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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MYH3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00051

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245437**
2.STATE VENDOR OR MEDICAID NO.
(L2) **816740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME - WATERTOWN**
(L4) **409 JEFFERSON AVENUE SOUTHWEST**
(L5) **WATERTOWN, MN** (L6) **55388**

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 **09/26/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (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
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 09/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/07/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/27/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245437

November 7, 2016

Ms. Stephanie Proper, Administrator
Elim Home - Watertown
409 Jefferson Avenue Southwest
Watertown, Minnesota 55388

Dear Ms.. Proper:

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 September 20, 2016 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 26, 2016

Ms. Stephanie Proper, Administrator
Elim Home - Watertown
409 Jefferson Avenue Southwest
Watertown, Minnesota 55388

RE: Project Number S5437024

Dear Ms. Proper:

On August 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 12, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 20, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 12, 2016, effective September 20, 2016 and therefore remedies outlined in our letter to you dated August 26, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245437 Y1	A. Building B. Wing Y2	9/26/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST WATERTOWN, MN 55388

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0246	Correction	ID Prefix F0257	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.15(e)(1)	Completed	Reg. # 483.15(h)(6)	Completed
LSC	09/20/2016	LSC	09/20/2016	LSC	09/20/2016
ID Prefix F0281	Correction	ID Prefix F0334	Correction	ID Prefix F0371	Correction
Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.25(n)	Completed	Reg. # 483.35(i)	Completed
LSC	09/20/2016	LSC	09/20/2016	LSC	09/20/2016
ID Prefix F0412	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.55(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/20/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	GL/mm	09/26/2016	15507	09/26/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/11/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245437 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/13/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST WATERTOWN, MN 55388

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 09/01/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 09/26/2016	SIGNATURE OF SURVEYOR 34764	DATE 09/13/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/9/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MYH3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00051

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245437**
2.STATE VENDOR OR MEDICAID NO.
(L2) **816740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME - WATERTOWN**
(L4) **409 JEFFERSON AVENUE SOUTHWEST**
(L5) **WATERTOWN, MN** (L6) **55388**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/12/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Bruess, NFE NEII 09/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 26, 2016

Ms. Stephanie Proper, Administrator
Elim Home - Watertown
409 Jefferson Avenue Southwest
Watertown, MN 55388

RE: Project Number S5437024

Dear Ms. Proper:

On August 12, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0970
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 21, 2016, 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 September 20, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

Your ePoC must:

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC

must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 12, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 12, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING _____ B. WING _____	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST WATERTOWN, MN 55388

(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. 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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate 1 of 3 residents (R29) reviewed for choices. Findings include: R29 stated on 8/10/16, at 1:35 p.m. she did not get to choose what time to get up in the morning. R29 stated "I would like to get up by seven [a.m.] but instead she was assisted out of bed "after	F 242	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.	9/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2016

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
	245437	A. BUILDING _____ B. WING _____	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST WATERTOWN, MN 55388

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F 242	Continued From page 1 eight." R29's Minimum Data Set (MDS) dated 6/24/16, indicated the resident's cognition was intact. The Preferences for Customary Routine and Activities section of R29's MDS indicated making choices was "very important" for R29, including choosing her own bedtime. Sleep and awake preferences, however, were not reflected in the resident's current care plan or on the NA assignment sheet. On 8/11/16, at 8:09 a.m. R29 was in bed and her eyes were closed. At 9:43 a.m. R29 was eating breakfast in the dining room. On 8/12/16, at 9:30 a.m. R29 was seated in her wheelchair in her room. R29 was visiting with family member (FM)-A. FM-A stated that although R29 had never mentioned she wished to get up earlier, she had always been an earlier riser at home, and preferred to get up at around 7:30 a.m. R29 added that her preference would be to get up by 7:30 a.m. "or else I get to breakfast too late." An interview with nursing assistant (NA)-B on 8/12/16, at 9:31 a.m. revealed R29 was up that day at 6:30 a.m. because she had an appointment. She further explained that she was aware R29 liked to get up early, however, when the facility was understaffed R29 had to wait until "8:30 [a.m.] or so." On 8/12/16, at 10:16 a.m. the director of nursing (DON) reported residents could get up whenever they wished. The DON stated if a resident wanted	F 242	It is the policy of Elim Home Watertown to comply with all resident rights including but not limited to, the right to have a choice over your schedule (for example, when you get up and go to sleep) your activities and other preferences that are important to you. To assure continued compliance, the following plan has been put into place; 1.Regarding cited resident: Resident R29 requested wake and bedtime has been care planned to accommodate the resident s preference. 2.Actions taken to identify other potential residents having similar occurrences: Residents will be asked their bedtime preference during their next scheduled MDS assessment to ensure their right to have a choice over their schedule is being honored. 3.Measures put in place to ensure deficient practice does not recur: New admissions will be asked upon arrival if their bedtime is important to them and if so at what time do you wish to sleep/wake. This information will be care planed. 4.Effective implementation of actions will be monitored by: The Administrator or Director of Nursing will audit monthly for six months to ensure new admits are asked their preference of bedtime and, that the time is being care planned and implemented. The data	

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F 242	Continued From page 2 to get up at a specific time the facility would try to honor it and then it would be care planned. Resident were asked if there is anything they wanted changed by the social services designee at the resident care conferences. If a resident indicated it was very important to choose their own bedtime, she expected staff to follow through to ensure direct staff was aware and to care plan those preferences. A policy regarding a resident's right to make choices was requested but not obtained.	F 242	collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Social Services Director, Director of Nursing or designee is responsible for maintain compliance in bedtime preference. Completion date for certification purposes only is: 9/20/16	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate 2 of 2 residents (R3, R34) with access to personal mirrors for personal cares when reviewed for environmental concerns. Findings include:	F 246	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet	9/20/16

