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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: K8N8

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 11/10/2014 4)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **113** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	113			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Reduction in the number of certified SNF/NF beds from 113 beds to 106 beds effective October 3, 2014, in accordance with a change in licensure. In accordance with Minn. Stat. 144A.071, Subd. 4B., as amended by the Minnesota Legislature, seven beds are being placed on layaway status effective October 3, 2014. All 106 facility beds are certified SNF/NF.

17. SURVEYOR SIGNATURE — Date :
Timothy Rhonemus, HFE NE II — 11/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, HFE NE II — 11/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/25/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/17/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245494
Electronically delivered November 18, 2014

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

Dear Mr. Lundeen:

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

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

Effective October 20, 2014 the above facility is certified for or recommended for:

106 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 106 skilled nursing facility beds.

Your request for waiver of has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

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,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 18, 2014

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

RE: Project Number S5494023

Dear Mr. Lundeen:

On September 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 11, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 10, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 20, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 11, 2014, effective October 20, 2014 and therefore remedies outlined in our letter to you dated September 29, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245494	A. Building B. Wing	11/10/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/20/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/20/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **10/20/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **10/20/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/20/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **10/20/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **10/20/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **10/20/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	11/18/2014	20794	11/10/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/11/2014			

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

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(L2) **615342900**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/11/2014** (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

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From (a) :
To (b) :

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

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X A. In Compliance With Program Requirements
Compliance Based On:
X 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: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	113			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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Reduction in the number of certified SNF/NF beds from 113 beds to 106 beds effective October 3, 2014, in accordance with a change in licensure. In accordance with Minn. Stat. 144A.071, Subd. 4B., as amended by the Minnesota Legislature, seven beds are being placed on layaway status effective October 3, 2014. All 106 facility beds are certified SNF/NF.

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NE II — 10/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 11/14/2014 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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03001
(L31)

30. REMARKS
Posted 11/17/2014 Co.

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

Electronically delivered
September 29, 2014

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

RE: Project Number S5494023

Dear Mr. Lundeen:

On September 11, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the September 11, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5494014 that was found to be unsubstantiated.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 21, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 21, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 11, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 11, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	09/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5494014 was completed. The complaint was not substantiated. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to properly assist and provide activities of daily living (ADL's) in a timely, dignified manner for 3 of 15 residents (R78, R41, R27) observed that were dependent upon staff for ADL's.	F 241	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of a deficiency was	10/20/14

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

Electronically Signed | 10/09/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	09/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 Findings include: R78's quarterly Minimum Data Set (MDS), dated 7/3/14, indicated R78 had short and long term memory problems, and required extensive assistance from staff for personal cares. During observation on 9/8/14, at 5:22 p.m., R78 was seated at the dining room table with other residents and had long facial hair on her upper lip and chin. Subsequent observations were completed on 9/9/14 at 9:29 a.m., 9/10/14 at 12:04 p.m., and 9/11/14 at 9:11 a.m. of R78 which continued to have long facial hair on her upper lip and chin. During interview on 9/11/14, at 10:11 a.m., nursing assistant (NA)-B stated routine shaving should be completed on female resident and R78's facial hair should have been removed. During a telephone interview, on 9/11/14, at 10:31 a.m., family member (FM)-A stated it was abnormal for R78 to have facial hair and it should be removed. FM-A further stated R78 would have been embarrassed to be seen with facial hair. During interview on 9/11/14, at 3:51 p.m., the director of nursing (DON) stated grooming should be routinely done on all residents. Further, the DON stated R78 should have been shaved. R41 annual Minimum Data Set (MDS) dated 8/22/14, identified R41 had diagnoses of dementia with behavioral disturbances, Alzheimer's disease, anorexia and depression.	F 241	correctly cited or factually based and it□s also not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. F241- Dignity and respect of individuality Regarding cited residents: Resident R 78 was assisted with the removing of her unwanted facial hair. Her care plan and NAR assignment sheet updated. R41 will be asked prior to application. The clothing protector will be placed on resident gently only after an explanation is given. R 27 met with both nursing and social services to establish a schedule in relation to providing cares. Risk vs benefits of mobility and skin integrity also discussed. Staff to provide assistance with cares as per resident preference. Actions taken to identify other potential residents having similar occurrences: Residents will continue to be groomed daily per their preferences. Shaving will be offered, if facial hair is observed. Staff will assist as per the care plan and PRN. Residents will be offered a clothing protector prior to the application. If a resident is unable to answer, staff will still continue to explain the procedure prior to applying the clothing protector/napkin. Residents are offered a choice in their plan of care. All efforts to meet the	

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F 241	Continued From page 2 The MDS also identified R41 was severely cognitively impaired and required extensive assistance of two staff for most of R12's activities of daily living (ADLs) including extensive assist of one at meal times. During meal time observations on 9/8/14 at 4:50 p.m., R41 was observed at the dining room table with a glass of water and a shirt protector on the table in front of her. The NA-B approached R41, and without first explaining to the resident about placing a shirt protector on them. NA-B picked up the shirt protector and placed the protector on the R41's right shoulder, and then flung the remaining portion of the protector across the front of R41's face to her left shoulder and attached it the protector behind R41's neck. R41's was startled while the protector was flung across her face, and jumped back in her chair. NA-B then stated, "Are you ready for supper." During interview on 9/11/14 at 10:30 a.m., the registered nurse (RN)-B stated that NA-B should not have flung the shirt protector across R41's face while placing it on the resident. R27's annual Minimum Data Set (MDS) 5/16/14, indicated she was cognitively intact, and was dependent in transfers and toileting with a mechanical lift. During an interview on 9/10/14, at 1:12p.m. R27 was very upset and loud as she stated, "I have to wait as long as 48 minutes and use the commode. They stopped [by the room] but then they did not show up." R27 was incontinent in the brief and stated she had told the staff at a care	F 241	individualized care needs are provided by nursing. Measures put in place to ensure deficient practice does not occur: Policy and procedure for shaving a resident updated. Meal service policy and procedure updated. Audits to observe dining room activity and grooming will be done weekly and prn. Care audits to be done weekly and prn. Call light audits will be completed weekly and prn. Staff is to be re-educated on the importance of dignity/grooming, explaining a procedure prior to performing task and assisting resident in a timely manner. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/20/14. Those responsible to maintain compliance will be: DON or designee.	

