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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: P7U8
Facility ID: 00375

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

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

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

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/26/2015** (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 **106** (L18)

13.Total Certified Beds **106** (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
	106			
(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 :
Brenda Fischer, Unit Supervisor 10/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 12/29/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/28/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245494
November 9, 2015

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

Dear Mr. Lundeen:

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

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

Effective October 26, 2015 the above facility is certified for or recommended for:

106 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 9, 2015

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

RE: Project Number S5494025

Dear Mr. Lundeen:

On October 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 17, 2015. 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 October 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 30, 2015 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 September 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 26, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 17, 2015, effective October 26, 2015 and therefore remedies outlined in our letter to you dated October 2, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245494	A. Building B. Wing	10/26/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	**10/26/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	**10/26/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	**10/26/2015**
ID Prefix **F0243** Reg. # **483.15(c)(1)-(5)** LSC	**10/26/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**10/26/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**10/26/2015**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**10/26/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**10/26/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**10/26/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**10/26/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**10/26/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**10/26/2015**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	**10/26/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	11/09/2015	10562	10/26/2015

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
9/17/2015	

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245494	02 - BUILDING 2	10/30/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	10/26/2015	ID Prefix Reg. # NFPA 101 LSC K0054	10/26/2015	ID Prefix Reg. # NFPA 101 LSC K0062	10/26/2015
ID Prefix Reg. # NFPA 101 LSC K0067	10/26/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/KJ	11/09/2015	27200	10/30/2015

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/21/2015

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: P7U8
Facility ID: 00375

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/17/2015** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **106** (L18)

13.Total Certified Beds **106** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	106			
(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 :
Bruce Melchert HFE NE II 10/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/22/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

Posted 10/28/2015 Co.

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 2, 2015

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

RE: Project Number S5494025

Dear Mr. Lundeen:

On September 17, 2015, 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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 27, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 27, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 December 17, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 17, 2016 (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

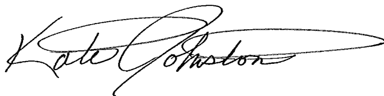
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING ______ B. WING ______	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		10/26/15

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

Electronically Signed — 10/12/2015

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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	245494	A. BUILDING ______ B. WING ______	09/17/2015

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R173), reviewed for insulin administration, was charged for his medication during his stay, even though it was covered under his Medicare benefit. Findings include: R173's Brief Interview for Mental Status (BIMS, a screening tool used to evaluate cognition), dated 9/16/15, identified R173 had intact cognition. R173's current physician orders dated 9/17/15, identified, "INSULIN INFUSION DISPOSABLE PUMP KIT CHANGE EVERY DAY OR AS DIRECTED [WIFE BRINGS IN CARTRIDGES OF HUMALOG INSULIN]."	F 156	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of a deficiency was correctly cited or factually based and it¿s also not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. F 156- Notice of Rights, Rules, Services, charges Elim Care and Rehab Center has the expectation that staff will show	

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F 156	Continued From page 3 R173's progress notes dated 9/11/15, identified, "...[R173]'s primary insurance is U Care for seniors ... admission agreement with arbitration clauses and patient privacy practices reviewed and signed willingly." During observation of insulin administration on 9/17/15, at 11:18 a.m. registered nurse (RN)-B removed a plastic bag containing several V-GO self-infusing cartridges of insulin (a device used to inject insulin in doses set by the user) from a refrigerator in the Turnaround Point medication room. The cartridges were branded by the manufacturer logo, "V-GO DISPOSABLE INSULIN DELIVERY." At 11:22 a.m. RN-B entered R173's room with the cartridge of insulin and handed it to R173, and at 11:48 a.m. (26 minutes later) R173 self administered the V-Go insulin delivery cartridges to himself. When interviewed on 9/17/15, at 1:30 p.m. RN-C stated R173's insulin cartridges are supplied by R173's family member (FM)-H who brings them into the facility from home. FM-H had been paying for and supplying the insulin since R173 was admitted to the facility, but RN-C added she was not sure why, because R173 was at the facility for rehabilitation, and his payment source was "Medicare Part A". Further, RN-C stated "the facility" should be paying for his insulin, to comply with Medicare coverage guidelines for R173. During interview on 9/17/15, at 1:40 p.m. the dispensing pharmacist (DP) stated they received the admission orders for R173 on his day of admission, but were unable to provide the cartridges, so they (the pharmacy) faxed the facility seeking clarification on what supplies were needed to fill the cartridges. However, the	F 156	competence and continued compliance of the following plan: Regarding cited residents: F173¿s medication was clarified by the nursing staff with family, pharmacy and MD. Pharmacy was unable to deliver insulin pump cartridges. Family updated staff that the cartridges were filled with Humalog insulin. Order clarified with MD and Humalog vial ordered from the pharmacy. Resident¿s family brought in receipts for Humalog insulin used to fill insulin pump cartridges prior to clarification. They were reimbursed for the medication used while at the facility. Total amount paid to family was $76.60. Actions taken to identify other potential residents having similar occurrences: Medicare medication audits will be completed to ensure that proper coverage and reimbursement has been established for Medicare benefit recipients. No residents were identified as needing reimbursement. Measures put in place to ensure deficient practice does not occur: Education provided to nursing staff on route of administration availability and the need to clarify orders. If route not currently available from the pharmacy, MD/GNP is to be contacted to seek clarification. Order changes will be made at the MD/NPs discretion. Admission procedure on Medicare coverage reviewed and updated to include information on reimbursement of medication expenses by facility.	

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F 156	Continued From page 4 pharmacy never obtained clarification from the facility. Furthermore, the facility should be paying for the medications to honor the Medicare A coverage agreement. On 9/17/15, at 1:49 p.m. FM-H and R173 were interviewed by RN-C and the surveyor. FM-H stated the cartridges are filled with Humalog (a type of insulin) from a regular vial which she brings from home. R173's payer source was Medicare and Ucare insurance, and the cost of the insulin was "expensive". FM-H was concerned with the cost of the medication and "who is paying for all this [medications and insulin]?" RN-C explained to FM-H the facility was obligated to pay for his insulin while he was at the facility for rehabilitation therapy services, and FM-H replied, "That would be great." During interview on 9/17/15, at 1:59 p.m. licensed social worker (LSW)-B stated residents being covered under Medicare A coverage should not be paying for any of their own medication while at the facility, "The facility gets that bill." When interviewed on 9/17/15, at 2:13 p.m. LSW-A stated R173 was covered under UCare insurance, but the rules were the same as Medicare A coverage, including the coverage of medications and insulin and the facility should be paying for R173's Humalog insulin, "All medications get covered under the benefit." During a subsequent interview on 9/17/15, at 3:36 p.m. FM-H stated the insulin being used by R173 to fill his V-GO cartridge was paid for out of their pocket, as their insurance was not covering it at that time because they were in the "donut hole" (period of time after you and your Medicare drug	F 156	Medicare medication audits will be completed weekly and prn. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee	

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F 156	Continued From page 5 plan have spent a certain amount of money for covered prescription drugs, you then have to pay all costs out-of-pocket for the medications, to a certain limit). When interviewed on 9/17/15, at 3:43 p.m. the director of nursing (DON) stated R173 had not yet been billed for any services or medications by either the pharmacy or facility, but the DON added nobody in the facility was aware of the potential concern until it had been brought up by the surveyor.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for the safe self administration of insulin for 1 of 1 residents (R173) observed to self administer insulin during the survey. Findings include: R173's Brief Interview for Mental Status (BIMS, a screening tool used to evaluate cognition), dated 9/16/15, identified R173 had intact cognition. During observation of medication administration on 9/17/15, at 11:18 a.m. registered nurse (RN)-B removed a plastic bag containing several V-GO	F 176	F-176 Resident self-administer drugs if deemed safe. Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: Self-administration of medication assessment was completed on R173 on 9/18/15. He was able to safely demonstrate that he could accurately manage his own insulin pump and the administration of insulin as per MD orders.	10/26/15

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F 176	Continued From page 6 self infusing cartridges of insulin (a device used to inject insulin in doses set by the user) from a refrigerator in the Turnaround Point medication room. The cartridges were labeled, "V-GO DISPOSABLE INSULIN DELIVERY", however did not identify the medication inside the cartridge, the dosing of the medication R173 was to receive, or directions for administration of the medication. At 11:22 a.m., RN-B entered R173's room with the cartridge of insulin and handed it to R173. RN-B asked R173 if the un-labeled cartridge contained the "correct insulin" for him, and R173 replied, "I think so." R173 set the cartridge on a bedside table next to his recliner chair, and stated he would apply it later after he let it "warm up a little bit." RN-B asked R173 if administering his insulin was "something you do yourself, or we do [for him]?" R173 stated he does it himself because using the cartridge was "a new thing" and many of the staff do not know how to operate it. At 11:48 a.m. (26 minutes later) R173 removed a plastic cap from the cartridge exposing a sticky surface used to attach the cartridge to the skin, and affixed it to his right arm, inserting a needle and pumping a gray trigger on the device seven times. R173 stated his physician was still adjusting the dosing, and the times he engages the pump on the device has been changing because of this. When interviewed on 9/17/15, at 11:31 a.m. RN-B stated R173 brought the V-GO cartridges from home when he admitted to the facility. RN-B had reviewed the Medication Administration Record, and the type of insulin R173 was to receive was not identified, but he was "able to use it properly by himself." R173's medical record was reviewed and	F 176	Actions taken to identify other potential residents having similar occurrences: Residents requesting to self-administer medications were reviewed and assessed by nursing supervisor or designee. Facility will audit and review self-administration of medications (SAM) assessments for completion. Measures put in place to ensure deficient practice does not occur: Education to be provided to nursing staff on the self-administration of medication (SAM) assessment completion. Weekly and prn SAM audits to be completed on residents with new requests to self-administer, admissions and readmission requests/desire to self-administer medications. Daily stand up meeting notes to now include any new SAM assessments to be reviewed by IDT. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee.	

