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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ILGE

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 04/29/2013 (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 **54** (L18)

13.Total Certified Beds **54** (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
	54			
(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 :
Gail Anderson, Unit Supervisor 04/29/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/29/2013 (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
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
Posted 5/13/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/24/2013
(L33)

DETERMINATION APPROVAL

CCN: 24-5562

Post Certification Revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective April 29, 2013, the facility is certified for 54 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5562 April 29, 2013

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

Dear Mr. Anderson:

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

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

Effective April 29, 2013, the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 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
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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

April 29, 2013

RE: Project Number S5562022

Dear Mr. Anderson:

On March 28, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 7, 2013. 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 April 29, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 11, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 16, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 7, 2013, effective April 16, 2013 and therefore remedies outlined in our letter to you dated March 28, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

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

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
245562	A. Building B. Wing	4/29/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/16/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/16/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/16/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/16/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/cbl	04/29/2013	28034	04/29/2013
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
3/7/2013			

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
245562	A. Building B. Wing 01 - 01 MAIN BUILDING	4/11/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 03/19/2013	ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 03/07/2013	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/01/2013
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/cbl	04/29/2013	03006	04/11/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/5/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ILGE

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: **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 **03/07/2013** (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 **54** (L18)

13.Total Certified Beds **54** (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
	54			
(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):

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Angela Hofmann, HFE NEII — 04/17/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 04/24/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/24/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3316

March 28, 2013

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

RE: Project Number S5562022

Dear Mr. Anderson:

On March 7, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Telephone: (218)332-5158

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 April 16, 2013, 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 April 16, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 7, 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 September 7, 2013 (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:

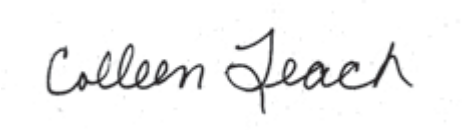
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Elders' Home
New York Mills, MN
Project #S5562022

ADDENDUM to POC

F-323

4. Any resident that is at risk for falls, or has had a fall, will be assessed by the Falls Committee and a screen request will be sent to the therapy department, for their recommendations. New admits, will be assessed at admission and a "Short Term Falls Care Plan" will be implemented until the Care Plan is completed.

5. The Falls Committee, will review all recommendations implemented by the nursing staff and therapy department, for appropriateness of suggested interventions and provide documentation of any changes they suggest.

Reoccurrence will be prevented by:

Audits of cares and therapy recommendation follow through, will be completed two times per week, on various residents for 90 days and the results shared with the Quality Assurance Committee and the input given on the need to increase/decrease, continue with random audits, or discontinue audits.

F-371

E. The Maintenance Supervisor, should audit the checklist for completion dates and initials, as well as, visually inspect the areas listed under (2a, 2b and 2c) on a bi-weekly basis, for the next three months and document those inspections. Results should be reported at the next Quality Assurance meeting. The Maintenance Supervisor, should continue to conduct random audits, on a permanent basis and correct any deviation from the POC, as well as, report the corrective action, to the Quality Assurance Committee.

Submitted: April 17, 2013
Cal Anderson, Adm.

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 _____	03/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	4/17/13 OK E addendum Ba	

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

Adm. — APR 10 2013

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.

RECEIVED
APR 11 2013
MN Dept of Health
Fergus Falls

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F 280	Continued From page 1 by: Based on interview, and document review, the facility failed to revise and update the plan of care when changes in interventions were identified from therapy services related to fall prevention for 3 of 3 residents (R38, R18, R51) in the sample. Findings include: R38 had diagnoses which included dementia and arthritis. A significant change Minimum Data Set (MDS) dated 12/18/12 identified severely impaired cognitive status. A corresponding Care Area Assessment (CAA) dated 12/21/12 indicated R38 triggered due to falls and history of wandering and was unsteady with transfers. The CAA identified R38 resided on the locked dementia unit due to a fear for his safety as he was cognitively unaware of safety needs and he wandered daily if he felt good. R38's plan of care dated 12/26/12, identified a risk for injury due to history of falls, which directed staff to give simple instructions, limit choices, and provide cues. However, lacked direction for R38 to be supervised at all times when in the wheelchair. An Elders Home Rehabilitation Screen, completed by therapy, dated 2/25/13 identified a recommendation for supervision while in wheelchair and "probably can restart FMP [Functional Maintenance Program] soon." On 3/6/13, at 2:12 p.m., licensed pratical nurse (LPN)-A was interviewed. She stated, "Ya can't have visual contact with him (R38) at all times, when taking care of others." LPN-A indicated she	F 280	Correction Plan for: F280 Corrective Action: 1. The Fall Interventions of supervision at all times when in wheelchair as recommended by Physical Therapy were added to Resident #38 Care Plan. He will continue to participate in FMP, with reviews quarterly or more often as needed. 2. The Fall Interventions of close supervision with mobility with the aid of a walker as recommended by Physical Therapy were added to resident #18 Care Plan. 3. Training on safe transfers given by Physical Therapy for resident #51 completed 4-8-13 for the nursing staff.	

