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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BK20

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00432

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/11/2018** (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 **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 02/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 02/12/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/30/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245562

February 12, 2018

Ms. Joan Gedde, Administrator
Elders Home Inc
South Tousley, PO Box 188
New York Mills, MN 56567

Dear Ms. Gedde:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 30, 2018 the above facility is recommended for:

45 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 12, 2018

Ms. Joan Gedde, Administrator
Elders Home Inc
South Tousley, PO Box 188
New York Mills, MN 56567

RE: Project Number S5562027

Dear Ms. Gedde:

On January 8, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 21, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 11, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 6, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 21, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 30, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 21, 2017, effective January 30, 2018 and therefore remedies outlined in our letter to you dated January 8, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BK20

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(L3) **ELDERS HOME INC**
(L4) **SOUTH TOUSLEY, PO BOX 188**
(L5) **NEW YORK MILLS, MN** (L6) **56567**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/21/2017** (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 **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE - NE II 01/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/30/2018 (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:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 8, 2018

Ms. Joan Gedde, Administrator
Elders Home Inc.
South Tousley, PO Box 188
New York Mills, MN 56567

RE: Project Number S5562027

Dear Ms. Gedde:

On December 21, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 30, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 30, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 21, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 21, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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
	245562	A. BUILDING _____ B. WING _____	12/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted December 18th through December 21st, 2017 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 12/18/17, through 12/21/17. Upon receipt of an acceptable electronic 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. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		1/30/18

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

Electronically Signed | 01/17/2018

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
	245562	A. BUILDING _____ B. WING _____	12/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 1 (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245562	A. BUILDING _____ B. WING _____	12/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 2	F 623		

including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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	245562	A. BUILDING _____ B. WING _____	12/21/2017

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

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F 623	Continued From page 3 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the ombudsman of facility initiated discharges for 2 of 2 resident (R1, R28) who were discharged to the hospital. Findings include: R28 had diagnoses that included inter-vertebral disc disorder, arteriosclerotic heart disease and weakness per his current face sheet. Review of R28's Progress Notes dated 10/9/17, revealed the social worker was visiting with R28 when he had complaints of back pain. At 1:42 p.m. a verbal order was received to send R28 to the emergency room via ambulance. R28 was not able to move his left arm at all and was not able to follow direction to move his left arm. R28 was alert and oriented, had been eating and drinking well and had been up to use the bathroom. R28 was sent out at 1:30 p.m. via ambulance to the hospital. At 4:51 p.m. the progress note revealed R28 was admitted to a Fargo hospital with elevated troponin levels (increased risk of heart attack). On 12/21/17 at 11:39 a.m. social service director (SSD) confirmed the facility had not notified the ombudsman of facility-initiated transfers/discharges at the time of hospitalizations and the ombudsman was not aware R28 had been discharged to the hospital	F 623	F623 The Ombudsman has been notified of the facility initiated transfers of R28 and R1 to an acute care facility on 12/24/18. A list of all resident transfers and discharges since 5/12/17 has been compiled and sent to the Ombudsman on 1/9/18. An audit will be completed monthly using a tracking tool to ensure all facility initiated transfers are sent to the ombudsman. A policy and procedure was developed on using the tracking tool and notifying the ombudsman monthly of all facility initiated transfers. All staff were provided education on F623 and notification to the ombudsman and the facility's policy and procedure on 1/17/18 Audit results will be reported to the Quality Assessment and Assurance Committee. The Licensed Social Worker is responsible.	

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F 623	Continued From page 4 on 10/9/17. In a follow up interview at 1:12 p.m. the SSD indicated the ombudsman had not been contacted of R28's discharge due to staff being unaware they needed to contact the ombudsmen and they recently found out they needed to contact the ombudsman in regard to discharges and transfers. The SSD confirmed she was not aware they needed to contact the ombudsman at the time of R28's discharge. Review of R1's Admission Record indicated R1 had diagnoses which included major depressive disorder, chronic lymphocytic leukemia and delirium. Review of R1's progress notes from 9/1/17, through 12/21/17, revealed on 10/2/17, at 4:42 p.m. R1 had not returned to the facility after an appointment at the clinic and facility staff called the clinic and were informed that R1 was admitted to acute care facility with bilateral plural effusions. The medical record lacked documentation the notification of the emergency transfer was sent to the Long Term Care (LTC) ombudsman. On 12/21/17, at 11:06 a.m. social service director (SSD) stated she had not sent any facility-initiated transfer notifications to the LTC ombudsman. On 12/21/17, at 11:08 a.m. Minimum Data Set (MDS) coordinator stated she was unaware of who sends the facility-initiated transfer notifications to the LTC ombudsman. During a	F 623		