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F 241	Continued From page 3 conference early in the morning and sometimes around luch time that, "I always wait. They know I like to get up early and they make me wait until 10:00 a.m. to get up. By then breakfast is almost done." (Open dining is 8:00 a.m. - 10:00 a.m. for breakfast.) R27 reported she has problems with incontinence in her brief at least weekly, because she does not receive timely assistance by staff. R27 stated," Sometimes they come in and say they will come back and they just go in the hall and talk." A facility policy on dignity was requested, but none was provided.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow established care plan interventions for 2 of 8 residents (R32, R126) who needed assistance with meals and grooming as identified in the care plan. Findings include: R32's quarterly Minimum Data Set (MDS), dated 7/19/14, indicated R32 had moderate cognitive impairment, required supervision with eating, and extensive assistance with activities of daily living (ADLs).	F 282	F282 Services by qualified persons/per care plan- Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: R 32 was reviewed and his CP updated with his laying his head on the table. NP updated on his status and potential for not sleeping. Medications reviewed. Actiwatch (wrist device used to monitor sleeping	10/20/14

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F 282	Continued From page 4 R32's care plan, dated 8/25/14, indicated R32 required staff help to open packages, cut up foods, and apply condiments as needed. During a dining observation on 9/9/14 at 12:17 p.m., R32 was sitting in the Skyview (SV) dining room at a table with other residents in a wheelchair. R32 had his arms at his side, and forehead lying on the table with his eyes closed. During this time several unknown nursing assistants (NA's) were observed to pass plated food to other residents in the same dining room, walking past R32 (with his head on the table). An un-identified NA placed a plate of food in front of R32, she made no attempts to wake or assist R32 to eat. After approximately 20 minutes, R32 lifted his head and stared at the plate of food for several minutes, making no attempts to feed himself. R32's tablemate stated to staff in the area that R32 needed to be moved closer to the table, however staff did not respond. R32's tablemate then cut up R32's chicken and R32 proceed to start eating his meal. A subsequent observation of R32 seated in his wheelchair at the dining room table with his head on the table was made on 9/11/14, at 12:06 p.m.. NA-A placed a plate of Salisbury steak, mashed potatoes, and a mixed vegetable medley in front of R32, at 12:20 p.m., and walked away without waking or assisting R32 with his meal. R32's tablemate asked staff to cut up the meat for him (R32) to which staff replied they would return and do it. R32 began attempting to cut up his meat at 12:35 p.m., however was unable to do so. R32 placed a fork in the steak patty, and picked up the entire steak from the plate and began to take several bites from the steak. R32's tablemate	F 282	patterns) was offered; he declined, but will be re-approached. Staff feels that he lays head down related to his HOH. A pocket talker was given to the resident to utilize during meals. His care plan and NAR assignment sheet were updated. R 126□s CP and NAR assignment sheet updated with residents need for staff to monitor dressing and the removal of soiled clothing and daily. Actions taken to identify other potential residents having similar occurrences: Residents who were identified as needing assistance at meals were reviewed by nursing and dietary. Updates made to forms listing the diets, assistance needs and preferences were placed into the homemaker□s binders. New admits re-admits and those identified by staff as a change of condition will be reviewed for assistance needs during meals. Measures put in place to ensure deficient practice does not occur: Homemaker job duties were reviewed and updated. They will now oversee the cutting of food, opening of packages and set up of assistive devices. Audits to observe dining room activity and will be done weekly and prn. Homemaker job duties were updated to include checking for soiled linens and clothes left in the resident rooms during their laundry rounds. Audits on homemaker findings will be done weekly and prn. Elim Care policy and procedure on linen handling was updated. Staff is to be educated on newly updated	

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F 282	Continued From page 5 again asked staff to cut up his meat, which was completed by an un-identified NA. R32 ate almost all of his served food after being provided assistance from staff. When interviewed on 9/11/14, at 1:01 p.m., NA-D stated R32 should have had staff assistance to cut up his meat and not been left at the table with other residents if he was sleeping. When interviewed on 9/11/14 at 2:56 p.m., the director of nursing (DON) stated she was unaware the tablemate's cutting up R32's food and verified staff should have followed the care plan. R126 quarterly minimum data set (MDS) dated 7/1/14, identified R126 had diagnoses of prostate, colon cancer and dementia. The MDS also identified R126 was severely cognitively impaired, and only required oversight with no physical assistance with dressing and grooming. R126's care plan (lasted edited 1/3/14), identified R126 was independent with supervision with dressing and grooming. However, under the listed approaches the following was documented: "Supervision with dressing and grooming. Will wash up and change clothes with cues. Otherwise will not wash up and hang up soiled clothing in the closet." During telephone conversation with R126's family member (FM)-B, on 09/09/14 at 1:10 p.m., FM-B stated she visits frequently during the week, and had been noticing that R126 had been washing out his underwear and hanging/laying the items	F 282	homemaker duties to include the oversight of staff when assisting residents and the new duty of linen removal prn. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/20/14. Those responsible to maintain compliance will be: DON or designee.	

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F 282	Continued From page 6	F 282		

around his room and in his closet. FM-B stated that when she visits and notices this, she places the items in the laundry to wash, due to them being stained yellow. FM-B felt the staff should be checking with him and his laundry to assure his clothes are clean and not being re-worn before they are laundered.

During room observations with R126, on 9/10/14 at 9:00 a.m., R126 showed surveyor around his room at various art and wood projects that he had created which he was proud of. When asked about his clothing, R126 opened his closet and showed surveyor the white pair of tennis shoes he had. On top of the shoes was a pair of yellow stained underwear. The resident stated, his apartment did not have a laundry service, so "I do my best and wash them out in my sink. I lay them in here to dry." In R126's closet there were three pairs of underwear laying throughout the bottom of the closet and one pair hanging out of the top drawer of a four drawer clear plastic Rubbermaid style cabinet.

In an interview on 9/10/14 at 9:30 a.m., the trained medication assistant (TMA)-A, stated that R126 dresses and grooms himself, and that staff are to only provide oversight when he comes out of his room. We make sure that his clothing matches, buttons are buttoned, zippers are zipped and he is dressed appropriately. When asked about his laundry needs, TMA-A stated that staff place the clean laundry in his closet and should be removing any soiled clothes they notice.