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F 176	Continued From page 7 included no indication R173 had been assessed to safely self administer his insulin, using the V-GO cartridge. During interview on 9/17/15, at 1:30 p.m. RN-C stated R173's V-GO cartridge was new, and staff "don't know a whole lot about it yet." RN-C stated R173 self administers different amounts of the insulin from the cartridge, but no assessment of his ability to safely self administer the medication had been completed, but should have "to make sure they're doing it accurately and safely." When interviewed on 9/17/15, at 3:43 p.m. the director of nursing (DON) stated R173 should have been assessed for safety before being allowed to self administer his own insulin using the V-GO cartridge, "[R173] should have the SAM [self administration of medication assessment] completed." A facility Medication - Self Administration policy dated 6/2000, identified, "All new admissions shall have their medications administered by facility staff, until an interdisciplinary team can determine the ability of the resident to self-administer their medications."	F 176		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241		10/26/15

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F 241	Continued From page 8 Based on observation, interview and document review, the facility failed to ensure for 2 of 3 residents (R6, R107) reviewed for activities of daily living were found to be unshaven, had soiled/long fingernails and was not provided assistance to enhance their dignity. Furthermore, the facility had not properly cleaned a commode and bath blanket with dried visible feces to enhance a residents dignity for 2 of 2 residents (R165, R73) who had feces on their personal care equipment. Findings include: LACK OF GROOMING: R6's annual Minimum Data Set (MDS) dated 6/16/15, identified R6 had intact cognition, and required "total dependence" on staff for his personal hygiene. During observation on 9/14/15, at 3:29 p.m. R6 was in his room in bed. R6 had long fingernails on both hands, with several of his nails having a dark colored substance visible underneath the nail. In addition, R6 had visible white and gray facial hair on his upper lip and chin. R6 stated he likes his nails kept "shorter" than they were, and did not want facial hair on his face. R6 stated he "used to shave everyday" because he was a salesman and "always was very clean." Further, R6 stated not being kept as clean as he used to before coming to the nursing home this "don't make me happy", and added, "What can I do about it?" When subsequently observed on 9/15/15, at 1:31 p.m. R6 continued to have long, dirty fingernails and visible facial hair on his face. When observed for evening cares on 9/15/15, at	F 241	F ¿ 241: Dignity and respect of individuality Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: On 9/17/15, R6 was approached and agreed to nail care on only his right hand. He refused nail care to his left hand. After much encouragement, he agreed to complete the nail care. Resident was also approached and assisted with the removal of unwanted facial hair. Staff continues to encourage his compliance with grooming assistance. He has a history of refusals of care; nursing is charting on his compliance. Care plan updated with his preferences with grooming assistance. R107¿s diet was reviewed and changed to regular diet with finger foods, to ease her ability and compliance with intake. Her CP was reviewed and updated. R165 continued to be independent with toileting. A new larger commode was ordered per resident preference, but unfortunately it was not the height he preferred. Facility to look into other available options. Housekeeping to check bathroom daily and clean commode PRN. R73 re-assessed for bowel and bladder in/continence. Nursing will also adjust the appropriate incontinent product. Elimination CP updated with residents needs and preferences. Actions taken to identify other potential residents having similar occurrences:	

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F 241	Continued From page 9 7:31 p.m. nursing assistant (NA)-E cleaned R6's face and eyes, and asked R6 if he "forget to shave today?" R6 responded that "nobody offered" to shave him, so it was not completed. NA-E finished R6's evening cares, however she did not offer to shave him, or trim and clean his fingernails despite even though R6 told NA-E he was not offered to get shaved. R6's care plan dated 6/18/15, identified R6 had an, "Alteration in ADLs of dressing, grooming and bathing..." Further, the care plan directed staff to complete, "Nail care as needed with bath..." During interview on 9/16/15, at 8:44 a.m. NA-B stated R6 required total assistance to complete his personal hygiene and grooming, "[We] do all of that for him." Staff were expected to complete personal hygiene for residents "every morning and evening." NA-B observed R6's facial hair and long, dirty fingernails. NA-B stated R6 "needs to be shaved", and his fingernails "need to be clipped down" adding, "It doesn't look good." When interviewed on 9/16/15, at 12:08 p.m. licensed practical nurse (LPN)-A stated R6 was "totally dependent" on staff for his care, and staff were expected to help him shave daily as R6 had a preference "to be clean shaven." Further, LPN-A was unaware of any preference to have long fingernails, and they should be clipped and cleaned, "They look like they could be cleaned underneath." On 9/17/15, at 8:31 a.m. family member (FM)-G was interviewed about R6's care in the facility. FM-G stated R6 used to clip his nails and shave "every single day." R6 used to be a salesman and appearance was very important to him.	F 241	Residents will continue to be groomed daily per their preferences. Shaving will be offered, if facial hair is observed. Nail care will be offered on bath days and prn. Staff will assist as per the care plan and PRN. Dining room audits will be conducted to review assistance and dignity needs during meals. Bathrooms will continue to be observed daily with cares and activities. Staff will clean appliances/devices when appropriate and/or notify the appropriate personnel if attention is needed. Residents noted to have a change in elimination will be re-assessed and CP updated with changes and preferences. Residents are offered a choice in their plan of care. All efforts to meet the individualized care needs are provided by nursing. Measures put in place to ensure deficient practice does not occur: Policy and procedure for shaving a resident reviewed/updated. Policy and procedure for nail care reviewed/updated. Nursing orders placed for nursing to document compliance/refusals of cares q shift. Care/grooming audits to be completed weekly and prn Audits to observe dining room activity will be done weekly and prn. Resident care equipment audits to be completed weekly and prn. Housekeeping routines will be reviewed and updated to accommodate resident needs. Bathroom and equipment audits to be completed weekly and prn.	

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F 241	Continued From page 10 Further, FM-G stated R6's grooming was not being completed "as often as I would like", and it was concern for his well-being, "A person does feel better about themselves when not laying there scuzzie in bed." LACK OF ASSISTANCE WITH EATING: R107's annual Minimum Data Set (MDS) dated 6/17/15, identified R107 had long and short term memory problems as she was "rarely/never understood", and required supervision with eating. During observation of the lunch meal on 9/16/15, at 12:25 p.m. R107 was seated at a table with one other resident in the Skyview dining room. R107 had a white colored lipped plate she was holding up from the table in her left hand which contained diced carrots, rice, and country fried steak. There were two glasses on the table, one contained a red juice with pieces of diced carrot in it, and a glass of water with food smeared all over the outside of the glass. R107 was picking up spilled rice and carrots from the table and eating it using her fingers while holding her plate in her hand. At 12:27 p.m. nursing assistant (NA)-C walked over to R107's tablemate and visited with her, however made no offer of assistance to R107 who continued to pick up food from the table using her fingers and eating it. At 12:29 p.m. NA-C served R107's tablemate her food, and promptly left the table making no offer to assist or re-direct R107 who was still eating the spilled rice and carrots from the table top using her fingers. At 12:31 p.m. R107 continued to play with the spilled food on her table until 12:39 p.m.	F 241	Staff is to be in-serviced on the importance of dignity/grooming, assisting resident in a timely manner, and the observation/cleaning of soiled linens and resident care equipment. The DON / designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee.	

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

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F 241	Continued From page 11 when NA-C served her a piece of banana cake in a small dish. NA-C made no offer to assist R107 to eat the cake or meal, as R107 continued to push food around on the table and plate using her fingers. At 12:42 p.m. registered nurse (RN)-F entered the dining room and offered R107's tablemate assistance with eating, but did not offer any assistance to R107 as she continued to eat food using her fingers. At 12:46 p.m. RN-F approached R107 at the table and asked, "How are you doing?", R107 responded with non-sensical speech. RN-F cut up R107's banana cake in the small dish using a fork and asked her, "Do you mind if I get this rice off of you?", as she brushed it off her clothing and onto the floor. RN-F then picked up the glass of red juice and removed it from the table telling R107 she was removing it "since you got a carrot in it" and left the table. R107 remained seated at the table pushing food around and eating using her fingers, spilling large amounts on the floor and herself until 12:51 p.m. (26 minutes later) when she pushed the plate away from herself on the table using her soiled clothing protector. When interviewed on 9/16/15, at 12:57 p.m. NA-D stated R107 typically "wears a lot of it [food]" when she is left alone to eat by herself without any assistance. The staff often try to help her when they bring her a plate of food, however she would often refuse assistance so staff just leave her alone to "do what she does" with the food (referring to her playing with it). During interview on 9/16/15, at 1:11 p.m. RN-F stated R107 will "sometimes use her utensils" for eating, adding she did not feel rice was an appropriate meal choice for R107 given her history of mixing up and playing with her food.	F 241		

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F 241	Continued From page 12	F 241		

RN-F stated R107 should have been re-approached and offered cues and encouragement to eat her meal, and added, "We don't have anything different in place" if R107 is playing with her food and not accepting assistance. Further, RN-F stated other residents and visitors were watching R107 play with her food and it "looks bad."

SOILED COMMODE WITH FECES

R165's MDS, dated 8/13/2015, indicated he was cognitively intact, and independent with toileting.

During observation on 9/15/2015 at 7:20 p.m., it was noted that in R165's bathroom, which was shared by another male resident in the adjoining room, a commode stood was over the toilet. R165's commode had a raised toilet seat, designed with a cut out bottom, placed over the existing bathroom toilet, and was equipped with side hand rails. The inside of the plastic bowl, between the seat and toilet, was covered with a layer of dried, dark brown-colored feces, extending around the entire inside circumference of the commode. The dried feces produced a lingering, malodorous scent in R165's bathroom.

During observation the next day, on 9/16/2015 at 9:24 a.m., R165's commode was again positioned over the toilet in the bathroom. The inside of the commode bowl remained unclean, with dried feces still present and a noticeable odor.

In an interview on 9/16/2015 at 12:53 p.m., R165 stated that when the commode bowl was "soiled and dirty like that, I don't even want to use the

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F 241	Continued From page 13	F 241		

bathroom." R165 said when it gets dirty, "It should be cleansed right away, and not left. "It is disgusting." R165 also stated that "today" was not the first time he encountered an unclean bathroom, and added he felt the bathroom, the floor, and toilet "can get very dirty between cleanings." R165 said the housekeeper only came to do a thorough cleaning "once a week."

In an interview on 9/16/2015 at 1:50 p.m., registered nurse (RN)-E stated R165's commode had been cleaned. RN-E said the nursing staff were responsible for the "day-to-day cleaning" in the resident rooms, including things like the commode. RN-E said she would "expect" R165's commode be clean, and that it "should have been cleaned sooner."

During an interview on 9/17/2015 at 1:53 p.m., the assistant director of nursing (ADON) in charge of infection control, stated that if feces is present on any surface, "It should be cleaned right away," and that this was "an infection control concern." The ADON stated the responsibility to clean up bodily fluids falls on "whoever sees it, it is all our responsibility." The ADON also said she would expect resident commodes "to be always cleaned."

SOILED BLANKET WITH FECES

R73's MDS dated 7/14/15, was independent with mobility, continent of bladder, and frequently incontinent of bowels (unable to control bowel movements).

R73's care plan, dated 7/14/15, identified R73

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F 241	Continued From page 14 required assistance to complete personal hygiene, and "Staff to clean up after incontinent episodes..." During observation on 9/14/15, at 11:51 a.m., R73 was seated in a recliner chair in her room on a white blanket. R73 stood up and walked to the bathroom exposing a visible, dark-tan discoloration, dried feces, on the blanket, measuring approximately three inches by one inch in size. During a subsequent observation on 9/16/15 at 8:14 a.m., R73's white blanket was in her recliner with several stuffed animals. The size of the stain had increased to approximately four inches by 2 inches in size. When interviewed on 9/16/15, at 1:43 p.m. nursing assistant (NA)-D stated R73's blanket in her recliner chair was soiled, and "looks like BM [bowel movement]." NA-D proceeded to change the soiled blanket with a new blanket. At approximately 1:50 p.m. on 9/16/15, NA-G stated R73 soiling her blanket in the chair with feces was "kind of a regular thing." NA-G also said R73's blanket was often stained "with bowel" and the blanket was "changed as needed." During a subsequent observation on 9/17/15, at 9:15 a.m., R73's had another white blanket again with visible, dark, tan-colored stain, possible feces, measuring approximately three inches by two inches in size. During interview on 9/17/15, at 11:04 a.m. family member (FM)-K stated R73 was not always able to perform her own cares due to her dementia. FM-K said R73 had "previous instances" of a blankets with feces left in her chair, sometimes for up to "several days without being changed, "	F 241		

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F 241	Continued From page 15 which identifies R73 was incontinent. FM-K stated this was upsetting to (R73), and "It annoys me, but it also makes me sad." Further, FM-K stated (R73) had expressed concerns with it before as well, and also said R73 "thinks someone else" was putting the blanket with feces on her chair. FM-K said "It bothers [R73] every time she sees it, and [R73] thinks someone else has done that." A facility policy regarding dignity was requested, but none was provided.	F 241		
F 243 SS=E	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 6 facility care units (Turnaround Point,a short term care unit), were provided an opportunity to be involved in resident council activities. This had the potential to affect all 15 residents (R172) who resided in the Turnaround Point unit.	F 243	F -243 Right to participate in resident/family group Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: All resident¿s	10/26/15