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F 623	Continued From page 5 follow up interview at 2:12 p.m., the MDS coordinator stated the facility had no procedure in place to update the LTC ombudsman when facility-initiated transfers/discharges occurred. On 12/21/17, at 2:37 p.m. director of nursing (DON) stated she learned of the regulation to send notification of facility-initiated transfers/discharges to the LTC ombudsman today. DON stated she would expect that the LTC ombudsman be updated with emergency transfers to an acute care facility and that the facility was working on a procedure to ensure completion of this notification. Review of facility policy titled, Transfer Discharge revised 12/16, indicated a copy of the notice will be sent to the office of the state long term care ombudsman on a monthly basis.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		1/30/18

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F 625	Continued From page 6 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 2 of 2 residents (R1, R28) reviewed for hospitalization. Findings include: R28 had diagnoses that included inter-vertebral disc disorder, arteriosclerotic heart disease and weakness per his current face sheet. Review of R28's Progress Notes dated 10/9/17, revealed the social worker was visiting with R28 when he had complaints of back pain. At 1:42 p.m. a verbal order was received to send R28 to the emergency room via ambulance. R28 was not able to move his left arm at all and was not able to follow direction to move his left arm. R28 was alert and oriented, had been eating and drinking well and had been up to use the bathroom. R28 was sent out at 1:30 p.m. via ambulance to the hospital. At 4:51 p.m. the progress note revealed R28 was admitted to a Fargo hospital with elevated troponin levels (increased risk of heart	F 625	F625 A bed hold notice was developed by the facility and put into use on 1/2/18. All residents who are transferred to an acute care facility will be given a bed hold notice starting 1/2/18. An audit will be completed every weekday at the management morning meeting using a tracking tool to ensure all facility initiated transfers are given a bed hold notice at the time of the transfer. This tracking tool will be used ongoing starting 1/15/18. The transfer checklist used by the licensed nursing staff has been updated to include giving the resident and/or their representative a bed hold notice. The policy and procedure for bed hold notices was reviewed and revised as needed. All staff were provided education on F625 and notification to the ombudsman and the facility's policy and procedure on 1/17/18. Audit results will be reported to the Quality	

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F 625	Continued From page 7 attack). Further review of R28's medical record lacked documentation that R28 or family/legal representative had been provided information on the facility's bed hold policy at the time of the hospital transfer. On 12/21/17 at 1:12 p.m. the social service director (SSD) reviewed R28's chart and confirmed R28 was not provided a bed hold policy/information prior to his discharge to the hospital. SSD indicated the nursing staff usually took the lead on making sure the resident/family/legal representative was given the information in regards to the bed hold policy. The SSD indicated she had never done a bed hold policy before, so she assumed nursing staff would provide this information to the resident/family/legal representative. The SSD also indicated staff would normally chart on the bed hold policy and she would normally followed up on the resident's condition and return to facility. Review of R1's Admission Record indicated R1 had diagnoses which included major depressive disorder, chronic lymphocyctic leukemia and delirium. Review of R1's progress notes from 9/1/17 through 12/21/17, revealed R1 had been hospitalized on 10/2/17. The medical record	F 625	Assessment and Assurance Committee. The Licensed Social Worker is responsible.	