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F 280	Continued From page 2 was unaware of current therapy recommendations and stated she felt the current therapy recommendations were "unrealistic." She stated therapy recommendations were usually added to the plan of care by the assistant director of nursing (ADON). R18 had diagnoses which included dementia with behavioral disturbance. A quarterly MDS dated 1/23/13 identified moderately impaired cognitive status and extensive assist required for activities of daily living (ADL's). A CAA dated 8/8/12 identified resident triggered for falls due to history of wandering, unsteady when turning around, and unable to follow directions. R18's plan of care dated 11/6/12, identified risk for falls related to mobility impairments, confusion, and unaware of safety needs. The plan of care listed various interventions which included to provide a safe environment, call-light within reach, and appropriate footwear; however, the plan of care lacked direction to utilize a walker and provide closer supervision. An Elder's Home Rehabilitation Screen form, completed by therapy, dated 2/25/13 indicated therapy recommended close supervision with mobility with the aid of a walker and provide closer supervision. On 3/6/13, at 2:15 p.m. LPN-A stated R18 was independent with walking. She stated R18 sometimes remembers to use her walker and other times she does not. LPN-A stated, "I don't know if she should have constant supervision for safety," and LPN-A confirmed she was not aware of recommendations from therapy.	F 280	Corrective Action as it applies to other residents: 1. The Policy and Procedure for revising Care Plans for Therapy recommendations was reviewed and revised. The DON will be given a copy of all Therapy recommendations to assure these recommendations are implemented and added to the resident Care Plans. 2. All resident Care Plans will be reviewed to assure that all Therapy recommendations have been added. 3. A Memo on updating Care Plans with Therapy recommendations was given to the ADON and Therapy staff to assure the revised procedure is followed. Date of Completion: 4-16-13	

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F 280	Continued From page 3 R51 had diagnoses which included Alzheimer's disease. A significant change MDS dated 1/9/13 identified severely impaired cognitive status and required extensive assist with ADL's. R51's plan of care dated 1/21/13 identified risk for falls due to confusion and listed various interventions of providing a safe environment, bed alarm, chair alarm as needed, and two hour toileting schedule; however, the plan of care lacked a recommendation from therapy for R51 to have assist with all transfers dated 2/12/13. A Physical Therapy Evaluation dated 2/12/13 indicated staff would benefit from training on safety with transfers for R51 and recommended staff to assist with all transfers. Review of the nursing notes from 9/27/12 to 3/4/13 revealed on 1/28/13 resident required extensive assistance with ambulation. On 1/31/13, resident attempts to ambulate independently. On 2/18/13, resident continues to require extensive assist with walking. On 3/6/13, at 2:18 p.m., LPN-A stated R51 had frequently attempted to transfer by herself. She indicated R51 was not safe to transfer herself without staff assist and confirmed she was unaware of any recommendations from therapy. On 3/6/13, at 9:22 a.m. the director of nursing (DON) was interviewed. The DON confirmed the current facility policy and indicated the assistant director of nursing (ADON) was responsible to update all residents care plans with any therapy recommendations.	F 280	Reoccurance will be prevented by: Audits of Care Plans to assure the Therapy recommendations have been added, will be conducted 2 times weekly on various residents for 90 days and the results shared with the QA Committee and the input given on the need to increase/decrease or discontinue the audits. The Correction will be monitored by: DON or Designee	

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F 280	Continued From page 4 On 3/7/13, at 1:25 p.m., the ADON confirmed the facility fall policy and verified the current plan of care for R38, R18, and R51 lacked revisions of therapy recommendations.	F 280		
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 implement adequate interventions to prevent and/or minimize the risk of reoccurring accidents/falls in the special care unit for 3 of 3 residents (R38, R18, R51) reviewed who were at risk for falls. Findings include: Residents residing in the special care unit who had experienced multiple falls were not provided with sufficient supervision to minimize the risk of accidents including falls. R38 had diagnoses which included dementia and arthritis. A significant change Minimum Data Set (MDS) dated 12/18/12 identified severely impaired cognitive status. A corresponding Care Area Assessment (CAA) dated 12/21/12 indicated R38 triggered due to falls and history of	F 323	Corrective Action: F323 1. Therapy recommendations for residents #18, 38, and 51 were added to Care Plan and training scheduled for nursing staff per recommendations. 2. Resident #51 will be moved to the main area of the facility as due to her advanced Dementia, she is no longer appropriate for the Special Care Unit. Corrective Action as it applies to other residents: 1. The Policy and Procedure for Accident/Supervision was reviewed and remains current.	

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F 323	Continued From page 5 wandering and was unsteady with transfers. The CAA identified R38 resided on the locked dementia unit due to a fear for his safety as he was cognitively unaware of safety needs and wandered daily if he felt good. R38's plan of care dated 12/26/12, identified a risk for injury due to history of falls, which directed staff to give simple instructions, limit choices, and provide cues. However, the plan of care lacked direction for R38 to be supervised at all times when in the wheelchair. In review of R38's Resident Accident/Incident Report dated 2/23/13, post fall analysis recommended R38 would not be left in wheelchair unsupervised. In addition, a nurses note dated 2/23/12 identified R38 was not to be left in wheelchair unsupervised. An Elders Home Rehabilitation Screen, completed by therapy, dated 2/25/13 identified a recommendation for supervision while in wheelchair and "probably can restart FMP [Functional Maintenance Program] soon." On 3/6/13, 7:16 a.m., R38 was seated at a chair in the dining room, and the alarm was clipped to the resident's shirt and a chair. No staff were in the hall or dining room area. R38 came to a standing position and sounded a personal alarm. When the alarm sounded, licensed practical nurse (LPN)-A walked from inside a resident's room to the dining room to assist R38 back to a sitting position in a recliner chair and gave the resident a magazine. LPN-A then returned down the hall to a resident room.	F 323	2. Additional staff coverage utilizing Housekeeping, Activities, and Nursing Staff will be provided in the Special Care Unit at key times during day/evening in order to assist with resident supervision. This schedule may be altered after trail periods in order to utilize staff at the most opportune times based on trials. 3. An Inservice on Therapy Recommendations and the additional staffing patterns in the Special Care Unit will be held with all staff on 4-8-13. Date of Completion: 4-16-13	

