m. R7 did not open eyes at all during the transfer, appeared very sleepy. Nursing assistant (NA)-G and NA-I placed R7's feet onto the tray of a standing mechanical lift and had to pull him forward to place the lifts sling behind his back. NA-G placeed R7's hands on the "steering wheel," (which was the handles on the mechanical lift to hold onto while being transfered) and kept telling R7 to "hang on," while NA-G physically kept replacing R7's hands on handles several times as they would fall off. The lift sling was hooked up, and NA-I raised the lift to where R7 would have to stand, and kept telling R7 to stand. R7's knees remained buckled throughout transfer, not bearing any weight. R7's arms went up in the air as he was hanging by the sling under his arms.	F 323	**Actions taken to identify other potential residents having similar occurrences:** **Regarding safe use of Stand-up Lift:** Written protocol for use of Stand-up lift attached to all stand-up lifts for staff's quick reference. **Regarding fall assessments:** Continue to meet daily to review falls within last 24 hours. Night shift to begin conducting falls huddle during shift that a fall occurs. New form designed for use by night shift to better relay information to day shift and to help establish root cause of fall and appropriate intervention. **Measures put in place to ensure deficient practice does not occur:** Policy and Procedures related to Use of Mechanical Lift and Fall follow-up were reviewed. Care giver staff re-educated on safety policy regarding proper use of the stand-up lift and protocol following a resident fall. **Effective implementation of actions will be monitored by:** ADON/RN unit manager/Night Supervisor or nurse designee will observe staff transferring residents with stand-up lift daily x's 2 weeks on each shift then weekly x's 1	

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F 323	Continued From page 52 R7 made no attempt to stand or bear any weight on his legs, during the transfer. NA-I and NA-G stated this was typically how R7 transfers the last couple of months. NA-G stated they, "we are just following the care plan" with the use of the mechanical standing lift. Neither NA-G or NA-I had reported to a nurse that R7 was no longer bearing weight while using the standing lift, or questioned if the standing lift remained appropriate for R7. R7 was again observed for a transfer on 8/13/13, at 10:10 a.m. Staff used a full body (four point) lift at this time. Registered nurse (RN)-A stated they switched R7 to the four point lift after it was reported last evening R7 was no longer able to stand in the stand lift. When interviewed on 8/15/13, at 8:35 a.m. registered nurse (RN)-D stated, the nurse aides should not have use the standing lift if R7 was lethargic, and R7's inability to stand should have been reported so that R7's ability could have been assessed. When interviewed on 8/15/13, at 10:00 a.m. RN-E, who was charge of staff training, stated she specifically trains nurse aides in each lift type and demonstrates, "hanging by the arm pits," to show staff when the standing lift is no longer appropriate for a resident. Staff are trained, that if a resident is lethargic or unable to stand, to use the "four point lift," a full body lift instead. Staff should have used a full body lift for R7 and reported it to a nurse. A MedCare lift Operation Manual was supplied by maintenance engineer (ME)-F stated the particular lift used for R7 was lift number 4. The	F 323	month. Re-education will take place as needed during observed transfers. Protocol for use of stand-up lift was reviewed at staff meetings September 10th & 11th. ADON/Falls Coordinator or designee will audit completeness of post fall assessment and implementation of interventions for 1 month. Results of audits for falls and transfers will be sent to CQI Committee for review and determination of need for ongoing audits. **Those responsible to maintain compliance: DON/ADON** **Completion date for certification purposes only is 09-24-2013**	

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Operation Manual included on page 3; "The Medcare Stand was designed specifically for assisting your patients to a standing position. Once in a standing position, you or your staff can safely perform a number of patient care tasks...Because the Stand is an assistive device, it should only be used with patients that can bear the requisite amount of weight as determined by your facility. It also requires that patients possess more advanced motor skills than for the Medcare Lift."

An Elim Care and Rehab Center policy entitled Standing Assist Lift, dated April 2005, included under number "15. Monitor resident throughout the procedure. Nursing Assistant needs to use good judgement if resident or staff safety issue is apparent." Number 16. Always follow manufactuer reommendations for handling/use."