When asked, that facility provided a undated document entitled: Standards of Care / Expectations. However, there was not mention of

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F 282	Continued From page 7 what staff were to do for residents in regards to laundry. During interview on 9/11/14 at 9:10 a.m., 0910, registered nurse (RN)-B verified R126 needed more oversight for his dressing and grooming as identified in the care plan.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to properly assist a resident with eating for 1of 1 resident (R32) who needed supervision with eating. Findings include: R32's quarterly Minimum Data Set (MDS), dated 7/19/14, indicated R32 had moderate cognitive impairment, needed extensive assistance with activities of daily living (ADLs) and required supervision with eating. R32's care plan, dated 8/25/14, indicated R32 required staff help to open packages, cut up foods, and apply condiments as needed. During a dining observation on 9/9/14 at 12:17 p.m., R32 was sitting in the Skyview (SV) dining room at a table with other residents in a wheelchair. R32 had his arms at his side, and	F 311	F 311- Treatment/services to improve/maintain ADL□s Elim Care and Rehab Center has the expectation that staff will show competence and continued compliance of the following plan: Regarding cited residents: R 32 was reviewed and his CP updated with his laying his head on the table. NP updated on his status and potential for not sleeping. Medications reviewed. Actiwatch (wrist device used to monitor sleeping patterns) was offered; he declined, but will be re-approached. Staff feels that he lays head down related to his HOH. A pocket talker was given to the resident to utilize during meals. His care plan and NAR assignment sheet were updated.	10/20/14

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F 311	Continued From page 8 forehead lying on the table with his eyes closed. During this time several unknown nursing assistants (NA's) were observed to pass plated food to other residents in the same dining room, walking past R32 (with his head on the table). An un-identified NA placed a plate of food in front of R32, she made no attempts to wake or assist R32 to eat. After approximately 20 minutes, R32 lifted his head and stared at the plate of food for several minutes, making no attempts to feed himself. R32's tablemate stated to staff in the area that R32 needed to be moved closer to the table, however staff did not respond. R32's tablemate then cut up R32's chicken and R32 proceed to start eating his meal. During interview on 9/9/14, at 12:50 p.m., NA-C stated, "she [referring to the resident seated next to R32] just looks out for [R32] so she relays what he wants to us". NA-C further stated R32 has placed his forehead on the table in the past, "...his face on the table is normal." A subsequent observation of R32 seated in his wheelchair at the dining room table with his head on the table was made on 9/11/14, at 12:06 p.m.. NA-A placed a plate of Salisbury steak, mashed potatoes, and a mixed vegetable medley in front of R32, at 12:20 p.m., and walked away without waking or assisting R32 with his meal. R32's tablemate asked staff to cut up the meat for him (R32) to which staff replied they would return and do it. R32 began attempting to cut up his meat at 12:35 p.m., however was unable to do so. R32 placed a fork in the steak patty, and picked up the entire steak from the plate and began to take several bites from the steak. R32's tablemate again asked staff to cut up his meat, which was completed by an un-identified NA. R32 ate	F 311	Actions taken to identify other potential residents having similar occurrences: Residents who were identified as needing assistance at meals were reviewed by nursing and dietary. Updates made listing the diets, assistance needs and preferences were placed into the homemaker□s binders. New admits re-admits and those identified by staff as a change of condition will be reviewed for assistance needs during meals. Measures put in place to ensure deficient practice does not occur: Homemaker job duties were reviewed and updated. They will now oversee the cutting of food, opening of packages and set up of assistive devices. Audits to observe dining room activity and will be done weekly and prn. Staff is to be educated on newly updated homemaker duties to include the oversight of staff when assisting residents. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/20/14. Those responsible to maintain compliance will be: DON or designee.	

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F 311	Continued From page 9 almost all of his served food after being provided assistance from staff. When interviewed on 9/11/14, at 1:01 p.m., NA-D stated R32 would frequently place his forehead on the table. NA-D stated R32 struggles with sleep at times during the night, and frequently is observed to have his head on the table during meal service. Further, NA-D stated R32 should have had staff assistance to cut up his meat and not been left at the table with other residents if he was sleeping. When interviewed on 9/11/14 at 2:56 p.m., the director of nursing (DON) stated she was unaware of tablemate's cutting up R32's food. Further, the DON stated R32 having his head on the table during meals was not respectful and should not be happening.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete routine grooming for 1 of 4 residents (R78), whom was dependant on staff for activities of daily living. Findings include:	F 312	F 312- ADL care provided for dependent residents Elim Care and Rehab Center has the expectation that staff will show competence and continued compliance of the following plan:	10/20/14

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F 312	Continued From page 10 R78's quarterly Minimum Data Set (MDS), dated 7/3/14, indicated R78 had short and long term memory problems, and required extensive assistance from staff for personal cares (including grooming). R78's care plan, dated 7/10/14, indicated R78 required extensive (physical help from another person) assistance for an alteration in her ability to complete ADL's. During observation on 9/8/14, at 5:22 p.m., R78 was seated at the dining room table with other residents, she had long facial hair on her upper lip and chin. Subsequent observations of R78 were made on 9/9/14 at 9:29 a.m., 9/10/14 at 12:04 p.m., and 9/11/14 at 9:11 a.m.. R78 continued to have long facial hair on her upper lip and chin. During interview on 9/11/14, at 10:11 a.m., nursing assistant (NA)-B stated routine shaving should be completed on female residents and R78's facial hair should have been removed. When interviewed on 9/11/14, at 10:20 a.m., licensed practical nurse (LPN)-B stated R78 was dependant on staff for grooming and care and R78's facial hair should have been removed. When interviewed on 9/11/14, at 11:01 a.m., registered nurse (RN)-D stated grooming was expected to be completed daily on all residents. RN-D stated the facial should have been removed. RN-D further stated daily grooming to be, "...a standard of practice for nursing assistants." During interview on 9/11/14, at 3:51 p.m., the	F 312	Regarding cited residents Resident R 78 was assisted with the removing of her unwanted facial hair. Her care plan and NAR assignment sheet updated. Actions taken to identify other potential residents having similar occurrences: Residents will continue to be groomed daily per their preferences. Shaving will be offered, if facial hair is observed. Staff will assist as per the care plan and PRN. Measures put in place to ensure deficient practice does not occur: Policy and procedure for shaving a resident updated. Audits to observe dining room activity and grooming will be done weekly and prn. Staff is to be educated on the importance of dignity/grooming. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/20/14. Those responsible to maintain compliance will be: DON or designee	