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F 323	Continued From page 6 On 3/6/13, at 7:45 a.m., R38 was seated in the dining room with two other residents, eating breakfast. No staff present in the hall or dining room at this time, until LPN-A returned to the nurses desk at 7:55 a.m. On 3/6/13, at 11:39 a.m., R38 was seated at a table in the dining room, repeatedly tapping his foot on the floor. LPN-A stated R38 was "antsy" so she fixed him a sandwich and juice, then left the main corridor area. At 12:00 p.m., R38 stood up from the chair and sounded the alarm. LPN-A entered the dining room and walked with R38 back to his room. On 3/6/13, at 2:12 p.m. LPN-A was interviewed. She stated, "Ya can't have visual contact with him (R38) at all times, when taking care of others." LPN-A indicated she was unaware of current therapy recommendations and stated she felt the current therapy recommendations were "unrealistic." She stated therapy recommendations were usually added to the plan of care by the assistant director of nursing (ADON). R18 had diagnoses which included dementia with behavioral disturbance. A quarterly MDS dated 1/23/13 identified moderately impaired cognitive status and extensive assist required for activities of daily living (ADL's). A CAA dated 8/8/12 identified resident triggered for falls due to history of wandering, unsteady when turning around, and unable to follow directions. R18's plan of care dated 11/6/12, identified risk for falls related to mobility impairments, confusion, and unaware of safety needs. The	F 323	Reoccurrance will be prevented by: 1. Trial staffing patterns will be added for additional coverage in the Special Care Unit and will be adjusted according to resident needs. This will be an ongoing process with the goal of providing additional supervision in order to reduce falls. Our Fall tracking will include times, locations of falls, and staffing patterns adjusted accordingly with input from QA Committee. The Correction will be monitored by: DON or Designee	

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F 323	Continued From page 7 plan of care listed various interventions which included to provide a safe environment, call-light within reach, and appropriate footwear; however, the plan of care lacked direction to utilize a walker and closer supervision. R18 was observed on 3/6/13, at 7:16 a.m., as she was walking with a slow, shuffling gait down the hallway of the unit. R18 did not have a walker or staff present as she shuffled down the hallway. R18 continued to shuffle towards the dining room area until LPN-A entered the area and assisted her back to her room. R18 was observed again on 3/6/13, at 7:28 a.m., as she was slowly shuffling down the hallway alone, without the aid of a walker. No staff were in the area at this time. R18 sat herself in a chair at a table in the main corridor. On 3/6/13, at 2:12 p.m., while interviewing LPN-A at the nurses station, R18 was observed shuffling in the hall alone without the aid of a walker. She walked to a table in the main corridor and stood there looking at newspapers on the table. LPN-A stated, "we have to let her do her own thing or she becomes anxious and frustrated." On 3/7/13, at 1:28 p.m., R18 was again observed ambulating with a shuffling gait, alone down the main corridor of the unit without the aid of a walker. In review of R18's medical record, she had falls on 2/16/13, 1/5/13, 1/2/13, 10/13/12, and 9/6/12, all unwitnessed in which staff found resident on floor. An Elder's Home Rehabilitation Screen form, completed by therapy, dated 2/25/13	F 323		

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F 323	Continued From page 8 indicated therapy recommended close supervision with mobility with the aid of a walker and closer supervision with mobility. On 3/6/13, at 2:15 p.m. LPN-A stated R18 was independent with walking. She stated R18 sometimes remembers to use her walker and other times she does not. LPN-A stated, "I don't know if she should have constant supervision for safety," and LPN-A confirmed she was not aware of recommendations from therapy. R51 had diagnoses which included Alzheimer's disease. A significant change MDS dated 1/9/13 identified severely impaired cognitive status and required extensive assist with ADL's. R51's plan of care dated 1/21/13 identified risk for falls due to confusion and listed various interventions of providing a safe environment, bed alarm, chair alarm as needed, and two hour toileting schedule; however, the plan of care lacked a recommendation from therapy for R51 to have assist with all transfers dated 2/12/13. On 3/6/13, at 7:45 a.m., R51 was observed sitting in the dining room area with other residents. No staff were observed in the hall or dining room area until LPN-A returned to the area at 7:55 a.m. In review of R51's medical record, she had experienced a total of 14 falls from 9/15/12 to 2/2/13. On 2/2/13, R51 was sitting in the dining room area and was found sitting on the floor after the alarm sounded. The fall was unwitnessed but R51's wheelchair was pushed away from her. A Physical Therapy Evaluation dated 2/12/13	F 323		