R139 quarterly Minimum Data Set (MDS) dated 6/17/13, indicated R139 had severe cognitive impairment and required extensive assistance with transfers. The resident Falls Care Area Assessment (CAA) dated 12/13/2012 identified R139 having muscle and generalized weakness, impaired ambulation and frequent falls.

R139 was observed on 8/12/13 at 7:30 p.m., 8/13/13 at 9:48 a.m., 3:07 p.m.; 8/14/13 at 7:05 a.m., 7:41 a.m. either in his wheelchair or bed.

Review of the incident reports revealed the following information:

-On 8/10/13, at 10:55 p.m. R139 was found on the floor in his room after rolling/sliding out of bed. Factors noted at time of fall included

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resident losing strength/appeared to get weak and was unable to stand prior to the fall. Increased weakness was noted to be a new onset. Root cause of fall appeared to be that R139 was started on ditropan on 7/18/13 and now shows weakness when trying to stand and legs give out and appeared fatigued.

-On 8/10/13, at 8:00 a.m. R139 was found on the floor in his room after reaching for something. Factors noted at time of fall included resident losing strength/appeared to get weak after reaching for something out of reach. R139 was alone and unattended at the time of the fall. Root cause of the fall was thought to be toileting status and weakness.

-On 6/26/13, at 2:00 a.m. R139 was found on the floor in his room facing the wall after rolling/sliding out of bed. Factors noted at time of fall included persistent calling out for staff. R139 was alone and unattended at the time of the fall. Root cause of fall appeared to be that R139 was confused as to time of day.

-On 5/18/13, at 10:00 a.m. R139 was found on the floor in his room after attempting to self transfer reaching for something. Factors noted at time of fall included a mat on the floor and resident was unable to stand from low bed and appeared to have lost strength/get weak. R139 was alone and unattended at the time of the fall. Root cause of fall was thought to be that resident needed to use the toilet and had urinary urgency.

-On 5/16/13, at 8:15 a.m. R139 was found on the floor in his room. Factors noted at time of fall included resident losing his balance, possibly

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slipping on a wet floor from urine spot on mat and carpet and losing strength/appeared to get weak. Root cause was thought to be the need to toilet.

R139's care plan dated 2/24/13 included nursing restorative program to attain maximum functional potential by ambulating to one meal daily to maintain lower extremity strength.

Review of physical therapy progress notes indicated R139 was seen from 12/6/12 - 12/18/12 to improve strength and balance, with a goal to be independent with mobility on the nursing unit. R139 was discharged from therapy on 12/19/12 due to admission to the hospital. A progress note dated 1/14/13 indicated R139 had returned on 1/11/13 and was seen for initial physical therapy (PT) assessment which identify R139 was able to transfer easily with assist of one and able to ambulate with rolling walker and gait belt for 150 feet. R139 declined participation in rehab at this time but stated he would walk with nursing staff, so there was no physical therapy offered.

Review of the nursing rehab time log from 6/1/13 - 8/13/13 identified ambulation for R139 as follows: June 2013 R139 ambulated 17 out of 30 opportunities, July 2013 ambulated 14 out of 31 opportunities and from August 1 - 13th, 2013, ambulated 7 of 13 opportunities. There was only 7 days of 74 when R139 was reproached by staff three times to encourage ambulation.

The restorative progress note dated 6/18-13 identified, "Restorative program in place to ambulate with staff due to impaired mobility. He is able to ambulate 75 feet at a time with one assist..." The 8/10/13 restorative note identified

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F 323	Continued From page 56 "...restorative program in place to ambulate to one meal with staff assist daily to maintain lower extremity strength...resident participates about half of the time...Staff report resident has become weaker in the legs since the last review. Staff will continue to encourage participation." During an interview on 8/15/13 at 2:12 p.m., registered nurse (RN)-D stated R139 was walking with assist of one and in the restorative nursing program. RN-D stated the team lead would make a note every 60 days on his progress and verified that there was a weakness in leg strength from 6/18/13 to 8/10/13. RN-D stated she was not aware R139 had a change with leg weakness from June to August 2013. During an interview on 8/15/13 at 4:09 p.m., RN-E stated every Thursday falls are analyzed to determine a root cause. RN-E stated she was unaware that R139 had a change with leg weakness from June to August 2013, and had not assessed this as a potential concern related to R139's falls. Review of the Elim Care, Inc restorative nursing documentation with revision date of January 2010 indicates the restorative nursing therapy program be provided by the nurse/trained assistants under the supervision of the registered nurse and that minutes of therapy are documented, if the resident refuses to participate the staff member will document the minutes spent trying to get participation and the resident will be reproached at a later time. R23 had diagnoses that included dementia with behavioral disturbances, osteoarthrosis and	F 323		