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F 243	Continued From page 16 Findings include: During the initial tour of the facility on 9/14/2015, at 1:27 p.m., resident council meeting minutes were posted on several bulletin boards on all three floors of the facility. However, the minutes only pertained to separate meetings of resident councils, which took place on the second and third floors. The 2nd and 3rd floor each had separate resident councils, and meeting minutes, but contained no input from, or mention of, the Turnaround Point resident unit. When interviewed on 9/16/15, at 9:59 a.m. registered nurse (RN)-C stated residents on the Turnaround Point unit they were "typically not in the facility" for an extended period of time, but could also reside in the Turnaround Point unit for several weeks or months, depending on how the residents progress with their therapies. During interview on 9/17/15, at 1:36 p.m. R172 stated she had been residing on the Turnaround Point Unit for a couple weeks, and was "unaware of any Resident Council" for the short term unit, or posting of the minutes from the other floors, or if she was able to attend resident council meetings. When interviewed on 9/17/15, at 2:00 p.m., social worker (SW)-A stated the resident council minutes "are posted for the Turnaround Point residents," and that " there was no resident council" meeting offered to the Turnaround Point residents. SW-A stated, he felt the residents would not be interested, and that "They don't want to think about themselves as part of a unit." A facility policy on resident council meetings was	F 243	who reside on our short term care unit, turn around point, will be offered to participate in their own unit¿s resident council every month. Information for the change to these meetings is added to the monthly activity calendar and residents reminded by the nursing staff. Actions taken to identify other potential residents having similar occurrences: All residents on our short term stay unit (Turn Around Point) will be updated by the activity staff upon admission/re-admission of their option for attending a monthly resident council meeting. This information will be provided to the new/returning resident verbally and in writing via the activity calendar. Measures put in place to ensure deficient practice does not occur: Communication as to the time and place of all resident council meetings will be added to the activity calendars and posted throughout the facility. Residents are encouraged to attend. Attendance of participants will be collected at each resident council meeting. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance	

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F 243	Continued From page 17 requested, but none was provided.	F 243	will be: DON or designee.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation. interview and document review, the facility failed to ensure staff followed the plan of care for toileting assistance for 1 of 3 residents (R107) reviewed for urinary incontinence. Findings include: R107's annual Minimum Data Set (MDS) dated 6/17/15, identified R107 had long and short-term memory problems, was "rarely/never understood", required extensive assistance with toileting, and was frequently incontinent of bladder. R107's care plan dated 6/27/15, identified R107 to be incontinent of bladder with a goal of R107 having "...no skin breakdown r/t incontinence." Further, the care plan directed staff to, "Toilet every 2 - [to] 3 hours during the day and as needed." During an observation of toileting on 9/17/15, at 9:45 a.m., nursing assistant (NA)-B and registered nurse (RN)-F assisted R107 into the Skyview Spa. R107 was assisted to stand using	F 282	F -282: Services by qualified person/per care plan Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: R 107 was reviewed and reassessed for her elimination patterns. CP and NAR assignment sheets updated with residents needs/preferences. Actions taken to identify other potential residents having similar occurrences: Resident¿s with toileting plans will randomly be observed for compliance and audited on time compliance. Changes to individual CP and NAR assignment sheet made as needed. Measures put in place to ensure deficient practice does not occur: Education provided to nursing staff on timely toileting, following the CP and reporting any elimination pattern changes to nursing	10/26/15

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F 282	Continued From page 18 a mechanical lift, and her pants removed exposing a white incontinence pad that was visibly saturated with dark yellow urine. NA-B removed the incontinence pad and disposed of it in the trash can, however a lingering odor or urine remained in the room with NA-B adding the incontinence pad was "very" saturated. R107 was seated on the toilet but did not urinate. At 10:00 a.m. R107 was assisted to stand, and NA-B performed perineal cares before a new incontinence product was placed and R107 was assisted back into her wheelchair. When interviewed on 9/17/15, at 10:03 a.m. NA-B stated R107 has urinary incontinence "most of the time", and should be assisted to the toilet every "two to three hours." R107 had been assisted with morning cares and dressing by the previous shift "about 6 o'clock" that morning. This was the last time she was checked/toileted for incontinence. Further, NA-B reviewed a Last Time Touched document at the desk, and stated the last time R107 had been assisted since being dressed was 5:52 a.m. that morning, three hours and 53 minutes earlier. During interview on 9/17/15, at 10:11 a.m. NA-C stated she was NA-B's partner for the shift that particular day, and R107 had not been assisted with toileting since 5:42 a.m.. Further, NA-C stated R107 should be assisted to the bathroom and helped with toileting every "two to three hours." R107's Vitals Report dated 9/16/15 to 9/17/15, identified the last time R107 had been assisted with toileting as "05:52 [5:52 a.m.]", and R107 had been incontinent of urine at that time when assisted.	F 282	leadership. Toileting program audits being done weekly and prn. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee.	

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F 282	Continued From page 19 When interviewed on 9/17/15, at 10:17 a.m. RN-F stated the care plan is "a way for us to manifest our nursing assessments", and they are used "to direct the resident care." Further, R107 should have been assisted with toileting "every two to three hours" as directed by her plan of care. A facility policy on care planning was requested, but none was provided.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 5 residents (R107), reviewed for activities of daily living, was provided assistance with eating when required. Findings include: R107's annual Minimum Data Set (MDS) dated 6/17/15, identified R107 had long and short term memory problems, was "rarely/never understood", and required supervision with eating. R107's care plan dated 9/10/15, identified R107 required "encouragement with eating", and directed staff to, "Assist with feeding as res. [resident] allows."	F 311	F-311Treatment/services to improve/maintain ADLs Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: R107¿s diet was reviewed and changed to regular diet with finger foods, to ease her ability and compliance with intake. Her CP and NAR assignment sheet was reviewed and updated. Actions taken to identify other potential residents having similar occurrences: Dining room audits will be conducted to review assistance and dignity needs	10/26/15

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F 311	Continued From page 20 During observation of the lunch meal on 9/16/15, at 12:25 p.m. R107 was seated at a table with one other resident in the Skyview dining room. R107 had a white colored lipped plate she was holding up from the table in her left hand which contained diced carrots, rice, and country fried steak, along with two glasses on the table, one contained a red juice with pieces of diced carrot in it, and a glass of water with food smeared all over the outside of the glass. R107 was picking up spilled rice and carrots from the table and eating it using her fingers while holding her plate. At 12:27 p.m. nursing assistant (NA)-C walked over to R107's tablemate and visited with her, however made no offer of assistance to R107 who continued to pick up food from the table using her fingers. At 12:29 p.m. NA-C served R107's tablemate her food, and promptly left the table making no offer to assist or re-direct R107 who was still eating the spilled rice and carrots from the table top using her fingers. At 12:31 p.m. R107 continued to play with the spilled food on her table until 12:39 p.m. when NA-C served her a piece of banana cake in a small dish. NA-C made no offer to assist R107 to eat the cake or meal, as she continued to push food around on the table and plate using her fingers. At 12:42 p.m. registered nurse (RN)-F entered the dining room and offered R107's tablemate assistance with eating, but did not offer any assistance to R107 as she continued to eat food using her fingers. At 12:46 p.m. RN-F approached R107 at the table and asked, "How are you doing?" to her, and R107 responded with non-sensical speech. RN-F cut up R107's banana cake in the small dish using a fork and asked her, "Do you mind if I get this rice off of you?", as she brushed it off her clothing and onto the floor. RN-F then picked up the glass of red juice and removed it from the	F 311	during meals. Measures put in place to ensure deficient practice does not occur: Audits to observe dining room activity will be done weekly and prn. Staff is to be in-serviced on the importance of dignity/grooming and assisting resident in a timely manner. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee.	

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F 311	Continued From page 21 table telling R107 she was removing it "since you got a carrot in it" and left the table. R107 remained seated at the table pushing food around and eating using her fingers, spilling large amounts on the floor and herself until 12:51 p.m. (26 minutes later) when she pushed the plate away from herself on the table using her soiled clothing protector. When interviewed on 9/16/15, at 12:57 p.m. NA-D stated R107 typically "wears a lot of it [food]" when she is left alone to eat by herself without any assistance. The staff often try to help her when they bring her a plate of food, however she would often refuse assistance so staff just leave her alone to "do what she does" with the food (referring to her playing with it). Further, NA-D stated staff "should give her more finger food" so she could eat with her hands if that was her preference adding, "I wonder why there is no alternative offered [versus rice and carrots]." During interview on 9/16/15, at 1:11 p.m. RN-F stated R107 will "sometimes use her utensils" for eating, adding she did not feel rice was an appropriate meal choice for R107, given her history of mixing up and playing with her food. RN-F reviewed R107's care plan, and stated R107 "should have been re-approached, and offered cues and encouragement" to eat her meal. RN-F also said "We don't have anything different in place" if R107 is playing with her food and not accepting assistance. A facility policy on activities of daily living was requested, but none was provided.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		10/26/15

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F 312	Continued From page 22 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff assisted residents with personal hygiene and grooming for 2 of 3 residents (R6, R8) who were dependent upon staff for their cares. Findings include: R6's annual Minimum Data Set (MDS) dated 6/16/15, identified R6 had intact cognition, and required "total dependence" on staff for his personal hygiene. During observation on 9/14/15, at 3:29 p.m. R6 was in his room in bed. R6 had long fingernails on both hands, with several of his nails having a dark-colored substance visible underneath the nail. In addition, R6 had visible white and gray facial hair on his upper lip and chin. R6 stated he likes his nails kept "shorter" than they were, and did not want facial hair on his face. When subsequently observed on 9/15/15, at 1:31 p.m. R6 continued to have long, dirty fingernails and visible, uncut facial hair. When observed for evening cares on 9/15/15, at 7:31 p.m. nursing assistant (NA)-E cleaned R6's face and eyes, and asked R6 "forget to shave today?" R6 responded that "nobody offered" to	F 312	F -312 ADL care provided for dependent residents Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: On 9/17/15, R6 was approached and agreed to nail care on only his right hand. He refused nail care to his left hand. After much encouragement, he agreed to complete the nail care. Resident was also approached and assisted with the removal of unwanted facial hair. Staff continues to encourage his compliance with grooming assistance. He has a history of refusals of care, nursing is charting on his compliance daily. Care plan updated with his preferences with grooming assistance. R8 will continue to be encouraged to allow staff to perform nail care on his bath days and PRN. Any refusals will be documented in his medical record. CP and NAR assignment sheet updated with his preferences with grooming/hygiene preferences. Actions taken to identify other potential	

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shave him, so it was not completed. NA-E finished R6's evening cares, however made no offer to shave him, or trim and clean his fingernails.

R6's care plan dated 6/18/15, identified R6 had an, "Alteration in ADLs of dressing, grooming and bathing..." Further, the care plan directed staff to complete, "Nail care as needed with bath..."

During interview on 9/16/15, at 8:44 a.m. NA-B stated R6 required total assistance to complete his personal hygiene and grooming, "[We] do all of that for him." Staff were expected to complete personal hygiene for residents "every morning and evening." NA-B observed R6's facial hair and long, dirty fingernails. NA-B stated R6 "needs to be shaved", and his fingernails "need to be clipped down."