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F 312	Continued From page 11 director of nursing (DON) stated grooming should be routinely done on all residents and R78 should have been shaved. An undated facility Standards of Care/Expectations policy did not include an expectation or standard on how often shaving should be completed for residents.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess, complete thorough monitoring or change pressure ulcer interventions to prevent further skin breakdown for 1 of 1 resident (R1) with pressure ulcers that resulted in actual harm for R1. Findings include: R1's initial Minimum Data Set (MDS) dated 5/30/14, identified diagnoses of anemia, diabetes mellitus type II , arthritis, and non-Alzheimer's	F 314	F 314, SS=G Treatment/SVCS to prevent/heal pressure sores It is the policy of Elim Care and Rehab Center to identify and assess residents who are at risk for pressure ulcers or other potential impairments of skin integrity. Elim Care and Rehab Center strives to ensure that residents entering the facility will not develop a pressure ulcer unless the individual□s clinical condition demonstrated unavoidable skin breakdown. Elim Care and Rehab Center implements interventions and treatment in	10/20/14

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F 314	Continued From page 12 dementia. In addition, the MDS indicated R1 had moderate cognitive impairment, was incontinent of bladder, needed assist of 1-2 persons for bed mobility, needed assist for activities of daily living, was dependent on a mechanical lift to transfer from bed to wheelchair/toilet, and was non-ambulatory. R1 was identified at risk for developing pressure ulcers and had two pressure ulcers at stage II (partial thickness loss of dermis as shallow open ulcer with a red or pink wound bed without slough) upon admittance to the facility. The pressure ulcer Care Area Assessment (CAA) dated 6/5/14, identified a Braden scale (a tool used to determine pressure ulcer risk) score of 18, indicating a high risk for pressure ulcer development. The CAA identified, "Resident was admitted with two pressure ulcers to her coccyx area that staff are treating." The CAA also indicated R1 was repositioned every 2 hours and as needed, and was at risk for impaired skin integrity due to impaired mobility, impaired cognition, incontinence, antidepressant medication use and diagnosis of diabetes. R1 required a specialized mattress and cushion in her wheelchair to reduce pressure. R1's care plan dated 6/10/14, identified potential for altered skin integrity related to a history of pressure ulcers to the coccyx. The care plan directed the staff to apply Baza (barrier cream) per physician's order dated 5/23/14, three times per day to pressure ulcer(s), assess pressure ulcer for stage, size and length, presence of granulation and epithelization, and assess condition of surrounding skin weekly. The care plan also indicated R1 had a pressure relieving mattress and cushion for her wheelchair.	F 314	accordance with resident needs, goals and recognized standards of practice, addresses the potential for infection, monitors and evaluates residents responses to the same and revises Elim Care and Rehab Center s approaches as appropriate. Regarding cited residents: R1 was observed to have skin impairments when observed on 9/10/14. NP diagnoses of these areas are candidiasis and excoriation of the buttocks. A UA/UC was obtained, showing yeast in her urine, supporting this diagnosis. Resident s status continued to decline, due to terminal diagnosis. Resident signed up with hospice on 9/26/14. Resident was placed an alternating pressure mattress and continued to be turned and repositioned per her comfort level, not to exceed her previously care planned timing of 2 hours side to side in bed and 1.5 hours if able to get up into wheelchair. Resident continued to decline in status and skin was monitored. Resident passed away on 10/4/14. Actions taken to identify other potential residents having similar occurrences: All residents who have a noted pressure ulcer were reviewed by designated nursing staff. Each floor of the facility has a designated nurse to observe and document on wounds. Upon resident s admit/re-admit, nursing staff will view noted skin impairments and, if identified as a pressure area, the designated nurse will include them on their wound rounds.	

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F 314	Continued From page 13 Nursing staff was to provide an update on R1's pressure ulcer progress to both the director of nursing (DON) and the dietician weekly. Staff were directed to reposition R1 every two hours, encourage side to side in bed, and limit time in wheelchair to 1.5 hours. During observation on 9/9/14, at 3:25 p.m.. R1 was observed to have just returned from a music program and was seated in her wheelchair on a pressure relieving cushion. During this time, R1 was observed to slide down in her wheelchair and to be able to boost herself back into the seat of the wheelchair. She continued this repetitive motion several times. R1 stated she was not uncomfortable. At 3:40 p.m. nursing assistant (NA) -C was observed to approach R1 and ask if she would like to go to the bathroom. R1 responded yes, and NA-C got an EZ-stand mechanical lift and assisted R1, with co-worker NA-Z, into the bathroom. During the observation it was noted R1 had two Allevyn dressings over the two pressure areas proximal to the coccyx. R1 had been incontinent of urine and also voided urine into the toilet. NA-C stated we ask [R1] if she needs to use use the bathroom every two hours and she is repositioned at the same time. During observation of pressure ulcer on 9/10/14, at 8:55 a.m. registered nurse (RN)- D stated she performs wound care every three days as ordered by the physician. R1 was in bed lying on her left side on a pressure relieving mattress while RN-D removed R1's incontinence pad. There were no dressings noted on the two pressure ulcers (PU). RN-D measured and described the pressure ulcers as follows: Right; open area on buttock 1.3 centimeters (cm) x 1.2 cm, 50% granulation and 50% slough, minimal	F 314	Measures put in place to ensure deficient practice does not occur: Facility will do skin assessments on admit and re-admit of all residents. All new skin impairments are discussed at the daily IDT stand up meeting. Weekly skin checks are done by nursing staff. All wounds are monitored weekly by the designated wound nurse. Weekly F314 audits showing measurements are completed and turned in to DON. Education for wound nurses on proper documentation of wound staging, measurement techniques and treatments completed with DON/ADON. Education also provided to all nursing on the proper use of forms related to event tracking on separate appropriate forms and the difference between a clinical condition and a pressure ulcer. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/20/14. Those responsible to maintain compliance will be: DON or designee.	

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F 314	Continued From page 14 serous drainage. Left open area on buttock was 1.2 cm X 1.0 cm, 50% granulation, 50% slough and minimal serous drainage. There was a center crease open area 1.0 cm x 0.2 cm, 100% granulation, which was a new pressure ulcer. All three pressure ulcers had no depth and were identified as stage II. The pressure ulcers were cleaned with Derma wound cleanser and then an Allevyn dressing (foam bandage) was applied to all three pressure areas. RN-D stated she was not aware of the third pressure ulcer that had developed on the center area of R1's buttocks until now. Review of the facility Skin Integrity Events (SIE)-Elim Pressure Ulcer Follow Up form that was used to document the pressure ulcers on a weekly basis identified the following: The SIE form dated 5/23/14, indicated R1 had a left pressure ulcer measuring 0.6 cm x 0.5 cm, right pressure ulcer 0.4 cm x 0.4 cm, stage II, 100% granulation, no drainage, no odor and no pain reported by R1, and identified friction and shear could be a potential problem. The "wound note" dated 5/23/14, indicated a, "Braden score 17 [at risk for pressure ulcer development]," treatment provided was Baza protect (barrier cream) twice a day and Calmoseptine cream (a cream used for pain) three times a day to coccyx area, as identified in the initial physician orders dated 5/23/14. There was no distinction if the description of the pressure ulcers characteristics were for the left, right or both pressure ulcers. The SIE form dated 5/27/14, identified right coccyx pressure ulcer was 3 cm x 2 cm, stage II 100 % granulation, no drainage and no odor, no reported pain by R1. The "wound note" dated	F 314		

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5/27/14, identified "Area is showing improvement" it (right) measures 4 cm x 2 cm and is 100% epithelial tissue. Tissue surrounding wound was is intact. She denies pain to the area. Barrier cream applied. There was no indication that left pressure ulcer was measured at this time. Also the pressure ulcer had increased from 0.6 cm x 0.5 cm to current size of 3 cm x 2 cm.