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F 323	Continued From page 57 history of falls. The quarterly MDS dated 6/17/13, indicated R139 had severe cognitive impairment and required one person assist for transfers and ambulation. R23's care plan dated 12/24/12 included "ensure proper footwear is worn for transfers and ambulation". R23 was observed on 8/13/13 at 9:21 a.m. ambulating with a rolling walker and one nursing assistant. R23 had a shuffling gait and was wearing gripper socks on the carpeted floor. On 8/14/13 at 12:09 p.m. R23 was observed sitting at the dining room table in his wheelchair wearing gripper socks. Review of the facility progress notes from 6/9/13 - 8/12/13 identified five falls. Review of the Fall Scene Investigation Report revealed the following information: -On 8/12/13 at 4:00 a.m. R23 fell during ambulation attempting a self transfer in his room and was wearing gripper socks and using his walker. Factors noted at time of fall included resident lost his balance and lighting was an issue. Root cause was thought to be pain and trying to get up and walk in room when it was dark. -On 6/23/13 at 9:15 p.m. R23 fell during ambulation and was found in an unoccupied room wearing gripper socks. Factors noted at time of fall included resident lost his balance, lost strength/appeared to get weak and assist device was not used. Root cause was thought to be an unfamiliar environment, weakness and walker was not used.	F 323		

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-On 6/17/13 at 8:00 p.m. R23 fell during staff assisted transfer after losing his balance. R23 was wearing gripper socks and was using his walker. Root cause was identified as loss in balance and weakness.

-On 6/17/13 at 12:50 p.m. R23 fell during ambulation in his room, was wearing gripper socks and was using his walker. Factors observed at time of fall included resident slipping and losing his balance and lost strength/appeared to get weak. Root cause was thought to be caused by the bed height being a couple inches too high.

-On 6/9/13 at 2:00 p.m. R23 fell during ambulation in his room. R23 was wearing gripper socks and was using his walker. Factors observed at time of fall included resident losing his balance and lost strength/appeared to get weak. Root cause was thought to be caused by resident stating he was too hot and getting out of bed on his own.

Although R23 wore gripper socks on carpet for the past five falls, there was no indicaiton that the facility looked at this as a possible cause for his falls.

During an interview on 8/15/13 at 2:35 p.m., RN-D stated they decided to use gripper socks on R23 because he takes his shoes off all of the time, further stating he should have shoes on, but the aides do not always put them on. RN-D stated R23 often self transfers and most of his falls are without his walker.

During an interview on 8/15/13 at 4:09 p.m.,

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F 323	Continued From page 59 RN-E stated analyzes the falls with the interdisiciplinary team to determine a possible cause, and did not look at the gripper socks use on carpeting as a potential cause, stating "we missed it".	F 323		
F 353 SS=E	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 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 observation, interview and document review, the facility failed to provide adequate staffing to ensure residents received assistance with activities of daily living for 15 of 106 residents (R47, R3, R66, R98, R62, R5, R34, R12, R105,	F 353	F 353 It is the policy of Elim Care and Rehab Center provide sufficient staffing to provide 24-hour nursing care to all residents in accordance with the resident with care plan. Facilities plan for continued compliance with plan include: **Re: cited residents** R47, R3, R66, R98, R62, R5, R34, R12, R105, R10, R7, R24, R139, R130,R46 – care plans and acuity have been reviewed by nursing and interdisciplinary team to assure plans of care are appropriate – revisions reviewed by IDT team.	