When interviewed on 9/16/15, at 12:08 p.m. licensed practical nurse (LPN)-A stated R6 was "totally dependent" on staff for his care, and staff were expected to help him shave daily as R6 had a preference "to be clean shaven." Further, LPN-A was unaware of any preference to have long fingernails, and they should be clipped and cleaned, "They look like they could be cleaned underneath."

R8's quarterly MDS, dated 8/3/15, identified R8 was cognitively intact, had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of on side of the body), and required extensive assistance to complete personal hygiene.

During observation on 9/14/15, at 12:49 p.m. R8 was in his room and had long fingernails on both

residents having similar occurrences:
Residents will continue to be groomed daily per their preferences. Shaving will be offered, if facial hair is observed. Nail care will be offered on bath days and prn. Staff will assist as per the care plan and PRN.

Measures put in place to ensure deficient practice does not occur:
Policy and procedure for shaving a resident reviewed/updated. Policy and procedure for nail care reviewed/updated. Nursing orders placed for nursing to document compliance/refusals of cares q shift. Care/grooming audits to be completed weekly and prn

The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches.

Effective implementation of actions will be monitored by: 10/26/15

Those responsible to maintain compliance will be: DON or designee.

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F 312	Continued From page 24 of his hands. R8 stated, "I think they are too long right now." During observation on 9/15/15, at 6:56 p.m. R8 was lying on his back in his bed in his room. R8 had long fingernails noted on both of his hands. During a subsequent observation on 9/16/15, at 1:08 p.m. R8 continued to have long, untrimmed fingernails on both of his hands. When interviewed on 9/15/15, at 6:45 p.m. R8 stated, "I think my fingernails are too long right now." He also stated his nails are trimmed pretty much when the staff "get around" to it. R8 stated, "I like my nails nice and short." During interview on 9/16/15., at 1:10 p.m. nursing assistant (NA)-A stated that nursing assistant's trim resident's nails on their bath days. She further stated that R8's bath day was on Thursdays. NA-A also stated R8's nails "are long" and "they do need to be cut." In addition, NA-A was not sure when R8's nails were last trimmed or when staff had last offered to trim his nails. When interviewed on 9/17/15, at 10:56 a.m. registered nurse (RN)-D stated she was not aware of R8 ever refusing nail care. RN-D also stated R8 received his baths on the night shift and it was the night shifts responsibility to complete R8's nail care during his bath time. A facility Standards of Care / Expectations policy, dated 10/3/14, identified staff should "shave male residents" on a daily basis, and for nail care to be "completed on bath day..."	F 312		
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		10/26/15

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F 315 SS=D

Continued From page 25

RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation. interview and document review, the facility failed to provide timely assistance with toileting to promote urinary continence for 1 of 3 residents (R107), who was dependent upon staff for toileting..

Findings include:

R107's annual Minimum Data Set (MDS) dated 6/17/15, identified R107 had long and short-term memory problems, was "rarely/never understood", required extensive assistance with toileting, and was frequently incontinent of bladder.

During observation on 9/14/15, at 12:14 p.m. R107 was seated in her wheelchair in the Skyview dining room, and had a distinct urine odor present to her.

R107's Nursing Observations assessment dated 6/18/15, identified R107 had frequent episodes of functional urinary incontinence (incontinence

F 315

F - 315 No catheter, prevent UTI, restore bladder
Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan:

Regarding cited residents:
R 107 was reviewed and reassessed for her elimination patterns. CP and NAR assignment sheets updated with residents needs/preferences.

Actions taken to identify other potential residents having similar occurrences:
Resident¿s with toileting plans were observed for compliance and audited on time compliance. Changes to individual CP and NAR assignment sheet updated PRN.

Measures put in place to ensure deficient practice does not occur: Education

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F 315	Continued From page 26	F 315		

resulted from being unable to toilet themselves for mental or physical reasons). R107 was "at risk for incontinence r/t [related to] DX [diagnosis] of Alzheimer [sic], impaired mobility and medications", and directed staff to, "see care plan for current interventions."

R107's care plan dated 6/27/15, identified R107 to be incontinent of bladder with a goal of R107 having "...no skin breakdown r/t incontinence." Further, the care plan directed staff to, "Toilet every 2 - [to] 3 hours during the day and as needed."

During an observation of toileting on 9/17/15, at 9:45 a.m. nursing assistant (NA)-B and registered nurse (RN)-F assisted R107 into the Skyview Spa. R107 was assisted to stand using a mechanical lift, and her pants removed exposing a white incontinence pad that was visibly saturated with dark yellow urine. NA-B removed the incontinence pad and disposed of it in the trash can, however a lingering odor or urine remained in the room with NA-B adding the incontinence pad was "very" saturated. R107 was seated on the toilet but did not void on her own. At 10:00 a.m. R107 was assisted to stand, and NA-B performed perineal cares before a new incontinence product was placed and R107 was assisted back into her wheelchair.

When interviewed on 9/17/15, at 10:03 a.m. NA-B stated R107 has urinary incontinence "most of the time", and should be assisted to the toilet every "two to three hours." R107 had been assisted with am cares and dressing by the previous shift "about 6 o'clock" that morning, and that was the last time she was checked. Further, NA-B reviewed a Last Time Touched document at the

provided to nursing staff on timely toileting, following the CP and reporting any elimination pattern changes to nursing leadership. Toileting program audits being done weekly and prn.

The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches.

Effective implementation of actions will be monitored by: 10/26/15

Those responsible to maintain compliance will be: DON or designee.

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F 315	Continued From page 27 desk, and stated the last time R107 had been assisted since being dressed was 5:52 a.m. that morning (three hours and 53 minutes prior). During interview on 9/17/15, at 10:11 a.m. NA-C stated she was NA-B's partner for the shift that particular day, and R107 had not been assisted with toileting since 5:42 a.m.. Further, NA-C stated R107 should be assisted to the bathroom and helped with toileting every "two to three hours." R107's Vitals Report dated 9/16/15 to 9/17/15, identified the last time R107 had been assisted with toileting as "05:52 [5:52 a.m.]", and R107 had been incontinent of urine at that time when assisted. When interviewed on 9/17/15, at 10:17 a.m. RN-F stated R107 is frequently incontinent of urine and should be assisted with toileting "every two to three hours." A facility policy on urinary incontinence was requested, but none was provided.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		10/26/15

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F 323	Continued From page 28 by: Based on observation, interview and document review, the facility failed to ensure a grab bar did not have a large gap in Zone 3, as identified by the Food and Drug Administration (FDA) Hospital Bed System Dimensional, dated 3/10/06, to prevent potential entrapment, for 1 of 1 residents (R8) reviewed in the sample, who utilzed grab bars attached to his bed. Findings include: The FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/06, included information for facilities to reduce entrapment risks of patients beds, equipped with side rails/assist rails, which may result in death or serious injury. The guidance identified vulnerable patients as those who have problems with memory, sleeping, incontinence, pain, uncontrolled body movements, or who get out of bed unsafely without assistance. "These patients most often have been frail, elderly or confused." Zone 3 is defined as "the space between the inside surface of the rail and the mattress, compressed by the weight of a patient's head." The FDA recommended this space be less than 4 3/4" (inches), a space where a head could become entrapped. R8's quarterly Minimum Data Set (MDS) dated 8/3/15, indicated he was cognitively intact, had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of on side of the body). The MDS also indicated R8 required supervision and the assistance of one staff member for bed mobility, due to weakness of his upper and lower extremities on one side, and problems with balance.	F 323	F-323 Free of accident hazards/supervision/devices Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: R8¿s grab bar was viewed by the maintenance department who tightened the device to the bed frame. A new side rail assessment was completed once this correction was made. All measurements were within compliance. Actions taken to identify other potential residents having similar occurrences: Nursing staff audited all residents with grab bars to ensure that assessments were up to date and that all devices were securely attached. Any concerns were reported to the maintenance department immediately for repair. Measures put in place to ensure deficient practice does not occur: Nursing staff to physically check grab bars on beds prior to care conferences and IDT reviews with resident/family during that meeting. All parties involved in care conferences sign the side rail assessment form. Maintenance is auditing all side rails/positioning bars quarterly and PRN for safety concerns. The DON/designee will report findings of audits to the Quality Assurance	

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F 323	Continued From page 29 During observation on 9/15/15, at 6:56 p.m. R8's grab bar, which was approximately six inches wide and 18 inches in height, was fastened to the bed frame on the exit (left) side of the bed. When the rail was grasped, it could easily be pulled away from the bed, creating an approximately eight-inch gap between the mattress and the grab bar (Zone 3). R8's loose grab-bar rail could be moved back and forth with little effort, and was not securely fastened to the bed frame. During interview on 9/15/15, at 6:45 p.m., R8 stated he uses his grab bar "over and over" for repositioning. R8 further stated the grab bar "on my left side is shaky" and it "scare me and worry me" that my grab bar is loose. R8's facility Reposition Device/Grab Bar/ Side Rail Assessment, dated 8/11/15, indicated the Zone 3 measurements as 2 1/2 inches between the rail device and the mattress. The assessment did not identify if R8 was safe to utilize the grab bars, with the large gap in Zone 3, to ensure this was not an entrapment hazard for R8. During interview on 9/16/15, at 12:38 p.m., environmental services staff (ES)-A stated the grab bars on the resident beds "were not routinely checked," or on a maintenance schedule. ES-A further stated staff or residents "usually just tell me" if a grab bar needed to be tightened or replaced, or a work order was submitted to the maintenance department. ES-A looked at R8's grab bar at this time, and stated, "I do feel the grab bar is loose" and it "does need to be tightened."	F 323	Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee.	

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F 323	Continued From page 30 A facility policy on assistance devices/bed rails/side rails was requested, but none was provided.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		10/26/15

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F 431	Continued From page 31	F 431		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure insulin was properly labeled to ensure its safe administration for 1 of 1 residents (R173), observed to use insulin during the survey.

Findings include:

R173's Brief Interview for Mental Status (BIMS, a screening tool used to evaluate cognition), dated 9/16/15, identified R173 had intact cognition.

During observation of medication administration on 9/17/15, at 11:18 a.m., registered nurse (RN)-B removed a plastic bag containing several V-GO [a trademark name] self-infusing cartridges of insulin (a device used to inject insulin in doses set by the user) from a refrigerator in the Turnaround Point medication room. The cartridges were branded by the manufacturer, "V-GO DISPOSABLE INSULIN DELIVERY", but did not, however, identify the medication inside the cartridge, the dosing of the medication R173 was to receive, or directions for administration of the medication. At 11:22 a.m., RN-B entered R173's room with the cartridge of insulin and handed it to R173. RN-B asked R173 if the un-labeled cartridge contained the "correct insulin" for him, and R173 replied, "I think so." At 11:48 a.m. (26 minutes later) R173 self administered the un-labeled insulin to himself.

During interview on 9/17/15, at 11:30 a.m. RN-B stated R173 brought the un-labeled insulin cartridges from home, and she was "trusting what

F ¿ 431: Drug records, labels/store drugs & Biologicals
Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan:

Regarding cited residents: R 173¿s order was clarified with MD to identify the cartridge for his V-GO insulin pump, was indeed, Humalog insulin. A new vial with proper pharmacy labeling was ordered and delivered to the facility. After the self-administration of medication assessment was completed, resident was able to fill cartridge from provided vial with no issues noted. Resident was able to independently manage his insulin pump as per MD order and assessment also indicated.