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F 323	Continued From page 9 indicated staff would benefit from training on safety with transfers for R51 and recommended staff to assist with all transfers. Review of the nursing notes from 9/27/12 to 3/4/13 revealed on 1/28/13 resident required extensive assistance with ambulation. On 1/31/13, resident attempts to ambulate independently. On 2/18/13, resident continues to require extensive assist with walking. On 3/6/13, at 2:18 p.m., LPN-A stated R51 had frequently attempted to transfer by herself. She indicated R51 was not safe to transfer herself without staff assist and she confirmed she was unaware of any recommendations from therapy. On 3/6/13, at 9:22 a.m. the director of nursing (DON) was interviewed. The DON confirmed the current facility policy and indicated the ADON was responsible to update all residents care plans with any therapy recommendations. On 3/7/13, at 1:25 p.m., the ADON confirmed the facility fall policy and verified the current plan of care for R38, R18, and R51 lacked revisions of therapy recommendations. A Fall Prevention Policy revised 5/11/10, identified an analysis would be conducted with each fall, appropriate interventions would be implemented, and therapy would make recommendations for interventions in attempt to prevent further falls.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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F 371	Continued From page 10 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness. Ceiling air vents and windows over the food service and/or near food preparation areas were not maintained in a clean, sanitary condition which had the potential to affect all 47 residents residing in the facility who were served food out of the kitchen. Findings include: During tour on 3/6/13 at 1:25 p.m. the following sanitation problems were observed when entering the kitchen area from the common corridor: - Ceiling air vent approximately 24" X 24" to left of stationary steamtable had a heavy buildup of dust and was blowing air down towards the steam table. - Ceiling air vent approximately 12" X 12" to right of stationary steamtable had a heavy buildup of dust and was blowing air down towards the steam table. - Ceiling air vent approximately 24" X 24" located to left of the convection oven had dust buildup	F 371	Corrective Action: F371 1. A "Monthly Maintenance/Kitchen checklist" was created for Maintenance staff to follow on a monthly basis. 2. The checklist includes the following duties: a. Inspect all ceiling vents in the kitchen and dish room area. b. Vacuum all ceiling vents in kitchen dish room area. c. Clean fan hanging on wall in dish room area.	

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F 371	Continued From page 11 and was blowing air down within 2 feet of the food preparation area, having the potential for food contamination. - Ceiling air vent approximately 24" X 24" located over the True standup freezer in right corner of the kitchen prep area had noticeable dust buildup. - Two windows approximately 19 1/2" wide X 33" long over the two compartment sink were dirty and had blown tree seed debris on the screen that was inside the kitchen area. On initial tour on 3/4/13 at 1:15 p.m., the right window was observed to be open and blowing air which had the potential to contaminate food in the kitchen area. When interviewed on 3/6/13 at 1:30 p.m., the dietary manager confirmed the vents were dusty and needed cleaning. On 3/6/13 at 1:38 p.m. the maintenance manager (MM) stated he was unaware of a maintenance cleaning schedule for the vents. MM verified the vents needed cleaning. On 3/6/13 at 1:30 p.m., the Administrator stated he was not aware of a cleaning schedule or policy for cleaning the vents and further stated the facility had a changeover in maintenance personnel and he realizes "some things have fallen in the cracks" and they may have just done the maintenance without a schedule. No further information was provided.	F 371	d. Maintenance staff will date and initial the checklist, after all task have been completed. The Maintenance Supervisor, is responsible to ensure the tasks are being performed monthly. Date of completion: April 16, 2013.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 12 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sanitary	F 441	Corrective Action: F441 1. Reviewed Glove Policy and Dressing Change Policy with nurse of Resident R4 to assure understanding of Policy on 3-18-13. Corrective Action As It Applies To All Staff: 1. Glove use Policy was reviewed and revised on 3-18-13. 2. Dressing Change Policy was reviewed and revised on 3-18-13. 3. Written Memo education provided to nursing staff on Deficiency and procedures needed to be followed to correct deficient practices prior to finishing Plan of Correction and All-Staff Training on 3-15-13.	

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 _____	03/07/2013

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 441	Continued From page 13 technique was used for 1 of 2 residents (R4), whose dressing change was observed. Findings Include: During observations of R4's dressing change, RN-A failed to wash her hands after touching the soiled incontinent product, before setting up dressing supplies, and between removing the soiled dressing and applying a clean dressing. R4's diagnoses included a current stage 3 pressure ulcer to right buttocks, (measuring 3.0 cm x 1.6 cm x 3.6 cm, and had granulation tissue) multiple sclerosis, and hemiplegia. The quarterly Minimum Data Set (MDS) dated 1/11/13, indicated cognitively intact and had a pressure ulcer. R4's physician's orders dated 2/26/13 directed staff to change dressing daily. R4's right buttocks wound dressing change was observed on 3/6/13 at 9:20 a.m. with registered nurse (RN)-A. RN-A washed her hands and then assisted R4 with turning on her side and removed a soiled incontinence brief. RN-A then set up the dressing supplies with her soiled hands, including opening a clear dressing package, holding gauze in her hand and soaking it with normal saline, cutting a rope dressing and placing these items on the clear dressing package. RN-A then donned gloves, removed the soiled dressing with her right hand, which had been moderately saturated with a brown substance, placed that in a waste basket and removed only her right glove. RN-A replaced the right glove without washing her hands. RN-A then removed a cotton swab from a mailing envelope and probed the tunneling wound. RN-A used the same cotton swab to push a rope dressing into the wound, and replaced her right glove again without washing her hands. RN-A placed a cover dressing, assisted R4 with repositioning and then washed	F 441	4. Reviewed Glove Policy and Dressing Change Policy at All-Staff Meeting to assure understanding of policy on 3-27-13. Date of Completion: April 16, 2013 Recurrence Will Be Prevented By: Random Visual Audits will be completed by DON or Designee three times per week with varying staff for three months, to assure compliance with Glove Change and Dressing Change Policy and Procedure. Results will be shared with QA Committee and input given on the need for increase/decrease or discontinue audits.	