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F 625	Continued From page 8 lacked documentation that bed hold information was sent to the hospital for R1 or given to R1's resident representative at the time of transfer to the hospital. On 12/21/17, at 2:12 p.m. Minimum Data Set (MDS) coordinator stated R1's medical record lacked documentation that a bed hold policy/information was provided to R1 or their representative for transfer to hospital on 10/2/17. MDS coordinator indicated that bed hold policies would be the responsibility of nursing staff to provide at the time of a transfer, and that a process to ensure a bed hold policy/information were given at time of transfer were lacking. On 12/21/17, at 2:37 p.m. director of nursing (DON) stated she would expect a bed hold form to be filled out at the time of a transfer. The DON was unaware of who's responsibility it would be to complete the bed hold form, and that the facilty was currently taking a look at the process. Review of facility policy titled Bed Holds and Returns, revised on 3/2017, indicated prior to transfers and therapeutic leaves, resident or resident representatives will be informed in writing of the bed hold and transfer policy.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve	F 637		1/30/18

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F 637	Continued From page 9 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a significant change in status assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 1 resident (R25) reviewed for nutrition. Findings include: R25's admission MDS dated 8/25/17, identified R25 had moderately impaired cognition and had diagnoses which included Diabetes Mellitus, amnesia, and macular degeneration. The MDS indicated R25 felt tired or had little energy on nearly every day, had no pain and was always incontinent of bladder and frequently incontinent of bowel. The MDS further indicated R25 had no weight loss of 5 percent or more in the last month or loss of 10 percent or more in last 6 months. R25's quarterly MDS dated 11/24/17, identified R25 had severely impaired cognition and had diagnoses which included Diabetes Mellitus, amnesia, macular degeneration and anorexia. The MDS indicated R25 had trouble falling or staying asleep, or sleeping too much nearly every day, had occasional mild pain and was frequently incontinent of bladder and always incontinent of bowel. The MDS further indicated R25 had a loss of 5 percent or more in the last month or loss of 10 percent or more in the last 6 months and not	F 637	F637 R25 died on 1/11/18 before a significant change of status was completed. All current residents with a change of status will be reviewed to identify a need for a comprehensive significant change assessment. Timely, accurate, comprehensive significant change assessments will be completed on residents identified with a significant change in condition. With each quarterly and annual assessment, the MDS Coordinator will review the preceding assessment and will complete a SCSA if there has been a significant improvement or significant decline in two or more areas as defined in the RAI manual for all residents. Residents will be reviewed for changes in their condition at the morning IDT meetings. Residents with changes in their condition (improvement of decline) will be put on a IDT watch for 14 days and if a significant change is determined to occur by the IDT during this time due to changes in 2 or more areas as defined in the MDS manual, the MDS coordinator will complete a Significant Change of Status MDS. The morning meeting IDT will keep a record of residents with status changes	

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F 637	Continued From page 10 on a physician prescribed weight-loss regimen. Review of the above assessments indicated R25 had a decline in cognition from moderately impaired to severely impaired, presence of a resident mood item not previously reported by the resident or staff, R25's incontinence pattern changed and the emergence of unplanned weight loss problem. On 12/21/17, at 2:16 p.m. MDS coordinator confirmed she completed R25's quarterly MDS dated 11/24/17. MDS coordinator stated that she did not have a process for identifying when a SCSA would be required, but would speak with care staff, review progress notes or would identify through direct observation. After review of R25's coded data from her admission MDS dated 8/25/17, and quarterly MDS dated 11/24/17, she confirmed a decline in at least two areas and that a SCSA should have been completed on R25 after the MDS dated 11/24/17. On 12/21/17, at 2:32 p.m. director of nursing (DON) stated the MDS coordinator was responsible for completion of all facility residents' MDS. DON stated R25's change in cognition and significant decline in weight would constitute a SCSA and would have expected MDS coordinator to follow the facility policy. A facility policy titled Change in a Resident's Condition or Status revised 12/2016, indicated if a significant change in a resident's physical or mental condition occurs, a comprehensive assessment would be conducted as outlined in the MDS Resident Assessment Instrument (RAI) Instruction Manual.	F 637	that is reviewed at each meeting. An audit will be completed with each Quarterly and Annual assessment to determine if a significant change has occurred. The results of the audits will be reported to the Quality Assessment and Assurance Committee on a monthly basis for 3 months. The QAA committee will determine number and scope for continued audits at their March 2018 meeting. The policy and procedure were reviewed and no changes were needed. All staff were provided education on F637 and significant status changes on 1/17/18. The Director of Nursing is responsible.	