Actions taken to identify other potential residents having similar occurrences: Med rooms and med carts were audited to check for improper labeling of medications. Updated policy and procedures were requested from contracted pharmacy. This policy and procedure was reviewed and updated.

Measures put in place to ensure deficient practice does not occur: Nursing staff to receive education on proper labeling of medications and medication pass

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F 431	Continued From page 32 he's [R173] telling me" regarding the contents inside the cartridges. Further, RN-B allowed R173 to use the un-labeled insulin because she "didn't have a choice", and using un-labeled medications for administration "makes me [RN-B] nervous." When interviewed on 9/17/15, at 1:30 p.m. RN-C stated R173's family member was bringing the medication in from home to use, and it was "supposed to be labeled" with the current medication, dose, and expiration date. During interview on 9/17/15, at 1:40 p.m. the dispensing pharmacist (DP) stated medications being administered in the facility should be labeled accurately to include the medication name, dosage, directions for administration, and the date it was filled. Further, DP stated all medications should be labeled correctly so nursing staff could verify the "accuracy and correct dose" of the medication being administered. When interviewed on 9/17/15, at 3:43 p.m. the director of nursing (DON) stated she had observed R173's insulin cartridges and "didn't see any proper labeling on it." Further, the DON added R173's insulin cartridges should have been labeled to ensure safe administration of the medication. An undated facility Medication Labels policy identified, "Medications are labeled in accordance with facility requirements and state and federal laws." Further, the policy identified the following information must be present on a medication label to include, "Patient's name", "Specific directions for use...", and "Strength of	F 431	procedures. Staff will review the updated labeling policy and procedure provided by pharmacy. Med pass audits to also be conducted weekly and prn. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee.	

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F 431	Continued From page 33 medication."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		10/26/15

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	245494	A. BUILDING ______ B. WING ______	09/17/2015

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ELIM HOME	701 FIRST STREET PRINCETON, MN 55371

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F 441	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff cleaned and sanitized a blood glucose meter in between resident use, which had potential to affect 6 of 6 residents (R173, R172, R169, R20, R174, R175) who shared a glucometer; ensure staff properly handled soiled incontinence products and linens to reduce the potential spread of infection, which affected 2 of 5 residents (R117, R68) observed during cares; ensure staff washed hands after providing perineal care for 1 of 5 residents (R68) observed during cares, and; maintain clean resident care equipment for 1 of 1 residents (R165) who utilized a commode. Findings include: LACK OF CLEANING BLOOD GLUCOSE METER: R173 was observed during a blood glucose monitoring on 9/17/15, at 11:18 a.m. with registered nurse (RN)-B who pierced R173's finger using a lancet, and placed a large drop of blood on the collection strip of the Assure Platinum blood glucose meter to measure R173's blood glucose level. At 11:29 a.m. RN-B finished administering R173 medication and returned to the mobile medication cart in the hallway, placing the soiled blood glucose meter on top of the cart without disinfecting the meter after obtaining a sample of R173's blood. At 11:57 a.m. RN-B washed her hands in the medication room, and picked up the soiled blood glucose meter from	F 441	F-441 Infection control, prevent spread, linens Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: Registered Nurse (RN-B) was in-serviced on the proper glucose cleaning procedure. The certified nursing assistant (NAR-B) was in-serviced on proper hand washing procedures and the handling of soiled linens. The certified nursing assistant (NAR-F and NAR-B) were in-serviced on donning gloves, universal precautions and the proper handling of soiled incontinence products/ linens. R165 continued to be independent with toileting. A new larger commode was ordered per resident preference, but unfortunately it was not the height he preferred. Facility to look into other available options that meet his preferences. Housekeeping and nursing to check bathroom daily and clean commode PRN. Actions taken to identify other potential residents having similar occurrences: All resident¿s that require the use of a shared glucometer are at risk have the potential to be affected. All licensed staff	

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F 441	Continued From page 35 the medication cart. RN-B approached another resident, R174 in the dining room and assisted her to the Turnaround Point spa to check her blood glucose. RN-B placed a new collection strip into the machine and instructed R174 to hold out her finger to get a blood sample. RN-B was stopped by the surveyor before she used the soiled blood glucose meter. When interviewed on 9/17/15, at 11:57 a.m. RN-B stated she did not disinfect the blood glucose meter after using it to obtain R173's blood glucose reading, "You're right, I didn't", and added the meter should have been disinfected with a hydrogen peroxide wipe between each resident use. A Turnaround Point Diabetics form dated 9/17/15, identified R173, R172, R169, R20, R174, R175 currently resided on the unit, and were all using the same Assure blood glucose meter. During interview on 9/17/15, at 1:30 p.m. RN-C stated the glucometer was for community use (meaning all residents on the unit used it), and it should be disinfected between each resident, "After they [staff] use it, they clean it." Further, RN-C stated it needed to be cleaned for "infection control purposes." During in interview on 9/17/15 at 1:55 p.m., the assistant director of nursing (ADON) stated the protocol for shared glucometer included "cleansing it with disinfecting wipes" between resident use. Further, the ADON said, the glucometer was to be left in the disinfectant towel for "at least two minutes" before going on to the next resident. "That is the protocol," the ADON said.	F 441	will be in-serviced on the facility¿s policy for the performance and cleaning of the glucose machines between residents. All staff will be in-serviced on the facility¿s policy for hand washing. In-service training includes random observation of personnel performing hand washing procedures according to facility policy and also the handling of soiled linens. In-service training includes observation of each NAR changing bed linen and handling other soiled linens. Findings are reviewed with all personnel. Corrective action is provided as needed. Bathrooms will continue to be observed daily with cares and activities. Staff will clean appliances/devices when appropriate and/or notify the appropriate personnel if attention is needed. Residents noted to have a change in elimination will be re-assessed and CP updated with changes and preferences. Measures put in place to ensure deficient practice does not occur: The Director of Nursing Services (DNS), or designee will do the following; Glucometer audits will be conducted randomly every week for the next 4 weeks and PRN to ensure compliance from staff. Hand washing audits will be done randomly every week for 4 weeks and then prn. Cleanliness of residents and resident care equipment audits will be done randomly every week for 4 weeks and then prn Resident care equipment audits to be completed weekly and prn. Housekeeping routines will be reviewed and updated to	

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F 441	Continued From page 36 A Cleaning and Disinfecting your Assure Platinum Blood Glucose Meter manufacture manual dated 12/14, identified, "CMS [Centers for Medicare and Medicaid Services] guidelines read that blood glucose meters need to be cleaned and disinfected after each use", and staff should be cleaning the meters in between each resident as "...meters are at high risk of becoming contaminated with bloodborne pathogens such as Hepatitis B Virus [HBV], Hepatitis C Virus [HCV], and Human Immunodeficiency Virus [HIV]." IMPROPER HANDLING OF SOILED INCONTINENCE PRODUCTS AND LINENS: R117's quarterly Minimum Data Set (MDS) dated 6/17/15, identified R117 had severe cognitive impairment, and was "occasionally incontinent" of urine. During observation of morning care on 9/16/15, at 9:15 a.m. nursing assistant (NA)-F assisted R117 into the restroom. NA-F assisted R117 to take down her pants, exposing a urine soiled incontinence brief. NA-F removed R117's soiled incontinence pad using her bare hands, and threw it on the floor next to the toilet and a small trash can. NA-F applied a new incontinence pad to R117, and then washed her hands in the sink before completing R117's morning cares. When interviewed on 9/16/15, at 9:42 a.m. NA-F stated she did not have gloves on when she removed the urine soiled brief from R117, but "should have worn gloves" in case the urine from the soiled pad would have gotten on her hands.	F 441	accommodate resident needs. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee.	

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F 441	Continued From page 37	F 441		

During interview on 9/16/15, at 12:04 p.m. registered nurse (RN)-F stated NA-F should have followed standard precautions when handling R117's soiled brief and had gloves on. Further, RN-F stated gloves are used when handling soiled incontinence briefs to help "break the chain of infection."

R68's annual MDS, dated 5/29/2015, indicated severe cognitive impairment. The MDS further indicated R68 required extensive assistance with activities of daily living (ADLs), including one-person physical assist with personal hygiene.

During observation on 9/16/2015 at 9:16 a.m., nursing assistant (NA)-B provided R68 with routine morning cares. NA-B retrieved a plastic basin, filled it with warm water from the bathroom, and before returning to R68's bedside, donned gloves. NA-B did not wash her hands prior to the glove placement. Following the washing of R68's face, hands, arms, and upper body, NA-B provided R68 with perineal care. R68 was incontinent brief was moderately urine soaked, and also had a small amount of feces.. With gloves still on, NA-B took the plastic wash basin into the bathroom, flushed and rinsed the basin, removed and disposed her gloves, then returned the basin to the drawer. NA-B then took R68's denture cup into the bathroom, drained and rinsed off the dentures, donned a new pair of gloves, and placed the teeth into R68's mouth. NA-B did not wash her hands between the glove changes, after having just provided perineal care for R68. After removing the 2nd pair of gloves, NA-B completed grooming for R68. Exiting the room briefly, NA-B returned to R68's room with two plastic bags. NA-B relined the wastebasket

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F 441	Continued From page 38 with a new liner, tying shut the bag containing used gloves and R68's soiled brief. With the other bag, NA-B gathered the soiled linens and R68's gown from the floor, and bagged the articles. NA-B then pushed R68 out from her room in the wheelchair, the plastic bags swinging near the wheel chair handles as she pushed the wheel chair into the dining room. NA-B exited the dining room, plastic bags in had, and placed them in the soiled utility area. After emerging from the utility area, NA-B applied sanitizer to her hands. During an interview on 9/16/2015 at 9:56 a.m., NA-B stated "I did not wash my hands" after providing perineal cares for R68. NA-B stated she "should have washed my hands" before inserting R68's dentures. NA-B said she forgot to bring a bag into R68's room, and the soiled towels, gown and soaker pad "should have been placed in the bag" and not on the floor. NA-B also said she "should have washed with soap and water" after completing cares and dropping off the laundry, before assisting another resident. In an interview on 9/17/2015 at 1:53 p.m., the assistant director of nursing (ADON) stated "all staff" were trained to wash hands "before and after donning gloves," especially if staff were providing personal cares. The ADON also said the staff were trained to bring in three plastic bags into resident rooms, to replace the existing garbage can liners, and "one for personal laundry, and one for linens." The ADON also stated three had been "infection control (IC) training in July," and all nursing staff get training annually, and "all new hires" receive IC training "before going on the floor."	F 441		

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F 441	Continued From page 39 SOILED RESIDENT BATHROOM EQUIPMENT R165's MDS, dated 8/13/2015, indicated he was cognitively intact, and independent with toileting. During observation on 9/15/2015 at 7:20 p.m., it was noted that in R165's bathroom, which was shared by another male resident in the adjoining room, a commode stood over the stool. R165's commode was used as a raised toilet seat, designed with a cut out bottom, placed over the existing bathroom stool, and was equipped with side hand rails, which provided R165 stability, and a place to grip, allowing him to transfer independently on and off the seat. The inside of the plastic bowl, between the seat and toilet, was covered with a layer of dried, dark brown-colored feces, extending around the entire inside circumference of the bowl. The dried feces produced a malodorous scent in R165's shared bathroom. During observation the next day, on 9/16/2015 at 9:24 a.m., R165's commode remained positioned over the stool in the bathroom. The inside of the commode bowl remained unclean, with the dried feces present, and the odor was still present and noticeable. In an interview on 9/16/2015 at 12:53 p.m., R165 stated that when the commode bowl was"soiled and dirty like that, I didn't even want to use the bathroom." R165 said when it gets dirty, "It should be cleansed right away, and not left. "It is disgusting." R165 also stated that "today" was not the first time he encountered an unclean bathroom, and added he felt the bathroom, the floor, and toilet "can get very dirty between cleanings." R165 said the housekeeper only	F 441		