The SIE form dated 6/3/14, identified right coccyx pressure ulcer was 3 cm x 2 cm, stage II, 75% epithelial, 25% granulation, 25% slough, no drainage, no odor, and pain present at site. The left pressure ulcer was 4 cm x 2 cm. The "wound note" dated 6/3/14, identified "Areas to buttocks worse" both areas are "red, 10% granulation, 15% slough, 75 % epithelial, surrounding skin is intact, no drainage." New physician orders was given for Calmoseptine to wound on buttocks every shift until healed and then as needed (PRN). The size of the right pressure ulcer stayed the same however we can not determine if left pressure ulcer changed as it was not measured on 5/27/14. Also, there was no distinction if the pressure ulcers characteristics were for the left, right or both pressure ulcers.

The SIE form dated 6/10/14, identified right coccyx pressure ulcer 3 cm x 2 cm, stage I, 75% epithelial, 25% granulation and 0% slough no drainage no odor, and pain present at site. Left pressure ulcer was 3 cm x 2 cm. The "wound note" dated 6/10/14, identified "Area is showing improvement...Tissue is 75% epithelial and 25 % granulation. Tissue surrounding area was intact no drainage noted. [R1] reports pain to area which is relieved by repositioning...ordered cream applied." Review of physician orders does not identify any new orders received on this date. R1

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F 314	Continued From page 16 has pain at site according to SIE. There was no distinction if the characteristics of the pressure ulcers was for the left, right or both pressure ulcers The SIE form dated 6/17/14, identified right coccyx pressure ulcer 2 cm x 1 cm, (no stage identified) 75% epithelial, 25% granulation, and 0% slough, serous drainage, no odor, and pain present at site. Left pressure ulcer was 4 cm x 2 cm. There was no "wound note" written for this date even though the left pressure ulcer had increased in size from 3 cm x 2 cm on 6/10/14 to 4 cm x 2 cm on 6/17/14. Also, the drainage had changed and there was serous drainage, in either one or both of the pressure ulcers. There was no distinction if the characteristics of the pressure ulcers was for the left, right or both pressure ulcers The SIE form dated 6/24/14, identified left coccyx pressure ulcer 1 cm x 0.4 cm, stage II, 100% granulation tissue, and no drainage. The "wound note" dated 6/24/14, identified "Area is showing improvement, reports burning pain to the area. Scheduled pain medication given." Although the left pressure ulcer was measured there was no indication of a right pressure ulcer as being open or healed. The SIE form dated 7/01/14, identified left coccyx pressure ulcer 0.8 cm x 0.3 cm, stage II 100% granulation tissue and no drainage. No "wound rounds" note was written for this date, nor was there any documentation on right pressure ulcer. Although the left pressure ulcer was measured there was no indication if the right pressure ulcer was healed or open.	F 314		

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F 314	Continued From page 17 The SIE form dated 7/8/14, identified left coccyx pressure ulcer 0.5 cm 0.5 cm, stage II, 100% epithelial tissue, and no drainage. The "wound note" dated 7/8/14, identified, "Area is showing improvement, tissue surrounding is intact but erythematous, resident reports burning to the area and scheduled pain medication given. Area cleansed and ointment applied." Although the left pressure ulcer was measured there was no indication of a right pressure ulcer as being open or healed. The SIE form dated 7/15/14, identified left coccyx pressure ulcer 1.5 cm x 1 cm, which was not staged, 75% epithelial and 50% granulation and no drainage. The "wound note" dated 7/15/14, identified ..."on the left there is an area appears abraded with several superficially open areas. Has area on right butt crease with a superficially open area of 0.5 cm x 0.5 cm that was 100% granulated. Resident did complain of burning pain with cleansing, scheduled pain medication given one hour before assessment." The SIE form dated 7/22/14, identified left coccyx pressure ulcer 0.5 cm x 0.2 cm, stage I, 100% epithelial no drainage, no odor, no pain reported at the site. The "wound note" dated 7/22/14 identified " Area continues to show improvement" is 100% epithelial tissue. Tissue surrounding is intact. Continue to use ointment." Although the left pressure ulcer was measured there was no indication of a right pressure ulcer as being open or healed. The SIE form dated 7/29/14, identified left coccyx pressure ulcer 0.3 cm x 0.3 cm, stage II, 100% slough, no drainage, no odor, and no pain at site. There was no mention of the right pressure ulcer.	F 314		

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F 314	Continued From page 18 There was a nurse's progress note written 7/26/14, 9:50 a.m. that identifies weekly skin check completed with tub bath, "No skin issues noted." The "wound note" 7/26/14, 12:10 p.m. identified, "right buttock has an open area 0.5 cm x 0.3 cm, 100% granulation tissue was previously hard callous. Left buttock 0.7 cm x 0.4 cm 100% epithelial tissue not open, areas improving." The facility "wound note" is a contradiction of the weekly skin check list for tub bath check list on 7/26/14, at 9:50 a.m. identifying "No skin issues " whereas the "wound note" at 12:10 p.m. identifies two pressure ulcer areas. The SIE form only identifies the left coccyx pressure ulcer and not the right. All three notes are inconsistent with what the pressure ulcer location, size and characteristics are. The SIE dated 8/05/14, identified left coccyx pressure ulcer 0.3 cm x 0.3 cm, stage II 100% epithelial tissue, no drainage, no odor, no pain at the site. There is no mention of a right pressure ulcer nor was there a "wound" or nurse's progress notes completed on this date. R1's physician orders dated 8/11/14, indicated to apply Cavillon skin barrier film to buttocks/crease daily every night, and "diagnosis of moisture related skin breakdown, contact nurse practitioner (NP) in one week regarding skin." The SIE dated 8/12/14, identified left coccyx pressure ulcer 2 cm x 1 cm, right pressure ulcer 4 cm x 2 cm both stage II, 100% granulation, minimal serous drainage, area surrounding erythematous, and has pain at site. The "wound note" dated 8/17/14 identified "Area worsened, GNP [geriatric nurse practitioner] updated see new orders." The note identified there was a	F 314		

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significant increased size from measurements on 8/5/14 to present of left pressure ulcer. There was no distinction if the characteristics of the pressure ulcers were for the left, right or both pressure ulcers

The SIE dated 8/17/14, identified left coccyx pressure ulcers 2 cm x 1 cm, right measures 4 cm x 2 cm both are stage II, minimal serous drainage, 100% granulation, area surrounding is intact, and has pain at site. The "wound note" dated 8/17/14 identified, both are, "100% granulation , no drainage, surrounding skin is red, tegaderm dressing replaced NP was updated."