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F 353	Continued From page 60 R10, R7, R24, R139, R130, R46) who resided in the facility. In addition, 1 of 4 family members (F) -C interviewed had concerns that cares were not being completed due to lack of staffing. Additionally,14 staff members interviewed stated resident cares were not being consistently completed due to not having enough staff. Residents were dressed and placed back in bed by the night shift due to lack of staffing. R47 had diagnosis of dementia. R47's quarterly MDS dated 5/25/13 indicated she was severely impaired in decision making and needed extensive assistance in ADL's. R3 had diagnosis of Alzheimer disease. R3's quarterly MDS dated 7/4/13 indicated he was severely cognitively impaired in decision making and was totally dependant in his ADL's. R66 had diagnosis of Dementia. R66's quarterly MDS dated 5/28/13 indicated she was moderately impaired in decision making and needed extensive assistance in ADL's. R98 had diagnosis of Dementia. R 98's quarterly MDS dated 7/15 /13 indicated he was severely cognitively impaired in decision making and needed extensive assistance in ADL's. R62 had diagnosis of Dementia. R62's quarterly MDS dated 6/6/13 indicated she had moderately impaired decision making and needed extensive assistance in ADL'S. During interview 8/15/13 at 9:09 a.m., NA-J stated the night shift gets R47, R3 & R62 up around 4:00 a.m., toilets them and	F 353	**Actions taken to identify other potential residents having similar occurrences:** Root-cause analysis will be completed and action plans developed based on data from above and call light response data. A situational work-flow analysis of staffing pattern needs will be conducted to determine if adjustments to staffing are required. An additional 70 hours per pay period of night shift RN supervisor has been implemented since end of survey, orientation which began last night of survey. **Measures put in place to ensure deficient practice does not occur:** Call light response times will be audited and reviewed with focus on response greater than 10 minutes – daily x's 2 weeks (Mon – Friday) than weekly alternating days of week so alternating teams are audited x's 3 months and then periodically. Data will be sent to CQI Committee for review and determination of need for ongoing audits. **Those responsible to maintain compliance will be:** Director of Nursing/ADON and Administrator will oversee continuing compliance **Completion date for certification purposes only is 09-24-2013**	

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dresses them and places them back in bed to help them out because we are so busy in the morning.

During interview 8/15/13 at 11:46 a.m., NA-D stated the night shift usually gets up R3, R66 and R98 dresses them and places them back into bed due to lack of staff and helping out the day shift.

R62 had falls during the night shift due to lack of staffing.

R62 had diagnosis of Dementia. R62's quarterly MDS dated 6/6/13 indicated she had moderately impaired decision making and needed extensive assistance in ADL'S. R62's recent plan of care dated 8/8/13 indicated resident is at risk for falls due to history of past falls, diagnosis of osteoporosis, macular degeneration, glaucoma and coronary artery disease.

During record review R62 had the following falls during the night shift.

On 3/20/13 at 19:30, resident was found on floor with her wheelchair next to her bed, no injuries.

On 7/11/13 at 20:15, resident was found on floor in her room, no injuries.

On 8/4/13 at 20:20, R62 was found on floor next to her bed, no injuries.

During interview on 8/12/13 at 7:07 p.m., nursing assistant (NA)-A stated the night shift is often short staffed and resident cares can not always be done. NA-A stated the nightly rounds get completed, but answering call lights is not being

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F 353	Continued From page 62 done. NA-A stated R62, had falls directly related to lack of staffing. NA-A stated R62 will yell when she has to go to the bathroom. NA-A stated if staff does not get her she will self transfer and fall. NA-A also stated she had complained to the facility regarding the lack of staffing and not being able to perform necessary cares to residents but nothing has been done. NA-A stated at times she will go into a resident room's and shut off there call light without doing cares and tell them she will be back. NA-A also stated if there is a bath that needs to be completed in the evening it either does not get completed or she will do it at 1:00 a.m. or 2:00 a.m. if "the resident gets up to go to the bathroom I will give them their bath quick." Residents did not receive timely assistance with urinary incontinence (R7); and 5 of 6 residents (R130, R24 R46, R10, R139) did not receive restorative nursing as directed by their current plan of care. See F282 for additional information. Residents did not receive assistance with toileting in a timely manner to ensure their dignity for 5 of 5 residents (R34, R12, R105, R5, and R10) interviewed who complained of inadequate staff with toileting assistance. See F241 for additional information. Restorative nursing services for ambulation were not consistently provided for 3 of 5 residents (R130, R24, and R139) who had a walking program. Refer to F311 for additional information. Residents did not receive the necessary repositioning and toileting which had been determined as needed for R7. Refer to F314	F 353		