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F 441	Continued From page 40 came through "once a week." During an interview on 9/17/2015 at 1:53 p.m., the assistant director of nursing (ADON) in charge of infection control, stated that if feces is present on any surface, "It should be cleaned right away," and that it was "an infection control concern." The ADON stated the responsibility to clean up bodily fluids falls on "whoever sees it, it is all our responsibility." The ADON also said she would expect resident commodes "to be always cleaned." A facility document, "Infection Control, Housekeeping," revised August 2009, directed: "Routine cleaning procedures for bed, bedside table, chair, floors, etc, shall be followed when soiling or spills occur..." Further, the policy indicated "Surfaces soiled with blood or body fluids shall be cleaned in accordance with established procedures for cleaning up spills or splashes of blood or body fluids." A facility "Infection Control" document, updated August 2009, indicated it was the facility policy "...to keep the environment clean an microbiologically safe...To prevent infection in resident, staff and visitors."	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		10/26/15

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F 465	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean bathroom device for 1 of 1 residents (R165) whose raised-seat commode was observed unclean. Findings include: R165's admission Minimum Data Set (MDS), dated 8/13/2015, indicated he was cognitively intact. During observation on 9/15/2015 at 7:20 p.m., it was noted in R165's bathroom, which was shared by another male resident in the adjoining room, a commode stood over the stool. R165's commode was a raised toilet seat, designed with a cut out bottom, placed over the existing bathroom stool, and was equipped with side hand rails, which provided R165 stability, and a place to grip, allowing him to transfer independently on and off the seat. The inside of the plastic bowl, between the seat and toilet, was covered with a layer of dried, dark brown-colored feces, extending around the entire inside circumference of the bowl. The dried feces produced a malodorous scent in R165's shared bathroom. During observation the next day, on 9/16/2015 at 9:24 a.m., R165's commode, still positioned over the stool in the bathroom, had a noticeable odor, and the inside of the bowl remained unlearned, with the dried feces present. In an interview on 9/16/2015 at 12:53 p.m., R165 stated that when the commode bowl was"soiled and dirty like that, I didn't even want to use the	F 465	F - 465 Safe/functional/sanitary/comfortable environment Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: R165 continued to be independent with toileting. A new larger commode was ordered per resident preference, but unfortunately it was not the height he preferred. Facility to look into other available options that meet his preferences. Housekeeping and nursing to check bathroom daily and clean commode PRN. Actions taken to identify other potential residents having similar occurrences: Bathrooms will continue to be observed daily with cares and activities. Staff will clean appliances/devices when appropriate and/or notify the appropriate personnel if attention is needed. Residents noted to have a change in elimination will be re-assessed and CP updated with changes and preferences. Measures put in place to ensure deficient practice does not occur: Resident care equipment audits to be completed weekly and prn. Housekeeping routines will be reviewed and updated to	

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F 465	Continued From page 42 bathroom." R165 said when it gets dirty, "It should be cleansed right away, and not left. "It is disgusting." R165 also stated that "today" was not the first time he encountered an unclean bathroom, and added he felt the bathroom, the floor, and toilet "can get very dirty between cleanings." R165 said the housekeeper only came through "once a week." In an interview on 9/16/2015 at 1:50 p.m., registered nurse (RN)-E stated R165's commode had been cleaned. RN-E said the nursing staff were responsible for the "day-to-day cleaning" in the resident rooms, including things like the commode. RN-E said she would "expect" R165's commode be clean, and that it "should have been cleaned sooner." During an interview on 9/17/2015 at 1:53 p.m., the assistant director of nursing (ADON) in charge of infection control, stated that if feces is present on any surface, "It should be cleaned right away," and that it was "an infection control concern." The ADON stated the responsibility to clean up bodily fluids falls on "whoever sees it, it is all our responsibility." The ADON also said she would expect resident commodes "to be always cleaned." A facility document, "Infection Control, Cleaning/Disinfection," updated August 2009, indicated the facility policy was to "keep the environment clean and microbiologically safe," and "To prevent infection in resident, staff and visitors."	F 465	accommodate resident needs. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		10/26/15

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F 520	Continued From page 43 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment & Assurance (QA&A) committee developed, implemented, and re-evaluated actions plans to address identified concerns regarding the completion of activities of daily living (ADLs) in the facility. This affected 3 of 3 residents (R107, R6 and R8) in the sample identified as not having their ADL needs met, but had the potential to affect all residents who required staff assistance for their eating, shaving, and personal hygiene.	F 520	F-520 QAA Committee- members / meet quarterly / plans Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: All residents who have a change in their condition and/or ADL status are discussed daily at the IDT meeting. R107, R6 and	

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F 520	Continued From page 44 Findings include: R107's annual Minimum Data Set (MDS) dated 6/17/15, identified R107 had long and short term memory problems, was "rarely/never understood", and required supervision with eating. R107's care plan dated 9/10/15, identified R107 required "encouragement with eating", and directed staff to, "Assist with feeding as res. [resident] allows." During observation of the lunch meal on 9/16/15, at 12:25 p.m. R107 was seated at a table with one other resident in the Skyview dining room. R107 had a white colored lipped plate she was holding up from the table in her left hand which contained diced carrots, rice, and country fried steak, along with two glasses on the table, one contained a red juice with pieces of diced carrot in it, and a glass of water with food smeared all over the outside of the glass. R107 was picking up spilled rice and carrots from the table and eating it using her fingers while holding her plate. At 12:27 p.m. nursing assistant (NA)-C walked over to R107's tablemate and visited with her, however made no offer of assistance to R107 who continued to pick up food from the table using her fingers. At 12:29 p.m. NA-C served R107's tablemate her food, and promptly left the table making no offer to assist or re-direct R107 who was still eating the spilled rice and carrots from the table top using her fingers. At 12:31 p.m. R107 continued to play with the spilled food on her table until 12:39 p.m. when NA-C served her a piece of banana cake in a small dish. NA-C made no offer to assist R107 to eat the cake or	F 520	R8¿s change in their ADL status were discussed at the October QAPI meeting held on 10/12/15. Concerns with their ADL status discussed with IDT. Action plans in place. CP and NAR assignment sheet updated. R107¿s diet was reviewed and changed to regular diet with finger foods, to ease her ability and compliance with intake. Her CP was reviewed and updated. On 9/17/15, R6 was approached and agreed to nail care on only his right hand. He refused nail care to his left hand. After much encouragement, he agreed to complete the nail care. Resident was also approached and assisted with the removal of unwanted facial hair. Staff continues to encourage his compliance with grooming assistance. He has a history of refusals of care, nursing is charting on his compliance daily. Care plan updated with his preferences with grooming assistance. R8 will continue to be encouraged to allow staff to perform nail care on his bath days and PRN. Any refusals will be documented in his medical record. CP and NAR assignment sheet updated with his preferences with grooming/hygiene preferences. Actions taken to identify other potential residents having similar occurrences: Facility will continue to discuss changes in condition and/or ADL status daily at the IDT meeting. Dining room audits will be conducted to	

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	245494	A. BUILDING ______ B. WING ______	09/17/2015

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F 520	Continued From page 45 meal, as she continued to push food around on the table and plate using her fingers. At 12:42 p.m. registered nurse (RN)-F entered the dining room and offered R107's tablemate assistance with eating, but did not offer any assistance to R107 as she continued to eat food using her fingers. At 12:46 p.m. RN-F approached R107 at the table and asked, "How are you doing?" to her, and R107 responded with non-sensical speech. RN-F cut up R107's banana cake in the small dish using a fork and asked her, "Do you mind if I get this rice off of you?", as she brushed it off her clothing and onto the floor. RN-F then picked up the glass of red juice and removed it from the table telling R107 she was removing it "since you got a carrot in it" and left the table. R107 remained seated at the table pushing food around and eating using her fingers, spilling large amounts on the floor and herself until 12:51 p.m. (26 minutes later) when she pushed the plate away from herself on the table using her soiled clothing protector. When interviewed on 9/16/15, at 12:57 p.m. NA-D stated R107 typically "wears a lot of it [food]" when she is left alone to eat by herself without any assistance. The staff often try to help her when they bring her a plate of food, however she would often refuse assistance so staff just leave her alone to "do what she does" with the food (referring to her playing with it). Further, NA-D stated staff "should give her more finger food" so she could eat with her hands if that was her preference adding, "I wonder why there is no alternative offered [versus rice and carrots]." During interview on 9/16/15, at 1:11 p.m. RN-F stated R107 will "sometimes use her utensils" for eating, adding she did not feel rice was an	F 520	review assistance and dignity needs during meals. Residents will continue to be groomed daily per their preferences. Shaving will be offered, if facial hair is observed. Nail care will be offered on bath days and prn. Measures put in place to ensure deficient practice does not occur: Audits to observe dining room activity will be done weekly and prn. Staff is to be in-serviced on the importance of dignity/grooming, assisting resident in a timely manner, and the observation/cleaning of soiled linens and resident care equipment. Policy and procedure for shaving a resident reviewed/updated. Policy and procedure for nail care reviewed/updated. Nursing orders placed for nursing to document compliance/refusals of cares q shift. Care/grooming audits to be completed weekly and prn The DON/designee will report findings of audits, daily IDT change in ADL status/Change of condition to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 10/26/15 Those responsible to maintain compliance will be: DON or designee.	

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F 520	Continued From page 46 appropriate meal choice for R107, given her history of mixing up and playing with her food. RN-F reviewed R107's care plan, and stated R107 "should have been re-approached, and offered cues and encouragement" to eat her meal. RN-F also said "We don't have anything different in place" if R107 is playing with her food and not accepting assistance. R6's annual Minimum Data Set (MDS) dated 6/16/15, identified R6 had intact cognition, and required "total dependence" on staff for his personal hygiene. During observation on 9/14/15, at 3:29 p.m. R6 was in his room in bed. R6 had long fingernails on both hands, with several of his nails having a dark-colored substance visible underneath the nail. In addition, R6 had visible white and gray facial hair on his upper lip and chin. R6 stated he likes his nails kept "shorter" than they were, and did not want facial hair on his face. When subsequently observed on 9/15/15, at 1:31 p.m. R6 continued to have long, dirty fingernails and visible, uncut facial hair. When observed for evening cares on 9/15/15, at 7:31 p.m. nursing assistant (NA)-E cleaned R6's face and eyes, and asked R6 "forget to shave today?" R6 responded that "nobody offered" to shave him, so it was not completed. NA-E finished R6's evening cares, however made no offer to shave him, or trim and clean his fingernails. R6's care plan dated 6/18/15, identified R6 had an, "Alteration in ADLs of dressing, grooming and bathing..." Further, the care plan directed staff to	F 520		

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complete, "Nail care as needed with bath..."

During interview on 9/16/15, at 8:44 a.m. NA-B stated R6 required total assistance to complete his personal hygiene and grooming, "[We] do all of that for him." Staff were expected to complete personal hygiene for residents "every morning and evening." NA-B observed R6's facial hair and long, dirty fingernails. NA-B stated R6 "needs to be shaved", and his fingernails "need to be clipped down."