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F 441	Continued From page 14 her hands. RN-A was interviewed on 3/6/13 at 12:00 p.m., and when asked about removing gloves several times during the dressing change, RN-A stated that "I should have washed my hands or used sanitizer before putting new gloves on." The director of nursing (DON) was interviewed on 3/6/13 at 1:48 p.m. and stated RN-A should have washed her hands between glove changes, before setting up supplies, and between removing the soiled dressing and placing a clean dressing. Facility policy, dated 8/2003 and revised on 1/2010, and entitled, " Elders Home Hand Washing Policy " and " Dressing Change (Clean) " directed staff to proper and appropriate hand washing techniques that will aid in the prevention of transmission of infections when utilized: the use of gloves does not replace hand washing, after handling used dressing, contaminated tissue, after contact with body fluids, secretions, excretions, and broken skin.	F 441		

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	245562	A. BUILDING **01 - 01 MAIN BUILDING** B. WING _____	**03/05/2013**

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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Elders Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	POC ok FB 4-5-13 RECEIVED APR - 4 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 03.07.2013 DC: 04.16.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Adm. | (X6) DATE: APR - 1 2013

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Elders Home is a 1-story building with a partial basement. The original building was constructed in 1959 and was determined to be of Type II(111) construction. In 1993, an addition was added to the south that was determined to be of Type II (111). In 1999 an addition was added onto the Dinning Room to the west which is Type V (111). The building is divided into 4 smoke zones divided by 30 minute and 90 minute fire barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire detectors that are on	K 000		

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K 000	Continued From page 2 the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms have single smoke detectors that are battery operated. The facility has a capacity of 54 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by NOTE: K67 Based on an interview with Administrator (CA) and Maintenance Director (J) and a review of the original construction plans, it has been determined that the corridor is not being used as a part of the air handling system as previously thought. The exhausted air from the bathrooms, attached to the sleeping rooms, which do not have supply air to them, can be made up by the infiltration around the sleeping room doors and in accordance with CMS program letter C&S-06-18, NFPA 90A section 2-3.11.1 exception 2 this is not a a deficiency.	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by:	K 011	K 011 Mike's Lock & Key, Perham MN, repaired the door on March 19, 2013. Lead Maintenance, will inspect all fire barrier doors monthly and place the inspection results in a log book, to verify that they continue to latch correctly.	

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K 011	Continued From page 3 Observations revealed that the 1 1/2 -hour fire barrier door between the 1959 original building and the 1993 addition was not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1. This deficient practice could allow the products of combustion to travel from one building to another, which could negatively impact all the residents, staff and visitors of the facility. Findings include: During the facility tour on March 6, 2013, between 9:45 am and 11:45 pm, observations by surveyor 03006, revealed that the 1 1/2 hour fire barrier door, between the newer addition and the existing building, did not positively latch when allowed to become self closing. The Director of Maintenance (J) and the Administrator (CA) verified this finding during the facility tour and during the exit conference.	K 011		
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Observations and an interview with staff revealed that the exit discharges are covered with snow and do not comply with NFPA 101 "The Life Safety Code" (LSC) 2000 edition section 7.2.1.6.1. These deficient practice could affect patients, staff and visitors if the facility needs to	K 038	K 038 Maintenance staff, removed snow from the north east exit door and west wing exit door, on March 7, 2013. Lead Maintenance will inspect all emergency exits after a snowfall or drifting and remove snow, to provide for emergency access. During hours, when maintenance is not present, it will be the responsibility of the Charge Nurse, to inspect the exits during a snow event and notify maintenance staff on call, when excess snow needs to be removed.	

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K 038	Continued From page 4 be quickly evacuated. Findings include: During the facility tour on March 6, 2013, between 9:45 am and 11:45 pm, observations by surveyor 03006, revealed that snow has blown into the exit discharges and needs to be cleared from the exit discharge path from the north east exit door and from the west wing exit discharge to a public way. The Director of Maintenance (J) and the Administrator (CA) verified this finding during the facility tour and during the exit conference.	K 038		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Observations, a review of records and an interview with staff revealed that the automatic fire sprinkler system has not been maintained in accordance with NFPA 25 Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 1999 edition section 9.7.5. Failing to maintain the automatic fire sprinkler system could affect all residents, staff and visitors, if the sprinkler system fails to function properly in a fire emergency. Findings include: During the facility tour on March 6, 2013, between	K 062	K 062 Allied Fire Protection, from Fargo ND, installed a new fire sprinkler gauge on April 1, 2013. It will be the responsibility of the lead maintenance person, to insure that the fire sprinkler gauge is replaced every 5 years.	

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K 062	Continued From page 5 9:45 am and 11:45 pm, observations by surveyor 03006, a review of Elder Care sprinkler system testing records and an interview with the Administrator (CA) and Maintenance Director (J) revealed that the fire sprinkler system gauge was last replaced in August of 2006 (over 6 years ago) and has not be re-calibrated since that time as required every 5 years by NFPA 25 section 9.7.5. The Director of Maintenance (J) and the Administrator (CA) verified this finding during the facility tour and during the exit conference.	K 062		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3316

March 28, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5562022

Dear Mr. Anderson:

The above facility was surveyed on March 4, 2013 through March 7, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 1505 Pebble Lake Road #300, Fergus Falls, Minnesota 56537. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any 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(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00432	A. BUILDING: _____ B. WING _____	03/07/2013

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On March 4,5,6,7, 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; 1505 Pebble Lake Rd, Suite 300, Fergus Falls, MN 56537.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.	2 570		