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F 353	Continued From page 63 and F315 for additional information. Restorative nursing services for range of motion was not consistently provided for 2 of 3 residents (R46, and R10) reviewed who had a range of motion program. Refer to F318 for additional information. There were 1 of 4 family members interviewed that expressed concerns with adequate staffing. During interview on 8/14/13 at 10:15 a.m. family (F)-C stated concerns regarding R10's cares not being done related to short staffing had been brought up several times at care conferences. F-C stated she was not aware R10 was suppose to be getting any kind of ROM services and had never seen them done during her frequent visits to the facility. There were 14 staff members interviewed that expressed concerns about being able to meet the resident needs timely, or to accomplish all care planned tasks for each resident. During interview on 8/12/13 at 7:07 p.m. nursing assistant (NA)-A stated the night shift is often short staffed and resident cares can not always be done. NA-A stated the nightly rounds get completed, but answering call lights is not being done. NA-A felt R66 and R62 have both had falls directly related to lack of staffing. NA-A stated both these resident will yell when they have to go to the bathroom. She stated if staff does not get to them they will self transfer and fall. NA-A also stated she had complained to the facility	F 353		

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regarding the lack of staffing and not being able to perform necessary cares to residents but nothing has been done. NA-A stated at times she will go into a resident room and shut off a call light without doing cares and tell them she will be back. She also stated if there is a bath that needs to be completed in the evening it either does not get completed or she will do it at 1:00 a.m. or 2:00 a.m. if "the resident gets up to go to the bathroom I will give them their bath quick."

During interview on 8/12/13 at 7:15 p.m. registered nurse (RN)-A stated staffing is worse on nights in the facility. She stated second floor is often a concerns with staffing and residents will often know what number they are in line for using the bathroom. Residents will say, "I am number 6 to go to the bathroom." RN-A also stated residents are not being repositioned as assessed and restorative nursing and range of motion is not being completed on residents because the NA's "don't have time." RN-A stated R24 is suppose to walk to and from every meal daily but it is not being done because the resident walks so slow and the NA's don't have the time to walk her.

During interview on 8/12/13 at 7:44 p.m. licensed practical nurse (LPN)-B stated the night shift is "always short staffed." LPN-B stated she had concerns some residents are being put to bed early so the evening shift does not have to do cares on those residents, but LPN-B was unable to provide any names of specific residents.

During interview on 8/12/13, at 7:45 p.m. trained medication aide (TMA)-D stated nurse aides ask her to assist them with transferring residents to the toilet all the time. She does help them, but if she is in the middle of a medication pass, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

(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 353	Continued From page 65	F 353		

can not help until she is done. TMA-D stated that sometimes residents have to wait a long time to get to the bathroom.

During interview on 8/12/13, at 8:00 p.m. NA-I stated, "Residents call to go to the bathroom, we don't have time and the nurses won't help. We are often in the groups by ourselves and the residents just have to wait until we can get someone to help." NA-I stated the nurse aides are unable to reposition residents who need repositioning every two hours, they eventually get repositioned, but not as indicated by the care plan.

During interview on 8/12/13 at 8:20 p.m. trained medication aide (TMA)-A stated second and third floor are often short staffed during the night shift. TMA-A stated residents R34 and R105 have both complained about how long it takes to have their call lights answered. TMA-A stated R105 will often have to call the front desk to get cares done because it takes so long for her call light to be answered.