When interviewed on 9/16/15, at 12:08 p.m. licensed practical nurse (LPN)-A stated R6 was "totally dependent" on staff for his care, and staff were expected to help him shave daily as R6 had a preference "to be clean shaven." Further, LPN-A was unaware of any preference to have long fingernails, and they should be clipped and cleaned, "They look like they could be cleaned underneath."

R8's quarterly MDS, dated 8/3/15, identified R8 was cognitively intact, had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of on side of the body), and required extensive assistance to complete personal hygiene.

During observations on 9/14/15, 9/15/15 and 9/16/15 throughout the survey, R8 was noted having long fingernails on both of his hands.

When interviewed on 9/15/15, at 6:45 p.m. R8 stated, "I think my fingernails are too long right now." He also stated his nails are trimmed pretty much when the staff "get around" to it. R8 stated, "I like my nails nice and short."

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F 520	Continued From page 48	F 520		

During interview on 9/16/15., at 1:10 p.m. nursing assistant (NA)-A stated that nursing assistant's trim resident's nails on their bath days. She further stated that R8's bath day was on Thursdays. NA-A also stated R8's nails "are long" and "they do need to be cut." In addition, NA-A was not sure when R8's nails were last trimmed or when staff had last offered to trim his nails.

When interviewed on 9/17/15, at 10:56 a.m. registered nurse (RN)-D stated she was not aware of R8 ever refusing nail care. RN-D also stated R8 received his baths on the night shift and it was the night shifts responsibility to complete R8's nail care during his bath time.

During an interview on 9/17/2015, at 4:03 p.m. the administrator and director of nursing (DON) discussed current topics of the facility's quality assurance (QA) committee. The administrator emphasized that "all issues in the building" were reviewed each month during the QA meetings. The DON stated the QA agenda typically included a review of "incident reports, VAs (vulnerable adult), incidents, falls, complaints, any ethical issues, and our hospital readmission rates." The DON stated one PIP (process improvement program) that was a major focus of the QA this past year dealt with "skin issues." The DON said the facility had been "very proactive" in addressing skin concerns/pressure ulcers, especially based "prior surveys." The DON said other current QA projects included "always addressing" infection control, a program to "improve residents' sleep," and a "hospitality program" to increase resident overall satisfaction

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F 520	Continued From page 49 during their stay in the nursing home. There was no mention of a quality assurance program addressing a pattern of deficiency in resident activities of daily living (ADLs), which was again identified during the current survey. In continuing the interview, when asked about personal grooming, the DON stated "we have discussed a lot about completing personal grooming" and making sure residents get the help they need for ADLs. The DON stated that personal grooming "has been a day-to-day conversation," but that at present, "it was not a formal part" of the facility QA. Even though the facility was aware that resident's were not getting proper assistance with activities of daily living, there was no formal, quality assurance action plan developed or monitored by the facility's QA committee. The DON said "We'll bring it to the QA because we have deficiencies from the survey."	F 520		

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Elim Home Princeton was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/12/2015

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

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K 000	Continued From page 1	K 000		

ST. PAUL, MN 55101-5145, or

By e-mail to:
Marian.Whitney@state.mn.us
or
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 Princeton is a 3 story building with no basement. The original building was constructed in 1971 and was determined to be of Type II(111) construction. An additions was built on in 1989 of the same construction type,. Therefore the building was inspected as one building. The building also has an apartment complex attached that is properly separated.

The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility

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K 000	Continued From page 2 has a capacity of 106 beds and had a census of 97 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include:	K 029	K029 ¿ Door closers will be installed on these doors and storage removed from up against the electrical panel, all by 10-26-15. Jim Knutson, plant operations assistant, will be responsible for correction and monitoring to prevent recurrence.	10/26/15

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K 029	Continued From page 3 On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, observation revealed, that the following deficient conditions hazardous storage rooms throughout the facility: 1. Resident rooms 350 and 352 are resident rooms that were converted into storage rooms and are not equipped with self closing doors. 2. There was storage up against the electrical panels that are located in the first floor mechanical room by the fire alarm panel., This deficient condition was verified by the Facility Administrator (TL).	K 029		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire.	K 050	K050 ¿ Fire drill did take place during the day shift on 4¿28¿15 however complete documentation wasn¿t available at the time of survey. Documentation now has been found and is in our life safety code 3 ring binder. Jim Knutson, plant	10/26/15

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K 050	Continued From page 4 Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, during the review of all available maintenance documentation and interview with the Facility Administrator (TL) it was revealed that the facility failed to provide a day shift fire drill in the second quarter of the calendar year. This deficient condition was verified by the Facility Administrator (TL).	K 050	operations assistant, will be responsible for correction and monitoring to prevent recurrence.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, a review of the facility's available fire alarm maintenance and testing documentation for	K 054	K054 ¿ Smoke Detector sensitivity testing document ¿ will be printed and provided by our vendor by 10 ¿ 26 ¿ 15.	10/26/15

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K 054	Continued From page 5 the last 12 months, and an interview with the Facility Administrator (TL) revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by the Facility Administrator (TL).	K 054		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service	K 056	K056 ¿ Sprinkler heads will be replaced to be the same type in the same department ¿ vendor Viking Sprinkler to do the work by 10-16-15. Jim Knutson, plant operations assistant, will be responsible for correction and monitoring to prevent recurrence.	10/26/15

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ELIM HOME	**701 FIRST STREET** **PRINCETON, MN 55371**

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K 056	Continued From page 6 causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, observations have revealed that there are two different types of sprinkler head mixed in the same compartment, there are 2 quick response heads mixed in with standard type heads located in the 3rd floor Moonlight Bay and in the 2nd floor Pinecone Lane. This deficient condition was verified by the Facility Administrator (TL).	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire	K 062	K062 ¿ Annual Sprinkler test was completed on 9¿25¿15. Terri at Viking Sprinkler will schedule our inspections in a less than 52 weeks in the future. Paul Whitcomb, plant operations director, will be responsible for correction and monitoring to prevent recurrence	10/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	09/21/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 7 sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, a review of documentation and interview with the Facility Administrator (TL) revealed that at the time of the inspection the facility failed to provide any documentation for a current annual fire sprinkler test having been completed. This deficient condition was verified by the Facility Administrator (TL).	K 062		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire.	K 067	K067 ¿ Fire & Smoke Damper test / inspection documentation - will be printed and provided by our vendor by 10 ¿ 26 ¿ 15.	10/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**09/21/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 8 Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Facility Administrator (TL), that the facility had failed to provide documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years. This deficient condition was verified by the Facility Administrator (TL).	K 067		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was not limiting storage near electrical devices in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors of the facility. Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, observations revealed that there was an excessive amount of combustible items being	K 147	K147 ¿ Storage will be removed from up against the left panel, all by October 26. Jim Knutson, plant operations assistant, will be responsible for correction and monitoring to prevent recurrence.	10/26/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**09/21/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 9 stored around and up against the electrical transformers and panels that are located in the first floor mechanical room. This deficient condition was verified by the Facility Administrator (TL).	K 147		

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

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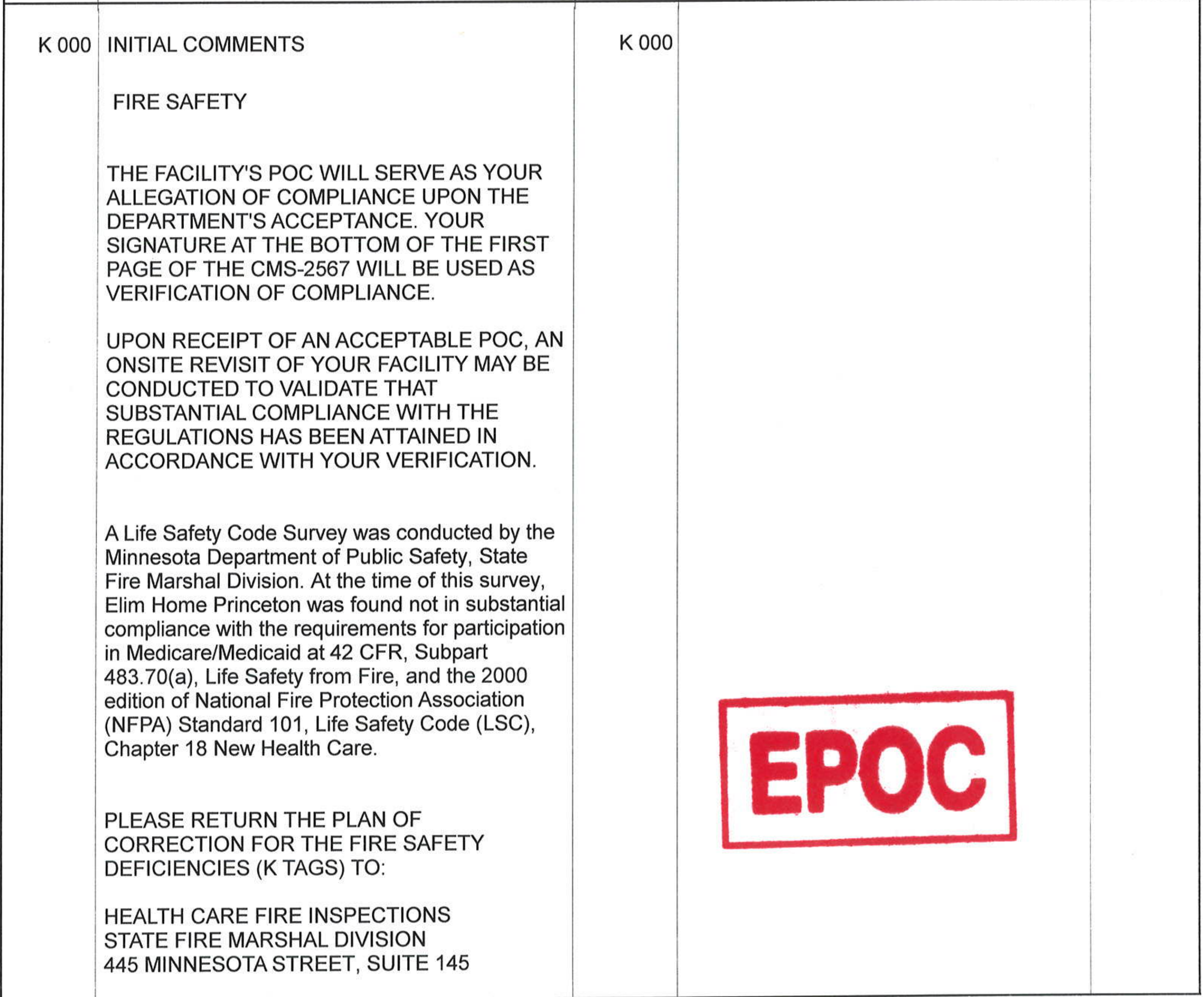
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **02 - BUILDING 2** B. WING ______	**09/21/2015**

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



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Elim Home Princeton 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/12/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING 02 - BUILDING 2 B. WING	09/21/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us or 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 Princeton is a 3 story building with no basement. The building construction type has been determined to be Type II(442). This inspection only reflects the building that opened 11-4-03. It is properly separated from the original building constructed in 1971. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 106 beds and had a census of 97 at the time of the survey.	K 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **02 - BUILDING 2** B. WING	**09/21/2015**