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F 637	Continued From page 11 The Resident Assessment Instrument manual dated 10/17, included the definition of a significant change as a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. The manual further directed when the interdisciplinary team (IDT) determined that a significant change occurred, the nursing home should document the initial identification of the significant change in the clinical record. The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. The manual clarified that MDS assessments are not required for minor or temporary variations in resident status.	F 637		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		1/30/18

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F 880	Continued From page 12 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 13 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility. In addition, the facilty lacked a water management program for the prevention of Legionella. This deficient practice had the potential to affect all 21 residents who resided in the facility. Findings include: On 12/21/17, at 1:40 p.m. the following items were identified by facility personnel to be tools for tracking and trending facility infections: - a laminated facility map was tacked to a small bulletin board in the registered nurse (RN)A's office. The laminated map had a color legend written on the right side of the map. A colored dot was placed on the map to identify rooms of residents with illnesses associated with: gastro intestinal (GI), urine, respiratory , head ache, and	F 880	F880 The facility has developed a comprehensive surveillance tool to track and trend all infections/illnesses. This tool was put into place on 1/1/18. This tool lists and tracks the resident, date of onset of infection/illness, site of infection/illness, diagnosis related to the infection/illness, if a culture was done and the results, if an x-ray was done, the organism if known, the antibiotic if prescribed, if isolation was done, if the infection/illness was health care associated, if a reculture was completed and the date the infection resolved. The total number of infections is broken down by category. The form data is reported to the QAPI committee each month. Forms for surveillance of symptoms for residents and staff were developed and placed into use 1/15/18. The forms list symptoms for respiratory, GI, Skin and urinary illnesses. The infection	

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F 880	Continued From page 14 eyes/ears. The map indicated four residents with GI symptoms, one resident with eyes/ears symptoms, and one resident with a head ache during the month of December. - a facility form titled Monthly Systemic Antibiotic List -October 2017. The form listed three residents by name and by room number, with a start date and duration of a named antibiotic. The form also had an area to document the reason the antibiotic was prescribed. The form identified one resident received an antibiotic for "urinary", another identified "other" and the third identified "not documented." - a facility form titled Monthly Infection Report For All Residents dated 2017. The form identified by month the total number of urinary tract infection (UTI), skin, upper respiratory infection (URI), lower respiratory infection (LRI), GI, surgery with wound infection, septic, total number of pathogens identified, other, and number with antibiotic treatment. The form identified the following documentation: January - 2 UTI's, 1 skin, 1 URI. February - 2 UTI's, 1 URI, 1 septic (admitted with this diagnosis). March -1 UTI. April - 2 UTI's, 1 skin. May - 2 UTI's, 1 URI. June - 2 UTI's 1 skin, 1 GI. July - no documentation. August - 3 UTI's. September - 1 UTI, 1 URI, 1 other, 3 treated with an antibiotic. October - 1 UTI, 1 URI, 2 treated with an antibiotic. November - 2 UTI's, 2 treated with an antibiotic. December - no documentation.	F 880	preventionist will use these forms to track and trend infections in staff and residents. A comprehensive Water Management Program was developed for Legionella prevention and detection and implemented on 1/15/18. The policy and procedure for infection surveillance was reviewed and no changes were needed. The Infection Preventionist will continue to work with ICAR on the facilities Infection Control program including surveillance and Legionella prevention. All staff were provided education on F880 in regards to infection surveillance and Water Management Program including Legionnaire's Disease on 1/17/18. A tracking log will serve as an audit tool will be completed as identified in the Water Management Program starting 1/17/18. Audits will include: Chlorine testing, water temperature testing, observation for biofilm, scale and sediment in the water. Results of the audits will be reported monthly to the Quality Assessment and Assurance Committee. The Infection Preventionist is responsible for the Infection Surveillance and the Administrator is responsible for the Water Management Program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245562	A. BUILDING _____ B. WING _____	12/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 The forms were not utilized to provide on going tracking and trending of signs and symptoms of infection, nor did it provide culture results of specific organisms. On 12/21/17, at 1:40 p.m. RN-A verified responsibility of the facility infection control program. RN-A identified the responsibilities included monitoring staff infection control practices, staff and resident tuberculosis testing, vaccinations, monitoring infections, tracking and trending these infections and antibiotic stewardship. RN-A identified a plan had been made, however; had not been set up and in place. RN-A indicated illnesses were tracked by placing a color coded dot on a laminated facility map with a dry eraser. RN-A indicated although she reviewed the twenty four hour summary each morning to identify infections, and placed them on the dry eraser board, she did not maintain written documentation or analysis of these infections, symptoms or culture results. RN-A indicated at the end of the month information regarding resident antibiotic use was gathered from the computer. This information was then reviewed at the quality assurance meeting. RN-A verified she planned to have a program in place to track and trend active infections in the building but had not implemented it at this time. On 12/21/17, at 02:14 p.m. the director of nursing (DON) indicated she was notified of resident infections during morning meetings and was notified when a resident started on an antibiotic. The DON identified facility policies were replaced approximately a month ago and all other pieces of the infection control program were the responsibility of the infection control nurse, RN-A. The DON indicated an infection control program	F 880		