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F 246	Continued From page 3 R34 was observed on 8/9/16, at 10:28 a.m. while sitting in a wheelchair in his room. The wheelchair width was wider than the door threshold into R34's bathroom. R34 reported he could not wash his hands or look into the bathroom mirror, as the bathroom was "very small." R34's admission Minimum Data Set (MDS) dated 6/21/16, indicated the resident had intact cognition, and required extensive assist from two staff for transferring and toileting, and limited staff assistance for personal hygiene. On 8/9/16, at 10:29 a.m. nursing assistant (NA)-B stated "I take [R34] down the hall and use the bathroom there as he is not able to go into his bathroom." R3 reported during an interview on 8/9/16, at 10:29 a.m. "There is no such thing as a mirror in here." He explained he could not fit his wheelchair between the wall and sink, and was unable to stand. The mirror was observed on the wall above the sink. The space between the wall and the sink could not have accommodated R3 while he was in a wheelchair. To gain access to view the mirror, it would have required the resident make a 90 degree turn while in his wheelchair. R3 explained a mirror of any type was unavailable in his room, hand-held or otherwise. At 1:30 p.m. R3 stated,"They said I can use the big mirror in the hallway because I can't get my chair in there. I am not going in the hallway to brush my teeth and comb my hair. I shouldn't have to." R3 then verified he could get his wheelchair into the bathroom to use the toilet but was unable to fit the wheelchair into the space between the wall and the sink to access a visual	F 246	requirements established by State and Federal law. It is the policy of Elim Home Watertown that bathroom mirrors are accessible for residents that are in wheelchairs. To assure continued compliance, the following plan has been put into place; 1.Regarding cited residents: Mirrors have been installed in resident R3 s room on 8/29/16. 2.Actions taken to identify other potential residents having similar occurrences: Bathroom mirrors were evaluated for residents in wheelchairs potentially not being able to see themselves. An audit of resident rooms will be completed to ensure residents are able to view themselves in their mirror a replacement mirror will be installed where needed based on resident preference. The facility will audit will audit 3 rooms per week until completed. 3.Measures put in place to ensure deficient practice does not recur: New mirrors will be installed in the resident s rooms that are unable to view the bathroom mirrors to ensure they are able to see themselves. New admissions will be audited for bathroom mirror accessibility within the first week. 4.Effective implementation of actions will be monitored by: After the mirrors are placed, we will audit	

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F 246	Continued From page 4 field of the mirror where it was hung above the sink. A 9/17/16, Care Assessment Area for Activities of Daily Living for R3 indicated R3 sometimes attempted to wash his own face and hands, brush teeth and comb hair after set up. The care plan, dated 6/7/16, noted R3's ability to dress, groom and bathe had deteriorated related to weakness caused by health issues. However, he was able to wash his face, hands, underarms, brush teeth, and comb hair after set-up. The care plan also indicated R3 liked to shave in public areas by the nursing station. On 8/11/16, at 7:34 a.m. a full-sized mirror was observed on the wall in the hallway near the nursing station. R37 was using the mirror to put on make up. An environmental tour was conducted with the director of maintenance (DM) and the director of environmental services (DES) on 8/12/16, at 10:00 a.m. A room of similar arrangement to R3 and R34 was observed. There was inadequate space between the sink and the wall in the bathroom to accommodate a wheelchair. The DM and DES verified that although the mirrors had been tilted downward to accommodate a person in a wheelchair, getting into proper position would have been very difficult for a person in a wheelchair. On 8/12/16, at 10:30 a.m. R3 reported he could only access his sink from the corner edge, as the bathroom was too small to maneuver a wheelchair. He stated he would shave more often if he had his own mirror, and did not like	F 246	the residents with new mirrors to ensure they can see themselves properly. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Environmental Services or designee will insure that all mirrors are accessible to residents. Completion date for certification purposes only is: 9/20/16	

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F 246	Continued From page 5 using the mirror in the hallway. The DES explained the facility did have bedside tables with small pop-up mirrors. The DES verified R3 did not currently have one of the pop-up mirrors, but would provide one for the resident. A policy for room accommodation was requested but not provided.	F 246		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain room temperatures at a comfortable level for 2 of 2 residents (R45, R41). This had the potential to affect all 5 residents living in the cold area. Findings include: R45 reported on 8/9/16, at 10:07 a.m. the room felt cold, and the resident was wearing a sweater. The temperature in the room also felt cool to the surveyor. On 8/12/16, at 12:30 p.m. R41 reported she did not like air conditioning and felt cool in the building. She would open a window to let in warm air and keep her door shut to not interfere with the thermostat.	F 257	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to follow State required, comfortable and safe room temperature levels. To assure continued compliance, the following plan has been put into place; 1.Regarding cited residents: Turned the thermostat up to 75 degrees	9/20/16

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F 257	Continued From page 6 On 8/12/16, at 10:00 a.m. an environmental tour was conducted with the maintenance director (MD) and the environmental services director (ESD). R45 was in her room and reported the room felt cool and she wore fleece sweaters to keep warm. The room temperature was taken by MD utilizing the facility specialized thermometer gun. The temperature registered 69 degrees Fahrenheit (F). The room directly across the hallway registered 68 F. The maintenance director explained the air conditioning was not working in an adjacent area of the building frequented by residents. When the doors were opened to the area, the warm air would come into the resident hallway and trigger the thermostat, located in a nearby room, to turn on the air conditioning in the resident rooms. The thermostat controlled a section of the rooms in the hallway. Each room did not have its own thermostatic control. The maintenance director verified he was aware of the issue. At the time of the survey the maintenance director adjusted the thermostat to create a warmer environment. He also verified the desired temperature was to be at least 71 F.	F 257	on the south wing where the resident rooms are located. A thermometer will be placed in the resident s room to monitor the temperature more efficiently. The thermostat was adjusted in resident R45 s room and the temperature is now being maintained between the 71-81 degree requirements. 2.Actions taken to identify other potential residents having similar occurrences: Continual checking of thermostat to ensure temperature level is acceptable and residents are comfortable. Environmental services staff will audit 5 rooms per week to ensure the temperature is within the desired 71-81 degrees. Repair adjacent air conditioner 9/1/2016. 3.Measures put in place to ensure deficient practice does not recur: The environmental services staff will continue to audit the room temps in 5 rooms per week as part of the preventative maintenance plan. 4.Effective implementation of actions will be monitored by: Director of Environmental Services or designee is responsible for maintaining. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued.	