R1's physician orders dated 8/18/14 included, "apply Allevyn dressing, change to buttock ulcer every three days, update NP if no improvement."

The SIE dated 8/21/14, identified right pressure ulcer area 2 cm x 1.5 cm, stage II, 100% granulation, serous drainage, and pain at site. SIE form also indicates left area has measurements of 0 cm x 0 cm, which identified the PU was not open. The "wound note" dated 8/20/14 indicated " Area is improving, no drainage, surrounding area is red", covered with foam dressing.

The SIE dated 8/25/14, identified right pressure ulcer 2 cm x 1.5 cm and left pressure ulcer 1.5 x 1 cm, both stage II, 100% granulation, minimal serous drainage, no odor, and pain at site. The "wound note" dated 8/25/14 indicated, "100% granulation with minimal drainage of serous type, surrounding skin has dark red patches with red spots NP was updated." New physician orders received were for four ounces house supplement due to weight loss. Although the 8/21/14 SIE

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identified the left PU measured 0 cm x0 cm, which was identified as not being open, the left PU measured 1.5 x 1 cm on 8/25/14.

The SIE dated 8/31/14, identified right pressure ulcer 1 cm x 1 cm and left 0.3 cm x 0.3 cm stage II, 100% granulation, minimal serous drainage, no odor, and pain at site. The "wound note" dated 8/31/14, indicated,"100% granulation both sides, minimal drainage, surrounding skin intact" use of foam dressings.

The SIE dated 9/4/14, identified right pressure ulcer 0.8 cm x 1 cm and left 0.4 cm x 0.3 cm . stage II, 100% granulation, minimal serous drainage, no odor and no pain at site.
The "wound note" dated 9/4/14 indicated," 100% granulation both sides, minimal drainage, surrounding skin intact," use of foam dressings.

The SIE dated 9/10/14, identified right pressure ulcer 1.3 cm x 1.2 cm and left 1.2 cm x 1 cm, both stage II, 50% granulation, 50% epithelial, minimal serous drainage, no odor and no pain at site. The "wound note" dated 9/10/14 indicated right open area has, "50% granulation, 50 % slough, and minimal serous drainage. Area on left buttock has 50% granulation, 50 % slough and minimal serous drainage. Small area in the center crease that is superficially open 1 cm x 0.2 cm , 100% granulation. Wounds were cleaned and foam dressings were applied. NP was updated and saw [R1]." There was a discrepancy in description of the ulcer from the SEI of 50% epithelial tissue, and the "wound note" identifying 50% slough.

During interview on 9/11/14, at 2:20 p.m., the above information was discussed with registered

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F 314	Continued From page 21 nurse (RN)-D who stated, when the new director of nursing (DON) came, we started to measure the pressure ulcers with only one nurse if possible. RN-D was unable to clarify the size differences between measurements of different notes, characteristics, or to identify whether the pressure ulcers were opened, closed or just reddened. She verified the only intervention modifications implemented for R1's pressure ulcers were the medical interventions of different creams and dressing changes. During interview on 9/11/14, at 5:58 p.m., the DON stated she was unable to determine by the facility documentation if the pressure ulcers had reopened, healed or worsened since admission to the facility. The DON verified two ulcers were present upon admission to the facility, and had concerns regarding pressure ulcer reassessment. Although the resident had pressure ulcers, and had changes in these ulcers with various sizes, characteristics and additional pressure ulcers (currently three), the facility had not reassessed R1's repositioning needs while in her wheelchair and bed since she was admitted to the facility in May 2014. There was no indication the facility had changed any pressure relieving devices in R1's chair or bed since admission, and the facility had not comprehensively reassessed R1's risk factors of sliding down in her wheelchair, which could cause potential shearing of current coccyx pressure ulcers. Even though the SIE on 5/23/14 identified that friction and shear could be a potential problem for R1. The lack of facility intervention and evaluation resulted in actual harm for R1.	F 314		

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F 314	Continued From page 22 The policy titled Wound Care Prevention and Treatment dated 11/13, directed staff to monitor skin on admission, readmission, and weekly by a licensed nurse. The policy indicated, if a new skin impairment was observed, the licensed nurse was to initiate the appropriate Event Form based on the type of skin concern.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess and implement interventions to reduce urinary incontinence for 1 of 2 residents (R162) who were incontinent of urine. Findings include: R162's admission Minimum Data Set (MDS), dated 6/24/14, indicated R162 had severe cognitive impairment, required extensive assistance with toileting, and was totally continent of bowel and bladder.	F 315	F315- No catheter, prevent UTI, restore bladder It is the policy of Elim Care, Inc. to ensure a comprehensive assessment has been completed on each resident at time of Admission, change in condition and readmission to the facility. Regarding cited residents: R 162 was re-assessed using a 3 day bowel and bladder assessment to identify a change in his condition r/t incontinence and mobility since admission. Observations	10/20/14