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F 880	Continued From page 16	F 880		

should be in place.

The facility policy titled Surveillance for Infections revised July 2017, identified The infection Preventionist will conduct ongoing surveillance for Healthcare-Associated infections (HAIs) and other epidemiological infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions.

LACK OF WATER MANAGEMENT PROGRAM FOR LEGIONELLA PREVENTION

On 12/21/17, at 1:40 p.m. RN-A verified the responsibility of the facility infection control program included the Legionella water management program. RN-A identified the Legionella program was also in the planning stage and not currently in place. RN-A indicated she was not aware a program was needed until recently.

A Center for Disease Control (CDC) document, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 6/5/17, indicated Legionnaire's disease was a serious type of pneumonia caused by bacteria, called Legionella that live in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained. Implementing a water management program can reduce a building's risk for growing and spreading Legionella.

On 12/21/17, at 02:14 p.m. the DON indicated new facility policies were in place and

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F 880	Continued From page 17 responsibility for the program was part of the infection control nurse role. A facility policy titled Legionella Water Management Program revised July 2017, indicated the purpose of the water management program was to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The policy indicated the program used was based on the Centers for disease Control and Prevention recommendations for developing a Legionella water management program.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a facility-wide antibiotic stewardship program which monitored the use of antibiotics. This deficient practice had the potential to affect all 21 residents who resided in the facility. Findings include: A review of the facility's infection control surveillance program was conducted on 12/21/17,	F 881	F881 An Antibiotic Stewardship Program has been established on 1/1/18. The policy and procedure for Antibiotic Stewardship was put in place on 1/1/18. A tracking tool has been developed to track all antibiotic use including cultures, antibiotics used, prevalence of infections, tracking and trending. The facility will continue to participate in the University of North Carolina project on a Quarterly	1/30/18

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F 881	Continued From page 18 at 1:40 p.m. with infection control nurse, registered nurse (RN)-A present. The infection control program lacked an antibiotic stewardship program. The infection control program lacked protocols for a facility-wide system to monitor the use of antibiotics which included (but not limited to) appropriate prescribing of antibiotics, criteria before antibiotic use and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns identified. On 12/21/17, at 1:40 p.m. RN-A verified responsibility of the facility antibiotic stewardship program. RN-A identified an antibiotic stewardship program had been started prior to her employment; however, she had just recently become aware of this. RN-A identified going forward, antibiotic use data would be gathered monthly from the computer and logged on a form provided by the University of North Carolina. RN-A indicated the University form included resident signs and symptoms of infection, antibiotics used, culture results and specific antibiotics used. This information would be sent electronically to the University of North Carolina on a quarterly basis for review. RN-A verified a plan was formed but had not been implemented at this time. On 12/21/17, at 02:14 p.m. the director of nursing (DON) indicated she was notified of resident infections during morning meetings and was notified when a resident started on an antibiotic. The DON identified facility policies were replaced approximately a month ago and all other pieces of the infection control program were the	F 881	basis. A tool was developed for staff to complete when an antibiotic is started and is forwarded to the Infection Preventionist. The IP tracks all antibiotics in use. Physicians were mailed a letter on 10/23/18 outlining the Antibiotic Stewardship Program. The tracking tool will serve as the audit and is completed with each new antibiotic started. All staff were provided with education on F881 and Antibiotic Stewardship on 1/17/18 The Quality Assessment and Assurance committee will receive a monthly report on the prevalence of antibiotic use each month, culture results and tracking and trending. The Infection Preventionist is responsible.	