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2 570	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to revise and update the plan of care when changes in interventions were identified from therapy services related to fall prevention for 3 of 3 residents (R38, R18, R51) in the sample. Findings include: R38 had diagnoses which included dementia and arthritis. A significant change Minimum Data Set (MDS) dated 12/18/12 identified severely impaired cognitive status. A corresponding Care Area Assessment (CAA) dated 12/21/12 indicated R38 triggered due to falls and history of wandering and was unsteady with transfers. The CAA identified R38 resided on the locked dementia unit due to a fear for his safety as he was cognitively unaware of safety needs and he wandered daily if he felt good. R38's plan of care dated 12/26/12, identified a risk for injury due to history of falls, which directed staff to give simple instructions, limit choices, and provide cues. However, lacked direction for R38 to be supervised at all times when in the wheelchair. An Elders Home Rehabilitation Screen, completed by therapy, dated 2/25/13 identified a recommendation for supervision while in wheelchair and "probably can restart FMP [Functional Maintenance Program] soon." On 3/6/13, at 2:12 p.m., licensed practical nurse (LPN)-A was interviewed. She stated, "Ya can't have visual contact with him (R38) at all times,	2 570		

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	00432	A. BUILDING: _____ B. WING _____	03/07/2013

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) COMPLETE DATE
2 570	Continued From page 3 when taking care of others." LPN-A indicated she was unaware of current therapy recommendations and stated she felt the current therapy recommendations were "unrealistic." She stated therapy recommendations were usually added to the plan of care by the assistant director of nursing (ADON). R18 had diagnoses which included dementia with behavioral disturbance. A quarterly MDS dated 1/23/13 identified moderately impaired cognitive status and extensive assist required for activities of daily living (ADL's). A CAA dated 8/8/12 identified resident triggered for falls due to history of wandering, unsteady when turning around, and unable to follow directions. R18's plan of care dated 11/6/12, identified risk for falls related to mobility impairments, confusion, and unaware of safety needs. The plan of care listed various interventions which included to provide a safe environment, call-light within reach, and appropriate footwear; however, the plan of care lacked direction to utilize a walker and provide closer supervision. An Elder's Home Rehabilitation Screen form, completed by therapy, dated 2/25/13 indicated therapy recommended close supervision with mobility with the aid of a walker and provide closer supervision. On 3/6/13, at 2:15 p.m. LPN-A stated R18 was independent with walking. She stated R18 sometimes remembers to use her walker and other times she does not. LPN-A stated, "I don't know if she should have constant supervision for safety," and LPN-A confirmed she was not aware of recommendations from therapy.	2 570		

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2 570	Continued From page 4 R51 had diagnoses which included Alzheimer's disease. A significant change MDS dated 1/9/13 identified severely impaired cognitive status and required extensive assist with ADL's. R51's plan of care dated 1/21/13 identified risk for falls due to confusion and listed various interventions of providing a safe environment, bed alarm, chair alarm as needed, and two hour toileting schedule; however, the plan of care lacked a recommendation from therapy for R51 to have assist with all transfers dated 2/12/13. A Physical Therapy Evaluation dated 2/12/13 indicated staff would benefit from training on safety with transfers for R51 and recommended staff to assist with all transfers. Review of the nursing notes from 9/27/12 to 3/4/13 revealed on 1/28/13 resident required extensive assistance with ambulation. On 1/31/13, resident attempts to ambulate independently. On 2/18/13, resident continues to require extensive assist with walking. On 3/6/13, at 2:18 p.m., LPN-A stated R51 had frequently attempted to transfer by herself. She indicated R51 was not safe to transfer herself without staff assist and she confirmed she was unaware of any recommendations from therapy. On 3/6/13, at 9:22 a.m. the director of nursing (DON) was interviewed. The DON confirmed the current facility policy and indicated the ADON was responsible to update all residents care plans with any therapy recommendations. On 3/7/13, at 1:25 p.m., the ADON confirmed the facility fall policy and verified the current plan of care for R38, R18, and R51 lacked revisions of	2 570		

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2 570	Continued From page 5 therapy recommendations. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are reviewing and revising the care plan as indicated and then providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement adequate interventions to prevent and/or minimize the risk of reoccurring accidents/falls in the special care unit for 3 of 3 residents (R38, R18, R51) reviewed	2 830		

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2 830	Continued From page 6 during the survey. Findings include: Residents residing in the special care unit who had experienced multiple falls were not provided with sufficient supervision to minimize the risk of accidents including falls. R38 had diagnoses which included dementia and arthritis. A significant change Minimum Data Set (MDS) dated 12/18/12 identified severely impaired cognitive status. A corresponding Care Area Assessment (CAA) dated 12/21/12 indicated R38 triggered due to falls and history of wandering and was unsteady with transfers. The CAA identified R38 resided on the locked dementia unit due to a fear for his safety as he was cognitively unaware of safety needs and he wandered daily if he felt good. R38's plan of care dated 12/26/12, identified a risk for injury due to history of falls, which directed staff to give simple instructions, limit choices, and provide cues. However, the plan of care lacked direction for R38 to be supervised at all times when in the wheelchair. In review of R38's Resident Accident/Incident Report dated 2/23/13, post fall analysis recommended R38 would not be left in wheelchair unsupervised. In addition, nurse note dated 2/23/12 identified R38 was not to be left in wheelchair unsupervised. An Elders Home Rehabilitation Screen, completed by therapy, dated 2/25/13 identified a recommendation for supervision while in wheelchair and "probably can restart FMP [Functional Maintenance Program] soon."	2 830		