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F 315	Continued From page 23 During an observation of personal cares, on 9/10/14 at 11:29 a.m., R162 was lying in bed with his eyes closed. Nursing assistant (NA)-G and R162's family member (FM)-A entered R162's room to provide care for R162. NA-G provided a breakfast sandwich to R162, to be heated up, by FM-A and left the room. FM-A removed some bedding from R162's bed which was saturated with urine. FM-A assisted R162 with dressing, removing a wet, soaked, soiled (with urine) white t-shirt. NA-G returned to R162's room and began to assist FM-A with cleaning and re-dressing R162 for the day. NA-G stated the beds mattress, and sheets were also wet and soaked with urine. R162 was upset with being wet, and continuously asked FM-A to scratch his back because it was itchy and bothering him. R162 was assisted to a standing position by FM-A and NA-G at 11:43 a.m., and his incontinent product was saturated with urine. NA-G stated the incontinence product was saturated, "nearly 100%" with urine. R162 had bilateral, redness noted on his buttocks when assisted to stand. When interviewed on 9/11/14 at 10:16 a.m., NA-B stated R162's bed was frequently saturated with urine, and this had happened several times before. During interview on 9/11/14, at 12:53 p.m., FM-A stated she had helped get R162 up and dressed again that day (9/11/14). FM-A stated the bed was soiled with urine again, just as the day prior. FM-A further stated the saturated bedding (from urine) was not something new and had been occurring for quite some time. Review of the facility Observation Report, Bladder	F 315	and a significant change MDS were completed. His CP was updated with his preferences and care needs. Risk and benefits were discussed with him and his family related to safety and refusal of cares. Actions taken to identify other potential residents having similar occurrences: Residents are reviewed quarterly and/or when they have a significant change. Those identified as having a change in their condition are discussed daily at an IDT stand up meeting. Measures put in place to ensure deficient practice does not occur: Elim Care s toileting of a resident policy and procedure updated. Education provided to staff to report changes in toileting patterns. Admissions/re-admissions/ and changes will be discussed daily and prn. Assessment audits will be completed weekly and prn. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/20/14. Those responsible to maintain compliance will be: DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	09/11/2014

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

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F 315	Continued From page 24 Function Observation dated 6/24/14, identifies R162 had not had a trial urinary toileting program attempted, there was no current toileting program. It also identified R162 was "always continent" and had "no signs of urinary incontinence." The bladder function status review identifies, "Resident has been continent of bladder since admission. he does have a history of incontinence and wears a pull-up. Staff are to offer and assist to toilet upon rising, before and /or after meals, @ [at] HS [hours of sleep] and upon request; offer as needed on rounds @ noc. He is at risk for incontinence d/t [related to] impaired cognition, history of bladder cancer, BPH [begin prostatic hypertrophy], history of UTI [urinary tract infections] and antidepressant medication use. Will monitor for changes and adjust plan of care as needed." R162's care plan, dated 7/31/14, indicated a goal for R162 to remain continent with routine toileting, and identified several interventions including: to provide assistance to toilet upon rising, before and/or after meals, at hour of sleep (HS) and upon request; monitor for changes in elimination pattern(s); and assistance for incontinence cares and incontinence product changes. Review of R162's most recent Bowel and Bladder Elimination Record Pattern Evaluation, dated 8/28/14 to 9/3/14, indicated R162 had several episodes of bowel and bladder incontinence several times during all shifts. However, most of the document was blank and did not identify if R162 was continent or incontinent on multiple days of the record during this time frame. There was no analysis of the data to determine what type of bladder program could be implemented.	F 315		

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F 315	Continued From page 25 When interviewed on 9/11/14, at 4:39 p.m., RN-C stated R162 was on the basic toileting plan used for several residents when they admit to the facility. RN-C stated sometimes staff rely on visible signs of incontinence to help know if a resident suffers from incontinence or not. RN-C stated no formal bowel and bladder assessment had been completed for R162, despite the collection of data from 8/28/14 to 9/3/14, since R162 admitted to the facility. Although R162 had a change in bladder function, there was no indication a comprehensive reassessment had been completed that included voiding patterns, type of incontinence, history of urinary incontinence (UI) and or UTI, hydration, medication, behaviors, risk/benefits, environmental factors and assistive devices to determine what type of bladder program could be implemented to reduce R162's risk for UI. A facility Bladder Management Program policy, dated 6/2000, indicated a purpose, "To identify residents with bladder management needs and to develop an individualized bladder program for each resident." The policy outlined four different bladder management programs to be used including: Complete Continence; Restorative Bladder Program; Maintenance Bladder Program; and Stay Dry Program. Further, the policy indicated the care plan should reflect the particular bladder management program used.	F 315		
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	F 323		10/20/14

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F 323	Continued From page 26 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 provide adequate supervision for 1 of 1 residents (R91), who eats alone in her room and was identified at risk of choking. Findings include: R91's quarterly Minimum Data Set (MDS), dated 8/22/14, indicated R91 had intact cognition, was independent with eating and needed assistance with meal set up, rejected evaluation or care necessary to achieve health and well-being 4-6 times during the review period. R91 was observed, on 9/10/14 at 1:28 p.m., to be lying in bed eating cereal with milk. R91 had a bedside table laying perpendicular over the bed, with the head of the bed nearly flat and not elevated to promote good posture for swallowing. At 1:31 p.m. nursing assistant (NA)-B was alerted to the potential safety hazard of R91 eating while laying flat in bed. NA-B stated R91 frequently eats in her room and the person who served R91 her tray of food should have raised the head of the bed. However, the resident at times will lower the head of he bed on her own and lowering the head of the bed during eating has been a behavior R91 has displayed in the past. R91's medical record did not indicate R91 had	F 323	F 323- Free of accident hazards/supervision/devices Elim Care and Rehab Center has the expectation that staff will show competence and continued compliance of the following plan: Regarding cited residents: R91 continues to prefer to eat in her room per her preference and refusal of assistance from staff. Risk vs. benefits of eating in room alone or while reclined in bed was discussed with resident and her family. They acknowledge the risk, but continue to respect resident□s wishes. Nursing did have ST assess resident. NP saw resident and wrote an order for a swallow evaluation. Resident has been observed during meals and periodically checked on by staff with no choking/swallowing episodes noted. Staff will continue to observe/assist during meal as resident allows. She is encouraged to keep HOB elevated. Care plan/ NAR assignment sheets update. Actions taken to identify other potential residents having similar occurrences: Residents who choose to eat in their room were checked for swallowing/chewing	