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F 257	Continued From page 7	F 257	5.Those responsible to maintain compliance will be: Director of Environmental Services or designee is responsible for maintaining compliance. Completion date for certification purposes only is: 9/20/16	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral medication was properly prepared prior to administration in accordance with manufacturer's instructions and standards of practice for 1 of 1 resident (R3) whose medication was crushed. Findings include: R3's medication pass was observed on 8/11/16, at 8:28 a.m. by trained medication aide (TMA)-A. TMA-A placed Miralax laxative powder into a cup and added approximately eight ounces of water, stirring in the powder to dissolve. She then placed potassium chloride capsules (for low potassium) in the cup and added water to dissolve the pills and make a slurry. TMA-A crushed the remaining medications, including isosorbide mononitrate ER (extended release, for chest pain), and mixed all the medications together. R3 was then given the medications, swallowing them without problems.	F 281	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to not crush uncrushable medication. To assure continued compliance, the following plan has been put into place; 1.Regarding cited resident: Contacted resident R3 s MD immediately to notify and request order to have medications crushed. MD changed prescription to a crushable medication.	9/20/16

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F 281	Continued From page 8 When asked about R3's medications TMA-A replied, "It is what the resident wants." TMA-A explained she typically crushed R3's medications. At the time of the observation, it was noted the isosorbide mononitrate ER had a direction sticker instructing the staff not to crush the medication. TMA-A confirmed she had crushed the medication and mixed it with the rest of the medications. The medication administration record which was in a three ring binder on the cart, did not specify that medications should or could have been crushed. The medication card included a label to not crush the isosorbide mononitrate ER. R3's current physician orders included torsemide and Metalazone (for fluid retention), Metoprolol Tartrate (blood pressure control), Miralax, potassium chloride and isosorbide mononitrate ER. Licensed pharmacist (LP)-A confirmed on 8/11/16, at 1:01 p.m. "This medication should not be crushed." LP-A explained crushing the medication may have led to an altered release of the medication in the body, as it was an extended release medication. Although it was allowable to cut the medication in half, it should not have been crushed. LP-B explained on 8/11/16, at 2:17 p.m. isosorbide mononitrate ER was in a wax matrix, meaning the active ingredient of the drug was adhered to the wax in the pill. It was this wax matrix that made it acceptable to split the pill but added, "This medication is not supposed to be crushed."	F 281	Pharmacy notified received new medication. Monitored blood pressure per Pharmacy recommendation. Reeducated TMA regarding crushable medication. 2.Actions taken to identify other potential residents having similar occurrences: Education to be provided to nurses and TMS s regarding dispersal of crushable medication by 9/20/16. Monthly audit on staff to ensure compliance. 3.Measures put in place to ensure deficient practice does not recur: Resident Medication Administration Records will be reviewed to ensure they are accurate. Licensed and registered nurses, and trained medication assistants will be provided in-service on Medication Administration Records as it relates to uncrushable meds by 9/20/16. Medication orders of 5 residents per month will be audited to ensure all meds that require crushing are appropriately identified. 4.Effective implementation of actions will be monitored by: The Director of Nursing or designee will audit the residents with crushed medications upon order and quarterly. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5.Those responsible to maintain	

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F 281	Continued From page 9 On 8/11/16, at 2:42 p.m. registered nurse (RN)-A stated there should have been an order from the physician to crush medications and R3 did not have such an order. She stated resident who had trouble swallowing to taking larger pills generally had orders to crush their medications. RN-A stated the isosorbide mononitrate medication card was labeled with directions not to crush the medication. R3 was prescribed a regular textured diet. On 8/12/16, at 11:19 a.m. the director of nursing (DON) stated she expected when medications were crushed, she would have expected a physician order allowing this for a resident. Staff should not have been crushing medications that indicated, "do not crush." She further explained that if a resident was prescribed medication that could not be crushed, but needed them crushed due to swallowing issues, other options such as an alternate form of the medication should have been considered.	F 281	compliance will be: Director of Nursing or designee is responsible for maintaining compliance. Completion date for certification purposes only is: 9/20/16	
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal	F 334		9/20/16

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F 334	Continued From page 10	F 334		

representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical

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F 334	Continued From page 11 contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer pneumococcal conjugate vaccine (Prevnar 13 or PCV13) for 2 of 5 residents (R33, R69) and provide risk/benefit information for the PCV13 vaccine for 2 of 5 residents (R9, R67) reviewed for vaccinations. Findings include: R9 was 96 year old resident whose progress notes indicated PCV13 was ordered in 4/16. Review of the Vaccine Administration Record dated 5/19/16, indicated "Refused by Pt. [patient]" A review of R9's record revealed no risk/benefit for the PCV13 refusal was provided to R9's responsible party. R9's quarterly Minimum Data Set (MDS) dated 5/19/16, indicated the resident had severely impaired cognition. On 8/10/16, at 7:01 p.m. the director of nursing (DON) verified the information had not been provided to the resident/responsible party. R33 was an 84 year old resident whose immunization record and medication	F 334	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Care, Inc. that all residents receive immunizations and vaccinations that aid in preventing infectious diseases unless medically contraindicated or otherwise ordered by the resident s attending physician or the facility s medical director. To assure continued compliance, the following plan has been put into place; 1.Regarding cited residents: Resident R33 was administered the PCV13 vaccine. Resident R9 refused the	

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	245437	A. BUILDING _____ B. WING _____	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST WATERTOWN, MN 55388

(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 334	Continued From page 12 administration record (MAR) revealed the resident had not received PCV13. R33's physician's orders and progress notes indicated the PCV13 had been ordered for R33 in April, 2016. On 8/11/16, at 8:15 a.m. the infection control nurse said R33 had been hospitalized with pneumonia in July, and he had not yet received PCV13. At 1:35 p.m. the DON explained the facility's pharmacist was coming to provide R33 with the PCV13 vaccination, and the resident's family member had consented to vaccination "today." R67's was an 89 year old resident who was cognitively intact and was admitted to the facility on 6/8/16 (according to the face sheet). Vaccination records revealed the resident had not been administered PCV13. A 6/15/16, progress note indicated R67 declined PCV13, however, the note did not reflect the resident had been informed of risk/benefit of vaccination. R69 was a 66 year old resident, admitted to the facility on 6/19/16 (according to the face sheet). However, the vaccination records did not reflect evidence the resident had been offered or had received the PCV13 vaccination. R69's face sheet identified a date of admission to the facility as 6/19/16. On 8/10/16, at 6:53 p.m. registered nurse (RN)-C stated RN-D had called families of residents in May 2016 and June 2016 to obtain consent to administer the PCV13 Pneumovax. RN-C explained that after consents had been received, requests was then faxed to the physician so orders could be obtained. On 8/10/16, at 7:01 p.m. the DON stated she had	F 334	vaccination; we are awaiting family confirmation of decline. R67 and R69 are no longer resident in our facility. 2.Actions taken to identify other potential residents having similar occurrences: DON reviewed admissions and faxed MD s as necessary and administered vaccination as ordered. 3.Measures put in place to ensure deficient practice does not recur: Upon new admissions facility checks to ensure PCV13 has been administered, if PCV13 has not been given the facility will administer PCV13 within two weeks as ordered by physician and resident consent. The administration of PCV13 will be tracked via Matrix. 4.Effective implementation of actions will be monitored by: Monitor upon admission for compliance, audited monthly by Registered Nurse Clinical Manager. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: Director of Nursing or designee is responsible for maintaining compliance. Completion date for certification purposes only is: 9/20/16	

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F 334	Continued From page 13	F 334		

planned on offering all residents the PCV13 vaccination, consistent with the Centers for Disease Control (CDC) recommendations. The DON stated she had created a PCV13 consent form and then called all the residents' responsible parties in 5/16, and had offered it to all residents residing in the facility at that time.