During interview on 8/12/13 at 8:25 p.m., TMA-E stated there is not enough staff help on nights, "I can't concentrate on meds when I am helping the other aide transfer and assist with cares. There used to be 3 aides on the floor including an activities aide, now it is a float and myself...this started about 2 weeks ago, I find it difficult to get cares done"

During interview on 8/12/13, at 8:30 p.m. NA-G stated, "We just can't get to everyone, we try really hard though." NA-G stated residents did not get toileted or repositioned as they are

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	245494	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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F 353	Continued From page 66 suppose to be. During interview on 8/12/13, at 8:40 p.m. trained medication aide (TMA)-D stated R56 is a fall risk and needs one on one attention, so the nurses or aides have to sit with him for hours every evening. This takes away care from other residents and staff can not ensure each resident gets repositioned or toileted when they are suppose to. During interview on 8/12/13 at 8:43 p.m., NA-E stated she sees a staffing shortage on all shift but night time is worse. NA-E expressed concern that she was 1 aide for the 18 residents on the unit that night. During interview on 8/14/13, at 1:08 p.m. NA-H stated she was not aware someone had turned off R105's call light. NA-H stated they do have trouble getting to call lights timely and if someone needs two assistants, she has to go find someone to help, often from a different unit. During interview on 8/14/13 at 7:05 a.m. TMA-B stated the facility is "always short staffed." She stated R10 does not get the cares required related to being short staffed. TMA-B stated night shift will often tell R10 he has to have a bowel movement in his pants because they don't have enough staff to get him on the bedpan. TMA-B stated R46 and R10 do not have their restorative nursing done because there is not enough staff to do cares and range of motion on these residents who take more time. During interview with NA-W on 8/14/13, at 8:34	F 353		

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ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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F 353	Continued From page 67 a.m. she stated, "I get called to help out other groups all the time, then I can't answer call lights in my own group. Residents have to wait a long time." NA-W did stated they often shut off call lights if someone needs two assist to help them to the toilet. They will have to wait until another aide is available to help them. This often takes a long time 30-60 minutes. During interview on 8/15/13, at 8:55 a.m. registered nurse (RN)-D stated the nurse aides have reported to her that they do not have enough help to meet resident needs such as repositioning and toileting. She has reported this to the director of nursing (DON) on several occasions. Short shift [4 hour shifts] have been added recently to try and help with this, but this short shift person is also responsible for activities, and can not always help with toileting or repositioning.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356	F 356 It is the policy of Elim Care and Rehab Center to post the nurse staffing data as specified on a daily basis at the beginning of each shift – in a readable format, in a prominent place readily accessible to residents and visitors. To assure continued compliance the following plan has been implemented.	

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F 356	Continued From page 68 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their nurse staffing information posting included the total number of hours worked for registered nurses, licensed practical nurses, and certified nurse aides. This had the potential to affect all 106 residents currently residing in the facility, and any family members, or visitors who may choose to view this information. Findings include: During the initial tour on 8/12/13, at 12:45 p.m. the required nurse staffing information was posted in the entry way, and noted to include classification of staff, number of staff, and the hours each classification worked. However, the posting did not include the total number of hours worked by each classification of nursing staff. Review of the nurse staffing postings from 7/30/13 through 8/12/13, revealed the total number of hours worked by each classification of nursing staff had not been included.	F 356	**Actions taken to identify other potential residents having similar occurrences:** Staffing Coordinator will post Nursing hours in main hallway for visitors to see in an easy to read format. The information will include Facility name; current date; total number and actual hours worked for RN's, LPN's, nurse aides. Resident census will also be included. Staffing Coordinator and designee will keep this board current with changes. As a backup, the Staffing Coordinator will train the RN unit managers and RN team leads regarding the proper posting of nursing hours form prior to 9-24-2013 **Measures put in place to ensure deficient practice does not occur:** Staffing Coordinator will update/monitor posting of nursing hours daily Monday through Friday and Team Leads will post on weekends and/or when staffing coordinator is out of office. Director of Nursing or Designee will audit weekly x 1month and as needed to assure compliance.	