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2 830	Continued From page 7 On 3/6/13, 7:16 a.m., R38 was seated at a chair in the dining room, and the alarm was clipped to the resident's shirt and a chair. No staff were in the hall or dining room area. R38 came to a standing position and sounded a personal alarm. When the alarm sounded, licensed practical nurse (LPN)-A walked from inside a resident's room to the dining room to assist R38 back to a sitting position in a recliner chair and gave the resident a magazine. LPN-A then returned down the hall to a resident room. On 3/6/13, at 7:45 a.m., R38 was seated in the dining room with two other residents, eating breakfast. No staff present in the hall or dining room at this time, until LPN-A returned to the nurses desk at 7:55 a.m. On 3/6/13, at 11:39 a.m., R38 was seated at a table in the dining room, repeatedly tapping his foot on the floor. LPN-A stated R38 was "antsy" so she fixed him a sandwich and juice, then left the main corridor area. At 12:00 p.m., R38 stood up from the chair and sounded the alarm. LPN-A entered the dining room and walked with R38 back to his room. On 3/6/13, at 2:12 p.m. LPN-A was interviewed. She stated, "Ya can't have visual contact with him (R38) at all times, when taking care of others." LPN-A indicated she was unaware of current therapy recommendations and stated she felt the current therapy recommendations were "unrealistic." She stated therapy recommendations were usually added to the plan of care by the assistant director of nursing (ADON). R18 had diagnoses which included dementia with behavioral disturbance. A quarterly MDS dated	2 830		

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2 830	Continued From page 8 1/23/13 identified moderately impaired cognitive status and extensive assist required for activities of daily living (ADL's). A CAA dated 8/8/12 identified resident triggered for falls due to history of wandering, unsteady when turning around, and unable to follow directions. R18's plan of care dated 11/6/12, identified risk for falls related to mobility impairments, confusion, and unaware of safety needs. The plan of care listed various interventions which included to provide a safe environment, call-light within reach, and appropriate footwear; however, the plan of care lacked direction to utilize a walker and closer supervision. R18 was observed on 3/6/13, at 7:16 a.m., as she was walking with a slow, shuffling gait down the hallway of the unit. R18 did not have a walker or staff present as she shuffled down the hallway. R18 continued to shuffle towards the dining room area until LPN-A entered the area and assisted her back to her room. R18 was observed again on 3/6/13, at 7:28 a.m., as she was slowly shuffling down the hallway alone, without the aid of a walker. No staff were in the area at this time. R18 sat herself in a chair at a table in the main corridor. On 3/6/13, at 2:12 p.m., while interviewing LPN-A at the nurses station, R18 was observed shuffling in the hall alone without the aid of a walker. She walked to a table in the main corridor and stood there looking at newspapers on the table. LPN-A stated, "we have to let her do her own thing or she becomes anxious and frustrated." On 3/7/13, at 1:28 p.m., R18 was again observed ambulating with a shuffling gait, alone down the	2 830		

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2 830	Continued From page 9 main corridor of the unit without the aid of a walker. In review of R18's medical record, she had falls on 2/16/13, 1/5/13, 1/2/13, 10/13/12, and 9/6/12, all unwitnessed in which staff found resident on floor. An Elder's Home Rehabilitation Screen form, completed by therapy, dated 2/25/13 indicated therapy recommended close supervision with mobility with the aid of a walker and closer supervision with mobility. On 3/6/13, at 2:15 p.m. LPN-A stated R18 was independent with walking. She stated R18 sometimes remembers to use her walker and other times she does not. LPN-A stated, "I don't know if she should have constant supervision for safety," and LPN-A confirmed she was not aware of recommendations from therapy. R51 had diagnoses which included Alzheimer's disease. A significant change MDS dated 1/9/13 identified severely impaired cognitive status and required extensive assist with ADL's. R51's plan of care dated 1/21/13 identified risk for falls due to confusion and listed various interventions of providing a safe environment, bed alarm, chair alarm as needed, and two hour toileting schedule; however, the plan of care lacked a recommendation from therapy for R51 to have assist with all transfers dated 2/12/13. On 3/6/13, at 7:45 a.m., R51 was observed sitting in the dining room area with other residents. No staff were observed in the hall or dining room area until LPN-A returned to the area at 7:55 a.m. In review of R51's medical record, she had experienced a total of 14 falls from 9/15/12 to	2 830		

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2 830	Continued From page 10 2/2/13. On 2/2/13, R51 was sitting in the dining room area and was found sitting on the floor after the alarm sounded. The fall was unwitnessed but R51's wheelchair was pushed away from her. A Physical Therapy Evaluation dated 2/12/13 indicated staff would benefit from training on safety with transfers for R51 and recommended staff to assist with all transfers. Review of the nursing notes from 9/27/12 to 3/4/13 revealed on 1/28/13 resident required extensive assistance with ambulation. On 1/31/13, resident attempts to ambulate independently. On 2/18/13, resident continues to require extensive assist with walking. On 3/6/13, at 2:18 p.m., LPN-A stated R51 had frequently attempted to transfer by herself. She indicated R51 was not safe to transfer herself without staff assist and she confirmed she was unaware of any recommendations from therapy. On 3/6/13, at 9:22 a.m. the director of nursing (DON) was interviewed. The DON confirmed the current facility policy and indicated the ADON was responsible to update all residents care plans with any therapy recommendations. On 3/7/13, at 1:25 p.m., the ADON confirmed the facility fall policy and verified the current plan of care for R38, R18, and R51 lacked revisions of therapy recommendations. A Fall Prevention Policy revised 5/11/10, identified an analysis would be conducted with each fall, appropriate interventions would be implemented, and therapy would make recommendations for interventions in attempt to prevent further falls.	2 830		

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2 830	Continued From page 11 SUGGESTED PERIOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents consistently are provided the appropriate interven. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 830		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness. Ceiling air vents and windows over the food service and/or near food preparation areas were not maintained in a clean, sanitary condition which had the potential to affect all 47 residents residing in the facility who were served food out of the kitchen. Findings include: During tour on 3/6/13 at 1:25 p.m. the following	21015		