On 8/11/16, at 8:15 a.m. the infection control nurse stated she did not track the residents' Pneumovax status but did track influenza vaccinations for the residents. Infection control nurse stated to talk to the DON about the residents' Pneumovax tracking. The infection control nurse stated the medical director had recommended the residents receive the PCV13 vaccination and that the DON was the one involved with the residents' PCV13s.

On 8/11/16, at 1:35 p.m. the DON explained the facility's pharmacist was coming to provide R33 with the PCV13 vaccination, and the resident's family member had consented to vaccination "today." The DON said she also planned to request physician orders for PCV13 for all admissions since May 2016, who had not been offered vaccination. The DON further stated she had written a new policy regarding immunizations as the old policy had not included the PCV13 Pneumovax recommendations. At 3:15 p.m. the DON stated the facility had not kept up with Pneumovax for new admissions, and two of the six newly admitted residents had been missed. The DON further stated the facility had not sustained the initiative with the new admissions since 5/15/16 and R67 and R69 had also not received the PCV13 Pneumovax. Although R33 had a physician's order for vaccination in April 2016, the R33 had been "missed." The DON

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F 334	Continued From page 14 further stated the PCV13 vaccine had been recommended for residents over 65 years old. On 8/12/16, at 9:08 a.m. the administrator stated the facility was planning to allow a two week window for newly admitted residents to be assessed and vaccinated for Pneumovax. The 5/15/16 to 8/31/16, Admit/Discharge Report provided by the facility indicated "No" by R67's and R69's names, indicating the residents had not received PCV13 vaccination. CDC guidelines recommend people age 65 and older get 1 dose of PCV13 and at least 1 dose of PPSV23. CDC guidelines indicated PCV13 may be recommended for people under age 65 depending on health conditions. The facility's undated Immunizations of Residents policy indicated "It is the policy of Elim Care, Inc. that all residents receive immunizations and vaccinations that aid in preventing infectious diseases unless medically contraindicated or otherwise ordered by the resident's attending physician or the facility's medical director...Facility tracks and offers annual influenza vaccine and pneumovaccines and others as required by CMS [Centers for Medicare and Medicaid Services]. Immunizations are offered upon admission and annually per CDC guidelines. Nursing staff provides resident/responsible party signs consent form indicating they accept or decline the immunization."	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		9/20/16

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F 371	Continued From page 15 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain proper dietary sanitation practices. This had the potential to affect all 41 residents who were served food from the kitchen. Findings include: An initial tour of the kitchen was conducted with dietary aide (DA)-A on 8/9/16, at 7:49 a.m. The following concerns were noted: 1) The upright backing steamer had a built up black stained substance on the door. 2) Dark oil and thick grease film was present on the kitchen table. 3) The french fry maker was left uncleaned, including old french fries. DA-A confirmed the french fries had been made on the previous day. 4) A pan covered with oil and a brown substance on it was left on the food preparation table. Pan liner paper was used to cover a small table. The paper was unclean with dark stains on it and dirty silverware was left on the paper. DA- A stated "I am sorry but I have to admit it is dirty." DA-A further stated she was uncertain what the stains/substance was on the paper. DA-A stated	F 371	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown To assure continued compliance, the following plan has been put into place; 1.Corrective Action: The kitchen microwave, steamer, food prep table, kitchen tables/counters, deep fryer & strainer have been thoroughly cleaned/scrubbed and are free of debris, grease and dirt by kitchen staff 8/11/16. A revised kitchen cleaning schedule has been put into place on 9/1/16. For the water pass cart, a designated separate bucket has been labeled for where the ice scoop should be placed on	

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F 371	Continued From page 16 the kitchen was supposed to be cleaned prior to the staff leaving for the day. DA-A further stated the identified concerns were left from the previous day, and should have been cleaned up "last night." 5) The microwave on the kitchen table had a black and brown stained substance on the inside top surfaces and inside the door. DA-A confirmed the microwave was not clean. On 8/9/16, at 8:05 a.m. the registered dietitian (RD)-A arrived and verified the steamer was not clean. During a follow up kitchen tour on 8/11/16, at 7:54 a.m. the following additional concerns were noted: 1) The wire scoop strainer was left unclean on the stove. 2) The black and brown stained substance in the microwave previously noted during the initial tour remained unclean. This was confirmed by DA-C. On 8/11/16, at 10:20 a.m. the certified dietary manager (CDM)-C acknowledged the unclean equipment in the kitchen, and explained that the staff should have cleaned the areas/equipment. CDM-C stated she was aware of the concerns with the cleanliness of the kitchen, and had reviewed those concerns with dietary staff. A plastic bucket with ice was observed on a cart in the hallway next to residents' rooms on 8/11/16, at 9:32 a.m. A scoop was laying on top of the ice inside the bucket. At 9:33 a.m. housekeeper (HK)-A verified the ice scoop was in the ice inside the bucket and explained, "The ice scoop should be on top of the bucket of ice."	F 371	the water pass cart. 2.Identify Other Potential Residents: All residents have the potential to be affected by this finding. 3.Systemic Changes: All dietary staff were provided in-service training on the sanitation policy and revised kitchen cleaning schedule, as well as setting up of the water pass cart utilizing a separate designated bucket for the ice scoop on 8/12/16. Nursing staff were trained as it relates to where to place the ice scoop on the water pass cart. 4.Monitoring: An audit will be performed three times per week to ensure compliance of the sanitation policy, kitchen cleaning schedule and water pass. Any concerns/issues noted during this audit will be addressed immediately. Audits will be forwarded quarterly to the QA/QI Committee to ensure compliance. The need for further monitoring will be determined by the QA/QI Committee. 5.Responsibility: Food Service Director or Designee Completion date for certification purposes only is: 9/20/16	

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F 371	Continued From page 17	F 371		

On 8/11/16, at 9:38 a.m. nursing assistant (NA)-A reported she had passed ice to the residents that morning, and she had left the scoop in the bucket of ice. NA-A stated she had been trained to leave the scoop on the ice inside the bucket between resident passes. NA-A stated that additionally three other staff helped pass ice to the residents that morning.

On 8/11/16, at 9:40 a.m. the administrator verified the ice scoop was inside the bucket and stated she would return the cart and bucket of ice back into the kitchen.