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F 323	Continued From page 27 suffered any aspiration or choking episodes since admission to the facility. R91's care plan, dated 5/15/14, indicated R91 had dysphagia (difficulty in swallowing), and had refused a speech therapy recommended diet of mechanical soft texture in favor of regular textured foods. The care plan did not identify if R91 was able to eat in her room without supervision with her head of the bed flat. When interviewed on 9/10/14, at 1:38 p.m., NA-A stated R91 should not be eating in bed without the head of the bed elevated as she could choke. NA-A further stated R91 has had behavior concerns with eating in her room before, and R91 does not consistently make appropriate choices for her own safety and care. During interview on 9/10/14, at 1:44 p.m., NA-G stated she served R91's tray, which consisted of rice krispies, bran flakes, coffee, milk, and diced peaches, to her. NA-G stated she raised R91's head of the bed when she delivered the food, however R91 frequently will lower it after staff leave. NA-G further stated R91 eating while laying flat in bed was a safety hazard and concern. When interviewed on 9/11/14, at 8:52 a.m., NA-H stated R91 will frequently eat in her room after being set-up with a tray by staff. NA-H stated staff typically do not check back on her until after she has finished eating. NA-H further stated staff would not be aware if R91 had choked because she frequently wants her door to remain closed. During interview on 9/11/14, at 1:42 p.m., registered nurse (RN)-D stated R91 typically	F 323	difficulties. ST Referrals made PRN. All are encouraged to come out for meals. Those who refuse are re-approached and then documented on. Measures put in place to ensure deficient practice does not occur: Meal service policy and procedure updated. Education provided to staff on resident preferences, risk vs benefits and level of observation/assistance. In-room dining audits will be completed weekly and prn. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/20/14. Those responsible to maintain compliance will be: DON or designee.	

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F 323	Continued From page 28 would eat in her room after having a meal tray delivered and was at risk for choking. RN-D stated when R91 eats while laying flat in bed was a safety concern. RN-D was unsure if a risk vs. benefit had ever been discussed with R91 regarding lying in bed eating without the head of the bed raised, which could potentially cause her to choke. When interviewed on 9/11/14, at 3:46 p.m., the director of nursing (DON) stated R91 should not be eating when laying flat in bed because of the risk of choking. A facility policy on meal trays and in-room dining was requested, but none was provided.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement desired dietary preferences to stabilize and maintain weight for 1 of 4 residents (R162) whom was	F 325	F 325- Maintain nutrition status unless unavoidable Elim Care and Rehab Center has the expectation that staff will show	10/20/14

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F 325	Continued From page 29 reviewed for nutrition and weight loss. Findings include: R162's admission Minimum Data Set (MDS), dated 6/24/14, indicated R162 had severe cognitive impairment, required set-up for meals, and had a most recent weight of 155 pounds (lbs). R162's Nutritional Assessment, dated 6/23/14, indicated R162 was at high risk of nutritional complication, but no referrals were necessary, and R162 was "very picky" about his food preferences. The document also identified R162's food preferences were provided by R162's family. R162's undated Food Preference Sheet, used by the facility for food preferences, indicated R162 was had a regular diet. The sheet indicated in bold print, "no tough foods, no mashed potatoes, no cheese, no pasta, no tomato sauces...". During interview on 9/10/14, at 11:25 a.m., NA-G stated R162 often doesn't eat breakfast as he is still in bed and had had a significant weight loss since admission to the facility. During meal observation, on 9/10/14 at 12:13 p.m., R162 was seated in a wheelchair at a table in the SkyView dining room. R162 was served a plate of ravioli with red sauce, garlic bread, and Italian green beans at 12:19 p.m.. R162's family member (FM)-P, whom was also present at the table, told NA-X that served the food, [R162] doesn't like that kind of food. NA-X continued to	F 325	competence and continued compliance of the following plan: Regarding cited residents: R162□s diet preferences (likes/dislikes) have been reviewed. CP and homemaker sheet updated with resident□s preferences. If he refuses, alternates are also offered. Actions taken to identify other potential residents having similar occurrences: Dietary staff to aid in the updating of resident preferences lists, which is done upon admit and prn. Measures put in place to ensure deficient practice does not occur: Meal service policy and procedure updated. Meal observation audits to be completed weekly and prn. Education provided on resident□s preferences lists. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/20/14. Those responsible to maintain compliance will be: DON or designee.	

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F 325	Continued From page 30 serve meals to other residents. R162 remained seated at the dining room table, eating bites of garlic toast only. R162 was asked if he liked ravioli by the surveyor at 12:44 p.m. (25 minutes after being served), R162 stated he did not like ravioli. NA-H, whom was walking by the table and heard surveyor ask R162 about his like or dislike or ravioli, asked R162 if he would like something else, and provided a single chicken strip and tator tots that she heated in the microwave. NA-H stated R162's family member brings them in for R162 to eat. R162 was removed from the dining room table by staff at 1:22 p.m., having consumed 3/4 (three-quarters) of the provided chicken strip, all of the tator tots, and all of the provided various juices. Review of R162's Vitals Report, dated 6/19/14 to 9/11/14, indicated the following weights (lbs): 6/19/14 - 158.6 6/20/14 - 158.6 6/21/14 - 159 6/22/14 - 155.2 6/23/14 - 154.8 7/08/14 - 159 7/27/14 - 146 8/12/14 - 143 9/11/14 - 139.6 R162 sustained a 19 lbs weight loss since admission to the facility. Review of R162's progress note, dated 8/1/14, indicated R162 completed a 3 day calorie count, averaging 1276 calories per day. This was calculated to be 71% of his estimated daily needs. An additional progress note, dated 8/18/14, completed by the registered dietician (RD) indicated R162 had sustained a 10% weight loss in 30 days. Further, the note indicated	F 325		

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F 325	Continued From page 31 supplements were started and for nursing to, "offer favorite foods." During interview on 9/11/14, at 3:22 p.m., registered nurse (RN)-C stated she was aware of R162's weight loss and that ravioli was not appropriate for R162 based on his identified preferences. Further, RN-C stated staff should not have waited for that long (25 minutes) to offer him a different meal when he was observed to not eat the ravioli. When interviewed on 9/11/14, at 4:21 p.m., registered dietician (RD)-A stated staff should be passing meals to residents based on their Food Preference Sheet. RD-A stated R162 should not have been given ravioli for lunch on 9/10/14, "We should be more aware of his preferences." A facility policy on nutrition was requested, but none was provided.	F 325		

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	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/10/2014**

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

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K 000	INITIAL COMMENTS Building #1 FIR SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Elim Home Princeton was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Elim Home Princeton is a 3 story building with no basement. The original building was constructed in 1971 and was determined to be of Type II(111) construction. An additions was built on in 1989 of the same construction type,. Therefore the building was inspected as one building. The building also has an apartment complex attached that is properly separated. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 113 beds and had a census of 107 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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	245494	A. BUILDING **02 - BUILDING 2** B. WING _____	**09/10/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Elim Home Princeton was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Elim Home Princeton is a 3 story building with no basement. The building construction type has been determined to be Type II(442). This inspection only reflects the building that opened 11-4-03. It is properly separated from the original building constructed in 1971. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 113 beds and had a census of 107 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is met.	K 000		

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