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21015	Continued From page 12 sanitation problems were observed when entering the kitchen area from the common corridor: - Ceiling air vent approximately 24" X 24" to left of stationary steamtable had a heavy buildup of dust and was blowing air down towards the steam table. - Ceiling air vent approximately 12" X 12" to right of stationary steamtable had a heavy buildup of dust and was blowing air down towards the steam table. - Ceiling air vent approximately 24" X 24" located to left of the convection oven had dust buildup and was blowing air down within 2 feet of the food preparation area, having the potential for food contamination. - Ceiling air vent approximately 24" X 24" located over the True standup freezer in right corner of the kitchen prep area had noticeable dust buildup. - Two windows approximately 19 1/2" wide X 33" long over the two compartment sink were dirty and had blown tree seed debris on the screen that was inside the kitchen area. On initial tour on 3/4/13 at 1:15 p.m., the right window was observed to be open and blowing air which had the potential to contaminate food in the kitchen area. When interviewed on 3/6/13 at 1:30 p.m., the dietary manager confirmed the vents were dusty and needed cleaning. On 3/6/13 at 1:38 p.m. the maintenance manager (MM) stated he was unaware of a maintenance cleaning schedule for the vents. MM verified the vents needed cleaning. On 3/6/13 at 1:30 p.m., the Administrator (A) stated he was not aware of a cleaning schedule or policy for cleaning the vents. (A) further stated the facility had a changeover in maintenance	21015		

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21015	Continued From page 13 personnel and he realizes "some things have fallen in the cracks" and they may have just done the maintenance without a schedule. No further information was provided. A SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review and revise food service policies and procedures to assure that food is stored and served in a sanitary manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as	21390		

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21390	Continued From page 14 defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sanitary technique was used for 1 of 2 residents (R4), whose dressing change was observed. Findings Include: During observations of R4's dressing change, RN-A failed to wash her hands after touching the soiled incontinent product, before setting up dressing supplies, and between removing the soiled dressing and applying a clean dressing. R4's diagnoses included a current stage 3 pressure ulcer to right buttocks, (measuring 3.0 cm x 1.6 cm x 3.6 cm, and had granulation tissue) multiple sclerosis, and hemiplegia. The quarterly Minimum Data Set (MDS) dated 1/11/13, indicated cognitively intact and had a pressure ulcer. R4's physician's orders dated 2/26/13 directed staff to change dressing daily. R4's right buttocks wound dressing change was observed on 3/6/13 at 9:20 a.m. with registered nurse (RN)-A. RN-A washed her hands and then assisted R4 with turning on her side and removed a soiled incontinence brief. RN-A then set up the dressing supplies with her soiled hands, including opening a clear dressing package, holding gauze in her hand and soaking it with normal saline, cutting a rope dressing and placing these items on the clear dressing package. RN-A then	21390		

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21390	Continued From page 15 donned gloves, removed the soiled dressing with her right hand, which had been moderately saturated with a brown substance, placed that in a waste basket and removed only her right glove. RN-A replaced the right glove without washing her hands. RN-A then removed a cotton swab from a mailing envelope and probed the tunneling wound. Then RN-A used the same cotton swab to push a rope dressing into the wound, and replaced her right glove again without washing her hands. RN-A placed a cover dressing, assisted R4 with repositioning and then washed her hands. RN-A was interviewed on 3/6/13 at 12:00 p.m., and when asked about removing gloves several times during the dressing change, RN-A stated that "I should have washed my hands or used sanitizer before putting new gloves on." The director of nursing (DON) was interviewed on 3/6/13 at 1:48 p.m. and stated RN-A should have washed her hands between glove changes, before setting up supplies, and between removing the soiled dressing and placing a clean dressing. Facility policy, dated 8/2003 and revised on 1/2010, and entitled, " Elders Home Hand Washing Policy " and " Dressing Change (Clean) " directed staff to proper and appropriate hand washing techniques that will aid in the prevention of transmission of infections when utilized: the use of gloves does not replace hand washing, after handling used dressing, contaminated tissue, after contact with body fluids, secretions, excretions, and broken skin. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure proper infection	21390		

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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) COMPLETE DATE
21390	Continued From page 16 control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21390		
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb	21415		

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21415	Continued From page 17 · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure all health care workers (HCWs) received a baseline tuberculosis (TB) screening to include a 2 step tuberculin skin test (TST), for 2 of 6 (maintenance manager(MM-A) and nursing assistant (NA)-A) employees reviewed for this screening. Findings include: MM-A was hired by the facility on 1/23/13. The Baseline TB Screening Tool for Health Care Workers form revealed MM-A had received a first step TST on 1/28/13, and results interpreted on 1/30/13. However, MM-A had not received the second step TST until 3/5/13, a total of 36 days after the first step TST.	21415		

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21415	Continued From page 18 NA-A had been hired by the facility on 2/7/13. The Baseline TB Screening Tool for Health Care Workers form revealed NA-A had received a first step TST on 2/7/13, and results interpreted on 2/9/13. However, the second step TST had not been completed for NA-A . When interviewed on 3/6/13 at 11:30 a.m., the director of nursing (DON) confirmed the facility policy and stated MM-A and NA-A should have received a second step TST within 1-3 weeks from the first step TST. An undated facility policy titled M. Tuberculosis Program for Health Care Workers, identified " All HCW will have a TST within three months prior to employment and a 2nd step 1-3 weeks later. " SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure TB policies and procedures were developed and implemented to ensure completion of the two step mantoux for all newly hired employees. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21415		