On 8/11/16, at 9:42 a.m. registered nurse (RN)-A stated there should have been a separate cup to put the ice scoop into instead of the scoop being left on the ice in the bucket.

On 8/11/16, at 10:20 a.m. CDM-C stated she was aware there was a problem with passing ice water and returning the ice scoop to the bin. A pitcher would be placed by the ice bucket to ensure the scoop was not returned to the ice bucket.

On 8/12/16, at 10:24 a.m. the director of nursing (DON) stated the bucket of ice was provided by dietary staff every morning. The expectation was to have a separate pail for the ice scoop, and the scoop itself was not to be left in the bucket of ice. The DON stated the NAs passed the ice in the morning to the residents and the kitchen staff passed the ice in the afternoon.

The facility's 2/26/14, Sanitation policy indicated, "It is the policy of Elim Care, Inc. that the food service area shall be maintained in a clean and sanitary manner. All utensils, counters, shelves

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F 371	Continued From page 18 and equipment shall be kept clean. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary and sanitized using hot water and or chemical sanitizing solution."	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure follow-up dental services were provided in a timely manner for 1 of 1 resident (R3) reviewed for dental services. Findings include: R3 stated during an interview on 8/9/16, at 10:30 a.m. he would have liked upper dentures. He could not remember the date of his last dental visit. When asked if the facility was addressing the situation to his satisfaction he stated, "They don't give a damn what you have to go through to eat something. I just leave food on my plate when	F 412	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to keep a record of all dental treatments and examinations in the resident's permanent medical record.	9/20/16

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F 412	Continued From page 19 I can't chew it. They don't care." R3 was observed to be edentulous. On 8/11/16, at 7:40 a.m. R3 consumed all of his breakfast, and denied difficulty chewing at that time. The care plan, dated 6/7/16, identified R3 was at risk for nutritional status due to heart problems and dementia. Staff were to encourage yearly dental exams and assist to make appointments as needed. The care plan also noted R3 was prescribed a regular diet and brushed his teeth after set-up. On 8/11/16, at 11:33 a.m. registered nurse (RN)-B explained R3 was edentulous. The resident had a dental appointment on 5/2/16, and requested upper dentures at that time. RN-B did not know the status of the resident's request, and said the facility's social services designee (SSD) handled dental issues. At 11:58 a.m. the SSD stated she would "look into it" and get back to the surveyor. A 5/2/16, Oral Health Screening from Direct Access Dental Hygiene Clinic, identified R3 as edentulous, and noted the resident requested upper dentures. On 8/12/16, at 10:38 a.m. the administrator explained that when a dental order was received the nurse who received the order updated the SSD, who then ensured the orders were addressed. The director of nursing (DON) then stated that if the order/request was dated 5/2/16, she would have expected it would have been addressed by 8/12/16. She further stated she believed the order had never been forwarded to	F 412	To assure continued compliance, the following plan has been put into place; 1.Regarding cited residents: Scheduled a follow up appointment for resident R3 to have root tips removed in 9/2016 which is necessary for dentures, following root tip removal dental appointment will be scheduled for resident R3 to receive dentures. 2.Actions taken to identify other potential residents having similar occurrences: Review residents who have had a dental visit in the last six months to ensure recommendations were obtained and implemented. 3.Measured put in place to ensure deficient practice does not recur: Education to be provided to nurses regarding communicating follow-up needs for dental services of residents by 9/20/16. Audits on each resident dental visit to be completed to ensure policy compliance and communication. 4.Effective implementation of actions will be monitored by: Staff Development and Quality Control Registered Nurse or designee will audit resident dental visits for the next year to ensure communication of follow up. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any	

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F 412	Continued From page 20 the SSD when received on 5/2/16. She explained the health unit coordinator scanned the order into the computer, the nurse noted the order, and then forwarded it to the SSD. The SSD would have then made the upcoming appointment for the resident. The DON further stated the SSD was unavailable, but had made a progress note 8/11/16, indicating she had been made aware of R3's request for an upper denture. A policy and procedure for dental services was requested but was not provided.	F 412	follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: Director of Nursing or designee is responsible for follow up. Completion date for certification purposes only is: 9/20/16	

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	245437	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2016**

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ELIM HOME - WATERTOWN	**409 JEFFERSON AVENUE SOUTHWEST** **WATERTOWN, MN 55388**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 09, 2016. At the time of this survey, Elim Home Watertown was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2016

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Elim Home Watertown is a one-story building with partial basement. The facility was constructed at three different times. The original building was constructed in 1964 and was determined to be of Type I(222) construction. In 1988, an addition was constructed to the north and was determined to be of Type II(111) construction. In 1998, an addition was constructed to the west and was determined to be of Type V (111) construction. The nursing home is separated from an apartment building by a complying two-hour fire wall assembly. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 46 beds and had a census of 32 at time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	**409 JEFFERSON AVENUE SOUTHWEST WATERTOWN, MN 55388**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 Because the original building and the two additions met the minimum construction types allowed for existing buildings, the facility was surveyed as one building, and one (1) Form CMS 2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.6.3.2. This deficient practice could affect 30 of 71 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable.	K 018	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.	9/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2016**

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K 018	Continued From page 3 Findings include: Based on observations and staff interview during the facility tour between 8:30 AM to 12:00 PM on 08/09/2016, revealed: 1) The corridor door to resident rooms 111, 131, 132 and the East Family Room did not positively latch into the door frame without force when tested during the facility tour. This deficient condition was verified by Environmental Service director (PS) and Maintenance (PS).	K 018	It is the intention of Elim Home Watertown to insure that all doors are not impeded from closing. The doors to the resident's rooms were adjusted to correctly close and are no longer impeded from closing and/or opening. The Environmental Director will continue to ensure doors are not impeded from fully closing and/or opening. Completion date for certification purposes only: 9/1/16	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
August 26, 2016

Ms. Stephanie Proper, Administrator
Elim Home - Watertown
409 Jefferson Avenue Southwest
Watertown, MN 55388

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5437024

Dear Ms. Proper:

The above facility was surveyed on August 9, 2016 through August 12, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00051	A. BUILDING: _____ B. WING _____	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST WATERTOWN, MN 55388

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 9, 10, 11, and 12, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to:	2 000		