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F 881	Continued From page 19 responsibility of the infection control nurse, RN-A. The DON indicated an antibiotic stewardship program should be in place. The facility policy titled Surveillance for Infections revised July 2017, identified The infection Preventionist will conduct ongoing surveillance for Healthcare-Associated infections (HAIs) and other epidemiological infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. No further policies or procedures were provided.	F 881		

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	245562	A. BUILDING **01 - 01 MAIN BUILDING** B. WING _____	**12/20/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Elders Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2018

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

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K 000	Continued From page 1	K 000		

By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

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

The building is fully sprinkler protected and also has an automatic fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The sleeping rooms have single smoke detectors that are battery operated.

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K 000	Continued From page 2 The facility has a capacity 45 beds and had a census of 21 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 21 of 21 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 712	K712 Fire drills will be conducted on a monthly basis and documented. The form was revised. Each fire drill form will be fully completed and presented to the Safety Committee on a monthly basis. The Safety Committee will review the form to ensure it is fully completed on a monthly basis and this review will serve as a monthly audit. The Environmental Services Director has educated the maintenance staff on the fire drill requirement for monthly testing, complete	1/30/18

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K 712	Continued From page 3 On facility tour between 10:00 a.m. to 2:00 p.m. on 12/20/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was found that the facility did not conduct 2 of 12 monthly tests of the DACT. This deficient condition was verified by a Maintenance Supervisor.	K 712	documentation of each fire drill and the revised form on 1/15/18. Audit results will be reported to the QAA committee on a monthly basis. The facility will be compliance on January 30, 2018. The Maintenance Director is responsible.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 21 of 21 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m.	K 901	K901 A Gas and Electrical Risk Assessment form has been completed on 1/15/18 and will be reviewed and revised as needed on a Annual and as needed basis. This completed form has been added to the Facility Risk Assessment Manual. The assessment will be reviewed by the QAA committee initially, annually and as needed with revisions at the regularly scheduled monthly meeting. The facility will be compliance on January 30, 2018. The Administrator is	1/30/18

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K 901	Continued From page 4 on 12/20/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide any risk assessment documenting or proof that the risk assessment had been completed at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 901	responsible.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that	K 914	K914 The testing and documentation of	1/30/18

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K 914	Continued From page 5 the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 21 of 21 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 12/20/2017, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 914	testing of all resident room receptacle outlets in building will be completed by 1/30/18. This testing will serve as the audit. All receptacles not meeting the standards during testing will be replaced. The resident room receptacle outlet testing has been placed on a yearly audit and will completed yearly and with outlet changes. The Environmental Services Director has educated the maintenance staff on the requirement for testing and documentation on 1/15/18. The testing results will be reported to the QAA committee at the regularly scheduled monthly meeting. . The facility will be compliance on January 30, 2018. The Maintenance Director is responsible.	

S5562027

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for Administrator: jgedde@eldershome.com

National Provider Identifier (NPI) Number: 1356321624
One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: ELDERS HOME INC City: NEW YORK MILLS

Name of Legal Entity Operating Provider: ELDERS HOME, INC.

Name and Address of Governing Board President:

Name: MARTIN MURSU
Address: 34886 STATE HWY 106
City/State/Zip: NEW YORK MILLS, MN 56567

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: _____ City: _____

Name of Legal Entity Operating Provider: _____

Name and Address of Governing Board President:

Name: Andrew Tumberg
Address: 325 Walker Ave. S.
City/State/Zip: New York Mills, MN 56567

SIGNATURE

Completed by: Stan Gedde, Adm.
Title: Administrator
Date: 12-18-17