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	245494	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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F 356	Continued From page 69 During interview 8/14/13, at 9:00 a.m. the nursing staff coordinator verified the missing information. A facility policy entitled Posted Nursing Staffing Hours Policy, dated July 2013, included; "The facility will post nursing staff hours per shift and the actual nursing hours worked in a visible location in a main hallway in an easy-to-read format for visitors to see."	F 356	**Effective implementation of actions will be monitored by:** The Director of Nursing/designee will report findings of audits to CQI Committee for compliance and further recommendations. **Those responsible to maintain compliance will be:** Director of Nursing will oversee continuing compliance. **Completion date for certification purposes only is 09-24-2013**	
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure vegetables were cooked in manner to retain their flavor, appearance, and palatability. This affected 4 of 19 residents (R12, R79, R131, and R88) who were interviewed about food quality. Findings include: R12's quarterly Minimum Data Set (MDS) dated 5/6/13, indicated he was cognitively intact. During interview on 8/12/13, at 3:17 p.m. R12 stated, "The vegetables have no taste, not over cooked, they just have no taste." R79's quarterly MDS dated 6/4/13, indicated she was cognitively intact. During interview on 8/12/13, at 3:46 p.m. R79 stated, "The vegetables are water soaked, they are not cooked with any salt, and they are tasteless." R131's admission MDS dated 7/13/13, indicated	F 364		

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	245494	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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F 364	Continued From page 70 she was cognitively intact. During interview on 8/12/13, at 6:29 p.m. R131 stated, "The noodles, vegetables, and things like that are overcooked, not cooked with any salt, they are tasteless." R88's annual MDS dated 6/28/13, indicated she was cognitively intact. During interview on 8/14/13, at 12:10 p.m. R88 stated, "The vegetables are always mushy and water-logged. We have been telling them that at our food committee. We have been trying to get them to change it, but they haven't." During observation of the noon meal on 8/14/13, at 12:10 p.m. the oriental vegetables were a mixture of green beans, broccoli and onions. They were pale, saturated with water, and fell apart easily with light pressure from a back of a spoon. The oriental vegetables were tasted by the surveyor, they were mushy, tasteless and not palatable. A review of the Food Committee notes dated 7/15/13, included, "want vegetables out of water-too soggy." During interview on 8/15/13, at 11:57 a.m. cook-A stated she normally cooks vegetables in the facilities steamer, however since rice also needed to be steamed for the dinner meal on 8/14/13, she did not steam the vegetables. Cook-A stated she had brought the oriental vegetables to a boil, then placed the vegetables and the cooking water into pans. These pans she had placed in a 250 degree Fahrenheit (F) oven until picked up by each units homemaking staff at about 11:40 a.m. Cook-A stated she should have drained the vegetables prior to placing them in the oven to keep warm. During interview on 8/15/13, at 1:47 p.m. the dietary director stated the vegetables come frozen in a box, they are portioned out and	F 364	**F 364 Nutritive Value / Appear Palatable / Prefer Temp** It is the policy of Elim Care and Rehab Center that each resident receives and we provide food prepared by methods that conserve nutritive value, flavor and appearance; and food that is palatable, attractive and at the proper temperature. **Re: cited residents** R12, R79, R131 and R88 **Actions taken to identify other potential residents having similar occurrences:** The dietary manager will interview residents to determine the palatability of the vegetables on a weekly basis x 4weeks and then quarterly for one year. The Dietary manager will report to the CQI committee on a quarterly basis x one year as to the findings of the audits. The dietary manager will ask residents monthly x 3 months at food committee meeting the palatability of the vegetables.	

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	245494	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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F 364	Continued From page 71 normally cooked in a steamer. The facility has no directions, policies, procedures or recipes on how long to cook or steam vegetables; it is up to the cook. Dietary staff does not have any manufacturer directions, for the steamer, to indicate how long each vegetable should be cooked. The dietary director stated she takes resident comments from the Food Committee and posts them in the kitchen. She does not formulate a plan, or instruct dietary staff on how to address resident food concerns. At 1:50 p.m. Cook-A stated she normally steams items such as broccoli for about 15-20 minutes each batch. During interview on 8/15/13, at 2:00 p.m. the maintenance director found the directions for the steamer in the maintenance room. A Southbend Simple Steam Countertop Steamers manufacturer's manual, undated, included directions on how long vegetables should be steamed. The manual's guidance suggested 8 minutes for items such as frozen and thawed broccoli, mixed vegetables 12 minutes. Even though the facility had been aware of resident concerns about vegetables being "too soggy," since 7/15/13, they had not instituted any cooking directions for staff regarding vegetables. This created water-logged vegetables, which potentially had a loss of nutritive value, were not palatable, attractive, or flavorful.	F 364	All dietary cooks have been re-educated by the dietary manager (as of September 2, 2013) regarding the importance of maintaining the nutritive value/appearance of vegetables in particular, in particular cook times and amounts of liquids. **Measures put in place to ensure deficient practice does not occur:** All newly hired dietary cooks will be educated by the dietary manager at the time of hire on the importance of maintaining the nutritive value/appearance vegetables relating to cooking times and the amount of liquid needed. **Those responsible to maintain compliance will be:** Director of Nutritional Services will oversee continuing compliance **Completion date for certification purposes only is 09-24-2013**	