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2 000	Continued From page 1 Minnesota Department of Health Health Regulation Division Licensing and Certification Program P.O. Box 64900 St. Paul, MN 55164-0900	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain proper dietary sanitation practices. This had the potential to affect all 41 residents who were served food from the kitchen. Findings include: An initial tour of the kitchen was conducted with dietary aide (DA)-A on 8/9/16, at 7:49 a.m. The following concerns were noted: 1) The upright backing steamer had a built up black stained substance on the door. 2) Dark oil and thick grease film was present on the kitchen table. 3) The french fry maker was left uncleaned, including old french fries. DA-A confirmed the french fries had been made on the previous day. 4) A pan covered with oil and a brown substance on it was left on the food preparation table. Pan liner paper was used to cover a small table. The	21015	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown To assure continued compliance, the following plan has been put into place; 1.Corrective Action: The kitchen microwave, steamer, food prep table, kitchen tables/counters, deep fryer & strainer have been thoroughly cleaned/scrubbed and are free of debris, grease and dirt by kitchen staff 8/11/16. A	9/20/16

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21015	Continued From page 2 paper was unclean with dark stains on it and dirty silverware was left on the paper. DA- A stated "I am sorry but I have to admit it is dirty." DA-A further stated she was uncertain what the stains/substance was on the paper. DA-A stated the kitchen was supposed to be cleaned prior to the staff leaving for the day. DA-A further stated the identified concerns were left from the previous day, and should have been cleaned up "last night." 5) The microwave on the kitchen table had a black and brown stained substance on the inside top surfaces and inside the door. DA-A confirmed the microwave was not clean. On 8/9/16, at 8:05 a.m. the registered dietitian (RD)-A arrived and verified the steamer was not clean. During a follow up kitchen tour on 8/11/16, at 7:54 a.m. the following additional concerns were noted: 1) The wire scoop strainer was left unclean on the stove. 2) The black and brown stained substance in the microwave previously noted during the initial tour remained unclean. This was confirmed by DA-C. On 8/11/16, at 10:20 a.m. the certified dietary manager (CDM)-C acknowledged the unclean equipment in the kitchen, and explained that the staff should have cleaned the areas/equipment. CDM-C stated she was aware of the concerns with the cleanliness of the kitchen, and had reviewed those concerns with dietary staff. A plastic bucket with ice was observed on a cart in the hallway next to residents' rooms on 8/11/16, at 9:32 a.m. A scoop was laying on top of the ice inside the bucket. At 9:33 a.m.	21015	revised kitchen cleaning schedule has been put into place on 9/1/16. For the water pass cart, a designated separate bucket has been labeled for where the ice scoop should be placed on the water pass cart. 2.Identify Other Potential Residents: All residents have the potential to be affected by this finding. 3.Systemic Changes: All dietary staff were provided in-service training on the sanitation policy and revised kitchen cleaning schedule, as well as setting up of the water pass cart utilizing a separate designated bucket for the ice scoop on 8/12/16. Nursing staff were trained as it relates to where to place the ice scoop on the water pass cart. 4.Monitoring: An audit will be performed three times per week to ensure compliance of the sanitation policy, kitchen cleaning schedule and water pass. Any concerns/issues noted during this audit will be addressed immediately. Audits will be forwarded quarterly to the QA/QI Committee to ensure compliance. The need for further monitoring will be determined by the QA/QI Committee. 5.Responsibility: Food Service Director or Designee Completion date for certification purposes only is: 9/20/16	

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21015	Continued From page 3 housekeeper (HK)-A verified the ice scoop was in the ice inside the bucket and explained, "The ice scoop should be on top of the bucket of ice." On 8/11/16, at 9:38 a.m. nursing assistant (NA)-A reported she had passed ice to the residents that morning, and she had left the scoop in the bucket of ice. NA-A stated she had been trained to leave the scoop on the ice inside the bucket between resident passes. NA-A stated that additionally three other staff helped pass ice to the residents that morning. On 8/11/16, at 9:40 a.m. the administrator verified the ice scoop was inside the bucket and stated she would return the cart and bucket of ice back into the kitchen. On 8/11/16, at 9:42 a.m. registered nurse (RN)-A stated there should have been a separate cup to put the ice scoop into instead of the scoop being left on the ice in the bucket. On 8/11/16, at 10:20 a.m. CDM-C stated she was aware there was a problem with passing ice water and returning the ice scoop to the bin. A pitcher would be placed by the ice bucket to ensure the scoop was not returned to the ice bucket. On 8/12/16, at 10:24 a.m. the director of nursing (DON) stated the bucket of ice was provided by dietary staff every morning. The expectation was to have a separate pail for the ice scoop, and the scoop itself was not to be left in the bucket of ice. The DON stated the NAs passed the ice in the morning to the residents and the kitchen staff passed the ice in the afternoon. The facility's 2/26/14, Sanitation policy indicated,	21015		

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21015	Continued From page 4 "It is the policy of Elim Care, Inc. that the food service area shall be maintained in a clean and sanitary manner. All utensils, counters, shelves and equipment shall be kept clean. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary and sanitized using hot water and or chemical sanitizing solution." SUGGESTED METHOD OF CORRECTION: The certified dietary manager (CDM) or designee could develop systems to ensure kitchen sanitation is completed in a timely manner and consistently maintained. The CDM or designee could educate all appropriate staff. The CDM or designee could develop monitoring systems to ensure ongoing compliance. The CDM could report these results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21075	MN Rule 4658.0645 Ice Ice must be stored and handled in a sanitary manner. Stored ice must be kept in an enclosed container. If the container is not mechanically cooled, it must be cleaned at least daily and more often if needed. If an ice scoop is used, the scoop must be stored separately to prevent the handle from contact with the ice. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain proper	21075	This Plan of Correction constitutes my written allegation of compliance for the	9/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21075	Continued From page 5 dietary sanitation practices. This had the potential to affect all 41 residents who were served food from the kitchen. Findings include: An initial tour of the kitchen was conducted with dietary aide (DA)-A on 8/9/16, at 7:49 a.m. The following concerns were noted: 1) The upright backing steamer had a built up black stained substance on the door. 2) Dark oil and thick grease film was present on the kitchen table. 3) The french fry maker was left uncleaned, including old french fries. DA-A confirmed the french fries had been made on the previous day. 4) A pan covered with oil and a brown substance on it was left on the food preparation table. Pan liner paper was used to cover a small table. The paper was unclean with dark stains on it and dirty silverware was left on the paper. DA- A stated "I am sorry but I have to admit it is dirty." DA-A further stated she was uncertain what the stains/substance was on the paper. DA-A stated the kitchen was supposed to be cleaned prior to the staff leaving for the day. DA-A further stated the identified concerns were left from the previous day, and should have been cleaned up "last night." 5) The microwave on the kitchen table had a black and brown stained substance on the inside top surfaces and inside the door. DA-A confirmed the microwave was not clean. On 8/9/16, at 8:05 a.m. the registered dietitian (RD)-A arrived and verified the steamer was not clean. During a follow up kitchen tour on 8/11/16, at 7:54	21075	deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown To assure continued compliance, the following plan has been put into place; 1.Corrective Action: The kitchen microwave, steamer, food prep table, kitchen tables/counters, deep fryer & strainer have been thoroughly cleaned/scrubbed and are free of debris, grease and dirt by kitchen staff 8/11/16. A revised kitchen cleaning schedule has been put into place on 9/1/16. For the water pass cart, a designated separate bucket has been labeled for where the ice scoop should be placed on the water pass cart. 2.Identify Other Potential Residents: All residents have the potential to be affected by this finding. 3.Systemic Changes: All dietary staff were provided in-service training on the sanitation policy and revised kitchen cleaning schedule, as well as setting up of the water pass cart utilizing a separate designated bucket for the ice scoop on 8/12/16. Nursing staff were trained as it relates to where to place the ice scoop on the water pass cart.	

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21075	Continued From page 6 a.m. the following additional concerns were noted: 1) The wire scoop strainer was left unclean on the stove. 2) The black and brown stained substance in the microwave previously noted during the initial tour remained unclean. This was confirmed by DA-C. On 8/11/16, at 10:20 a.m. the certified dietary manager (CDM)-C acknowledged the unclean equipment in the kitchen, and explained that the staff should have cleaned the areas/equipment. CDM-C stated she was aware of the concerns with the cleanliness of the kitchen, and had reviewed those concerns with dietary staff. A plastic bucket with ice was observed on a cart in the hallway next to residents' rooms on 8/11/16, at 9:32 a.m. A scoop was laying on top of the ice inside the bucket. At 9:33 a.m. housekeeper (HK)-A verified the ice scoop was in the ice inside the bucket and explained, "The ice scoop should be on top of the bucket of ice." On 8/11/16, at 9:38 a.m. nursing assistant (NA)-A reported she had passed ice to the residents that morning, and she had left the scoop in the bucket of ice. NA-A stated she had been trained to leave the scoop on the ice inside the bucket between resident passes. NA-A stated that additionally three other staff helped pass ice to the residents that morning. On 8/11/16, at 9:40 a.m. the administrator verified the ice scoop was inside the bucket and stated she would return the cart and bucket of ice back into the kitchen. On 8/11/16, at 9:42 a.m. registered nurse (RN)-A stated there should have been a separate cup to	21075	4.Monitoring: An audit will be performed three times per week to ensure compliance of the sanitation policy, kitchen cleaning schedule and water pass. Any concerns/issues noted during this audit will be addressed immediately. Audits will be forwarded quarterly to the QA/QI Committee to ensure compliance. The need for further monitoring will be determined by the QA/QI Committee. 5.Responsibility: Food Service Director or Designee Completion date for certification purposes only is: 9/20/16	

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21075	Continued From page 7 put the ice scoop into instead of the scoop being left on the ice in the bucket. On 8/11/16, at 10:20 a.m. CDM-C stated she was aware there was a problem with passing ice water and returning the ice scoop to the bin. A pitcher would be placed by the ice bucket to ensure the scoop was not returned to the ice bucket. On 8/12/16, at 10:24 a.m. the director of nursing (DON) stated the bucket of ice was provided by dietary staff every morning. The expectation was to have a separate pail for the ice scoop, and the scoop itself was not to be left in the bucket of ice. The DON stated the NAs passed the ice in the morning to the residents and the kitchen staff passed the ice in the afternoon. The facility's 2/26/14, Sanitation policy indicated, "It is the policy of Elim Care, Inc. that the food service area shall be maintained in a clean and sanitary manner. All utensils, counters, shelves and equipment shall be kept clean. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary and sanitized using hot water and or chemical sanitizing solution." SUGGESTED METHOD OF CORRECTION: The certified dietary manager (CDM) or designee could develop systems to ensure the ice pass is completed with a clean process. The CDM or designee could educate all appropriate staff. The CDM or designee could develop monitoring systems to ensure ongoing compliance. The CDM could report these results to the quality assurance committee.	21075		

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21075	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21075		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure follow-up dental services were provided in a timely manner for 1 of 1 resident (R3) reviewed for dental services. Findings include: R3 stated during an interview on 8/9/16, at 10:30 a.m. he would have liked upper dentures. He could not remember the date of his last dental visit. When asked if the facility was addressing the situation to his satisfaction he stated, "They don't give a damn what you have to go through to eat something. I just leave food on my plate when I can't chew it. They don't care." R3 was observed to be edentulous.	21325	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to keep a record of all dental treatments and examinations in the resident's permanent medical record. To assure continued compliance, the following plan has been put into place;	9/20/16

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21325	Continued From page 9 On 8/11/16, at 7:40 a.m. R3 consumed all of his breakfast, and denied difficulty chewing at that time. The care plan, dated 6/7/16, identified R3 was at risk for nutritional status due to heart problems and dementia. Staff were to encourage yearly dental exams and assist to make appointments as needed. The care plan also noted R3 was prescribed a regular diet and brushed his teeth after set-up. On 8/11/16, at 11:33 a.m. registered nurse (RN)-B explained R3 was edentulous. The resident had a dental appointment on 5/2/16, and requested upper dentures at that time. RN-B did not know the status of the resident's request, and said the facility's social services designee (SSD) handled dental issues. At 11:58 a.m. the SSD stated she would "look into it" and get back to the surveyor. A 5/2/16, Oral Health Screening from Direct Access Dental Hygiene Clinic, identified R3 as edentulous, and noted the resident requested upper dentures. On 8/12/16, at 10:38 a.m. the administrator explained that when a dental order was received the nurse who received the order updated the SSD, who then ensured the orders were addressed. The director of nursing (DON) then stated that if the order/request was dated 5/2/16, she would have expected it would have been addressed by 8/12/16. She further stated she believed the order had never been forwarded to the SSD when received on 5/2/16. She explained the health unit coordinator scanned the order into the computer, the nurse noted the order, and then forwarded it to the SSD. The SSD would have	21325	1.Regarding cited residents: Scheduled a follow up appointment for resident R3 to have root tips removed in 9/2016 which is necessary for dentures, following root tip removal dental appointment will be scheduled for resident R3 to receive dentures. 2.Actions taken to identify other potential residents having similar occurrences: Review residents who have had a dental visit in the last six months to ensure recommendations were obtained and implemented. 3. Measured put in place to ensure deficient practice does not recur: Education to be provided to nurses regarding communicating follow-up needs for dental services of residents by 9/20/16. Audits on each resident dental visit to be completed to ensure policy compliance and communication. 4.Effective implementation of actions will be monitored by: Staff Development and Quality Control Registered Nurse or designee will audit resident dental visits for the next year to ensure communication of follow up. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: Director of Nursing or designee is	