Elim Care & Rehab Center

Providing Senior Housing and Healthcare
in the Spirit of Christ's Love

September 17, 2013

Brenda Fischer

Re: Addendum to 2567

Here is our addendum. Please feel free to contact us at 763-389-1171 if you should have any further questions.

Respectfully,

Todd Lundeen, campus administrator

F225/226 **Measures put in place to ensure deficient practice does not occur:** IDT will review each submitted OHFC report to ensure process for filing and notification of appropriate parties has been completed. Review of OHFC reports will be reviewed at daily IDT meetings. CQI Committee to review results and determine pattern for continued audits.

F241 **Regarding cited residents:** Cited residents and their caregivers have been interviewed regarding strategies for staff to meet resident needs in a satisfactory period of time.

Measures put in place to ensure deficient practice does not occur: Staff and resident interviews to be conducted weekly x's 1 month based on results of daily call light reports exceeding 10 minutes regarding strategies for staff to meet resident needs in a satisfactory period of time. Results to be reviewed by CQI team and recommendations made for continuation of audits/interviews.

701 First Street, Princeton, MN 55371-1799
Telephone 763-389-1171 • *Fax* 763-389-0432 • *Internet* www.elimcare.org
Endorsed by and Affiliated with the Evangelical Free Church Of America

9/23/13

F246 **Measures put in place to ensure deficient practice does not occur:** Auditing will be completed by IDT weekly on new admissions for 3 months, and/or at least 5 random resident charts monthly. Audit results will be sent to CQI Committee for review and determination of need for ongoing audits.

F279 **Effective implementation of actions will be monitored by:** DON/ADON will audit 10% of facility charts monthly x's 3 months for complete and accurate care plan development, revision, review and implementation related to Coordination of Hospice care and Skin/Pressure ulcer care plan.

F282 **Effective implementation of actions will be monitored by:** RN Unit Managers, and/or nurse designee will complete 1 observation audit per day for each household for one month to assure restorative programs are being completed as written and revised as appropriate. Night supervisor will conduct 1 observation audit per night for one month to assure restorative programs are being completed as written and revised as appropriate. Audit results will be sent to CQI Committee for review and determination of need for ongoing audits.

F311 **Effective implementation of actions will be monitored by:** SEE F282

F353 **Measures put in place to ensure deficient practice does not occur:** Based on call light response times greater than 10 minutes, combined with residents that trigger for requiring extensive assist with cares, interviews will be conducted for 1 month of staff, residents and families regarding feelings of sufficient care giver staff to meet the needs of each resident in a timely manner. Audit results will reviewed weekly with the CQI / IDT team for adjustment of staffing assignments and determination of need for ongoing audits.

9/23/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	**701 FIRST STREET** **PRINCETON, MN 55371**

(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	INITIAL COMMENTS Surveyor: 03005 Building #1 FIR SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Elim Home Princeton was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Elim Home Princeton is a 3 story building with no basement. The original building was constructed in 1971 and was determined to be of Type II(111) construction. An additions was built on in 1989 of the same construction type,. Therefore the building was inspected as one building. The building also has an apartment complex attached that is properly separated. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 113 beds and had a census of 108 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **02 - BUILDING 2** B. WING _____	**08/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	**701 FIRST STREET PRINCETON, MN 55371**

(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	INITIAL COMMENTS Surveyor: 03005 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Elim Home Princeton was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Elim Home Princeton is a 3 story building with no basement. The building construction type has been determined to be Type II(442). This inspection only reflects the building that opened 11-4-03. It is properly separated from the original building constructed in 1971. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 113 beds and had a census of 108 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is met.	K 000		

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

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