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21325	Continued From page 10 then made the upcoming appointment for the resident. The DON further stated the SSD was unavailable, but had made a progress note 8/11/16, indicating she had been made aware of R3's request for an upper denture. A policy and procedure for dental services was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure dental services are provided in a timely manner. The DON or designee could educate all appropriate staff. The DON or designee could monitor to ensure ongoing compliance. The DON could report these results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325	responsible for follow up. Completion date for certification purposes only is: 9/20/16	
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season.	21705		9/20/16

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21705	Continued From page 11 C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain room temperatures at a comfortable level for 2 of 2 residents (R45, R41). This had the potential to affect all 5 residents living in the cold area. Findings include: R45 reported on 8/9/16, at 10:07 a.m. the room felt cold, and the resident was wearing a sweater. The temperature in the room also felt cool to the surveyor. On 8/12/16, at 12:30 p.m. R41 reported she did not like air conditioning and felt cool in the building. She would open a window to let in warm air and keep her door shut to not interfere with the thermostat. On 8/12/16, at 10:00 a.m. an environmental tour was conducted with the maintenance director (MD) and the environmental services director (ESD). R45 was in her room and reported the room felt cool and she wore fleece sweaters to keep warm. The room temperature was taken by MD utilizing the facility specialized thermometer gun. The temperature registered 69 degrees Fahrenheit (F). The room directly across the hallway registered 68 F. The maintenance director explained the air conditioning was not working in an adjacent area of the building frequented by residents. When the doors were opened to the area, the warm air	21705	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to follow State required, comfortable and safe room temperature levels. To assure continued compliance, the following plan has been put into place; 1.Regarding cited residents: Turned the thermostat up to 75 degrees on the south wing where the resident rooms are located. A thermometer will be placed in the resident s room to monitor the temperature more efficiently. The thermostat was adjusted in resident R45 s room and the temperature is now being maintained between the 71-81 degree requirements. 2.Actions taken to identify other potential residents having similar occurrences: Continual checking of thermostat to ensure temperature level is acceptable and residents are comfortable. Environmental services staff will audit 5	

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21705	Continued From page 12 would come into the resident hallway and trigger the thermostat, located in a nearby room, to turn on the air conditioning in the resident rooms. The thermostat controlled a section of the rooms in the hallway. Each room did not have its own thermostatic control. The maintenance director verified he was aware of the issue. At the time of the survey the maintenance director adjusted the thermostat to create a warmer environment. He also verified the desired temperature was to be at least 71 F. SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop systems to ensure temperatures are maintained at a comfortable temperature for residents. The director of maintenance or designee could educate all appropriate staff. The director of maintenance or designee could develop monitoring systems to ensure ongoing compliance. The director of maintenance could report these results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21705	rooms per week to ensure the temperature is within the desired 71-81 degrees. Repair adjacent air conditioner 9/1/2016. 3.Measures put in place to ensure deficient practice does not recur: The environmental services staff will continue to audit the room temps in 5 rooms per week as part of the preventative maintenance plan. 4.Effective implementation of actions will be monitored by: Director of Environmental Services or designee is responsible for maintaining. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: Director of Environmental Services or designee is responsible for maintaining compliance. Completion date for certification purposes only is: 9/20/16	
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members.	21830		9/20/16

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21830	Continued From page 13 (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or	21830		

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21830	Continued From page 14	21830		

family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of

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21830	Continued From page 15 the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate 1 of 3 residents (R29) reviewed for choices. Findings include: R29 stated on 8/10/16, at 1:35 p.m. she did not get to choose what time to get up in the morning. R29 stated "I would like to get up by seven [a.m.] but instead she was assisted out of bed "after eight." R29's Minimum Data Set (MDS) dated 6/24/16, indicated the resident's cognition was intact. The Preferences for Customary Routine and Activities section of R29's MDS indicated making choices was "very important" for R29, including choosing her own bedtime. Sleep and awake preferences, however, were not reflected in the resident's current care plan or on the NA assignment sheet. On 8/11/16, at 8:09 a.m. R29 was in bed and her eyes were closed. At 9:43 a.m. R29 was eating breakfast in the dining room. On 8/12/16, at 9:30 a.m. R29 was seated in her wheelchair in her room. R29 was visiting with family member (FM)-A. FM-A stated that although R29 had never mentioned she wished to get up earlier, she had always been an earlier riser at home, and preferred to get up at around 7:30 a.m. R29 added that her preference would be to	21830	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to comply with all resident rights including but not limited to, the right to have a choice over your schedule (for example, when you get up and go to sleep) your activities and other preferences that are important to you. To assure continued compliance, the following plan has been put into place; 1.Regarding cited resident: Resident R29 requested wake and bedtime has been care planned to accommodate the resident s preference. 2.Actions taken to identify other potential residents having similar occurrences: Residents will be asked their bedtime preference during their next scheduled MDS assessment to ensure their right to have a choice over their schedule is being	

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21830	Continued From page 16 get up by 7:30 a.m. "or else I get to breakfast too late." An interview with nursing assistant (NA)-B on 8/12/16, at 9:31 a.m. revealed R29 was up that day at 6:30 a.m. because she had an appointment. She further explained that she was aware R29 liked to get up early, however, when the facility was understaffed R29 had to wait until "8:30 [a.m.] or so." On 8/12/16, at 10:16 a.m. the director of nursing (DON) reported residents could get up whenever they wished. The DON stated if a resident wanted to get up at a specific time the facility would try to honor it and then it would be care planned. Resident were asked if there is anything they wanted changed by the social services designee at the resident care conferences. If a resident indicated it was very important to choose their own bedtime, she expected staff to follow through to ensure direct staff was aware and to care plan those preferences. A policy regarding a resident's right to make choices was requested but not obtained. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure residents are allowed/encouraged to make decisions regarding their care and services. The administrator or designee could educate all appropriate staff. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830	honored. 3.Measures put in place to ensure deficient practice does not recur: New admissions will be asked upon arrival if their bedtime is important to them and if so at what time do you wish to sleep/wake. This information will be care planed. 4.Effective implementation of actions will be monitored by: The Administrator or Director of Nursing will audit monthly for six months to ensure new admits are asked their preference of bedtime and, that the time is being care planned and implemented. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Social Services Director, Director of Nursing or designee is responsible for maintain compliance in bedtime preference. Completion date for certification purposes only is: 9/20/16	