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

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 18.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, during the review of all available maintenance documentation and interview with the Facility Administrator (TL) it was revealed that the facility failed to provide a day shift fire drill in the second quarter of the calendar year.	K 050	K050 ¿ Fire drill did take place during the day shift on 4¿28¿15 however complete documentation wasn¿t available at the time of survey. Documentation now has been found and is in our life safety code 3 ring binder. Jim Knutson, plant operations assistant, will be responsible for correction and monitoring to prevent recurrence.	10/26/15

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	245494	A. BUILDING **02 - BUILDING 2** B. WING	**09/21/2015**

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

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K 050	Continued From page 3 This deficient condition was verified by the Facility Administrator (TL).	K 050		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Facility Administrator (TL) revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by the Facility Administrator (TL).	K 054	K054 ¿ Smoke Detector sensitivity testing document ¿ will be printed and provided by our vendor by 10 ¿ 26 ¿ 15.	10/26/15
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		10/26/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245494	A. BUILDING **02 - BUILDING 2** B. WING ______	**09/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062 SS=F	Continued From page 4 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, a review of documentation and interview with the Facility Administrator (TL) revealed that at the time of the inspection the facility failed to provide any documentation for a current annual fire sprinkler test having been completed. This deficient condition was verified by the Facility Administrator (TL).	K 062	K062 ¿ Annual Sprinkler test was completed on 9¿25¿15. Terri at Viking Sprinkler will schedule our inspections in a less than 52 weeks in the future. Paul Whitcomb, plant operations director, will be responsible for correction and monitoring to prevent recurrence	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		10/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **02 - BUILDING 2** B. WING ______	**09/21/2015**

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

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K 067	Continued From page 5 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 3:00 PM to 6:00 PM on 09/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Facility Administrator (TL), that the facility had failed to provide documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years. This deficient condition was verified by the Facility Administrator (TL).	K 067	K067 ¿ Fire & Smoke Damper test / inspection documentation - will be printed and provided by our vendor by 10 ¿ 26 ¿ 15.	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 2, 2015

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

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number S5494025

Dear Mr. Lundeen:

The above facility was surveyed on September 14, 2015 through September 17, 2015 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility 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 144.56. 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.

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

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 is the Time Period For Correction.

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

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

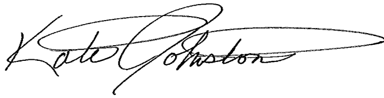
When all orders are corrected, the first page of the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338. A written plan for correction of licensing orders is not required.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,



Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00375	A. BUILDING: ______ B. WING ______	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	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:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00375	A. BUILDING: ____ B. WING ____	09/17/2015

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

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. 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.

On September 14th-17th, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00375	A. BUILDING: ______ B. WING ______	09/17/2015

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ELIM HOME	**701 FIRST STREET PRINCETON, MN 55371**

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation. interview and document review, the facility failed to ensure staff followed the plan of care for toileting assistance for 1 of 3 residents (R107) reviewed for urinary incontinence. Findings include: R107's annual Minimum Data Set (MDS) dated 6/17/15, identified R107 had long and short-term memory problems, was "rarely/never understood", required extensive assistance with toileting, and was frequently incontinent of bladder. R107's care plan dated 6/27/15, identified R107 to be incontinent of bladder with a goal of R107 having "...no skin breakdown r/t incontinence." Further, the care plan directed staff to, "Toilet every 2 - [to] 3 hours during the day and as needed."	2 565	corrected	10/26/15

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2 565	Continued From page 3	2 565		

During an observation of toileting on 9/17/15, at 9:45 a.m., nursing assistant (NA)-B and registered nurse (RN)-F assisted R107 into the Skyview Spa. R107 was assisted to stand using a mechanical lift, and her pants removed exposing a white incontinence pad that was visibly saturated with dark yellow urine. NA-B removed the incontinence pad and disposed of it in the trash can, however a lingering odor or urine remained in the room with NA-B adding the incontinence pad was "very" saturated. R107 was seated on the toilet but did not urinate. At 10:00 a.m. R107 was assisted to stand, and NA-B performed perineal cares before a new incontinence product was placed and R107 was assisted back into her wheelchair.

When interviewed on 9/17/15, at 10:03 a.m. NA-B stated R107 has urinary incontinence "most of the time", and should be assisted to the toilet every "two to three hours." R107 had been assisted with morning cares and dressing by the previous shift "about 6 o'clock" that morning. This was the last time she was checked/toileted for incontinence. Further, NA-B reviewed a Last Time Touched document at the desk, and stated the last time R107 had been assisted since being dressed was 5:52 a.m. that morning, three hours and 53 minutes earlier.

During interview on 9/17/15, at 10:11 a.m. NA-C stated she was NA-B's partner for the shift that particular day, and R107 had not been assisted with toileting since 5:42 a.m.. Further, NA-C stated R107 should be assisted to the bathroom and helped with toileting every "two to three hours."

R107's Vitals Report dated 9/16/15 to 9/17/15, identified the last time R107 had been assisted

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2 565	Continued From page 4 with toileting as "05:52 [5:52 a.m.]", and R107 had been incontinent of urine at that time when assisted. When interviewed on 9/17/15, at 10:17 a.m. RN-F stated the care plan is "a way for us to manifest our nursing assessments", and they are used "to direct the resident care." Further, R107 should have been assisted with toileting "every two to three hours" as directed by her plan of care. A facility policy on care planning was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized	2 910		10/26/15

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2 910	Continued From page 5	2 910		
	unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
	This MN Requirement is not met as evidenced by: Based on observation. interview and document review, the facility failed to provide timely assistance with toileting to promote urinary continence for 1 of 3 residents (R107), who was dependent upon staff for toileting..		corrected	
	Findings include: R107's annual Minimum Data Set (MDS) dated 6/17/15, identified R107 had long and short-term memory problems, was "rarely/never understood", required extensive assistance with toileting, and was frequently incontinent of bladder. During observation on 9/14/15, at 12:14 p.m. R107 was seated in her wheelchair in the Skyview dining room, and had a distinct urine odor present to her. R107's Nursing Observations assessment dated 6/18/15, identified R107 had frequent episodes of functional urinary incontinence (incontinence resulted from being unable to toilet themselves for mental or physical reasons). R107 was "at risk for incontinence r/t [related to] DX [diagnosis] of Alzheimer [sic], impaired mobility and medications", and directed staff to, "see care plan			

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2 910		2 910		

Continued From page 6

for current interventions."

R107's care plan dated 6/27/15, identified R107 to be incontinent of bladder with a goal of R107 having "...no skin breakdown r/t incontinence." Further, the care plan directed staff to, "Toilet every 2 - [to] 3 hours during the day and as needed."

During an observation of toileting on 9/17/15, at 9:45 a.m. nursing assistant (NA)-B and registered nurse (RN)-F assisted R107 into the Skyview Spa. R107 was assisted to stand using a mechanical lift, and her pants removed exposing a white incontinence pad that was visibly saturated with dark yellow urine. NA-B removed the incontinence pad and disposed of it in the trash can, however a lingering odor or urine remained in the room with NA-B adding the incontinence pad was "very" saturated. R107 was seated on the toilet but did not void on her own. At 10:00 a.m. R107 was assisted to stand, and NA-B performed perineal cares before a new incontinence product was placed and R107 was assisted back into her wheelchair.

When interviewed on 9/17/15, at 10:03 a.m. NA-B stated R107 has urinary incontinence "most of the time", and should be assisted to the toilet every "two to three hours." R107 had been assisted with am cares and dressing by the previous shift "about 6 o'clock" that morning, and that was the last time she was checked. Further, NA-B reviewed a Last Time Touched document at the desk, and stated the last time R107 had been assisted since being dressed was 5:52 a.m. that morning (three hours and 53 minutes prior).

During interview on 9/17/15, at 10:11 a.m. NA-C stated she was NA-B's partner for the shift that

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2 910	Continued From page 7 particular day, and R107 had not been assisted with toileting since 5:42 a.m.. Further, NA-C stated R107 should be assisted to the bathroom and helped with toileting every "two to three hours." R107's Vitals Report dated 9/16/15 to 9/17/15, identified the last time R107 had been assisted with toileting as "05:52 [5:52 a.m.]", and R107 had been incontinent of urine at that time when assisted. When interviewed on 9/17/15, at 10:17 a.m. RN-F stated R107 is frequently incontinent of urine and should be assisted with toileting "every two to three hours." A facility policy on urinary incontinence was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to monitoring and provision of incontinence care, and provide staff education related to the care of residents with urinary incontinence. The director of nursing or designee could develop an audit tool to ensure appropriate and timely incontinence care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing	2 915		10/26/15

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2 915	Continued From page 8	2 915		

home must ensure that:

A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to:

(1) bathe, dress, and groom;
(2) transfer and ambulate;
(3) use the toilet;
(4) eat; and
(5) use speech, language, or other functional communication systems; and

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 5 residents (R107), reviewed for activities of daily living, was provided assistance with eating when required.

corrected

Findings include:

R107's annual Minimum Data Set (MDS) dated 6/17/15, identified R107 had long and short term memory problems, was "rarely/never understood", and required supervision with eating.

R107's care plan dated 9/10/15, identified R107 required "encouragement with eating", and directed staff to, "Assist with feeding as res. [resident] allows."

During observation of the lunch meal on 9/16/15,

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2 915	Continued From page 9 at 12:25 p.m. R107 was seated at a table with one other resident in the Skyview dining room. R107 had a white colored lipped plate she was holding up from the table in her left hand which contained diced carrots, rice, and country fried steak, along with two glasses on the table, one contained a red juice with pieces of diced carrot in it, and a glass of water with food smeared all over the outside of the glass. R107 was picking up spilled rice and carrots from the table and eating it using her fingers while holding her plate. At 12:27 p.m. nursing assistant (NA)-C walked over to R107's tablemate and visited with her, however made no offer of assistance to R107 who continued to pick up food from the table using her fingers. At 12:29 p.m. NA-C served R107's tablemate her food, and promptly left the table making no offer to assist or re-direct R107 who was still eating the spilled rice and carrots from the table top using her fingers. At 12:31 p.m. R107 continued to play with the spilled food on her table until 12:39 p.m. when NA-C served her a piece of banana cake in a small dish. NA-C made no offer to assist R107 to eat the cake or meal, as she continued to push food around on the table and plate using her fingers. At 12:42 p.m. registered nurse (RN)-F entered the dining room and offered R107's tablemate assistance with eating, but did not offer any assistance to R107 as she continued to eat food using her fingers. At 12:46 p.m. RN-F approached R107 at the table and asked, "How are you doing?" to her, and R107 responded with non-sensical speech. RN-F cut up R107's banana cake in the small dish using a fork and asked her, "Do you mind if I get this rice off of you?", as she brushed it off her clothing and onto the floor. RN-F then picked up the glass of red juice and removed it from the table telling R107 she was removing it "since you got a carrot in it" and left the table. R107	2 915		

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2 915	Continued From page 10	2 915		

Continued From page 10

remained seated at the table pushing food around and eating using her fingers, spilling large amounts on the floor and herself until 12:51 p.m. (26 minutes later) when she pushed the plate away from herself on the table using her soiled clothing protector.

When interviewed on 9/16/15, at 12:57 p.m. NA-D stated R107 typically "wears a lot of it [food]" when she is left alone to eat by herself without any assistance. The staff often try to help her when they bring her a plate of food, however she would often refuse assistance so staff just leave her alone to "do what she does" with the food (referring to her playing with it). Further, NA-D stated staff "should give her more finger food" so she could eat with her hands if that was her preference adding, "I wonder why there is no alternative offered [versus rice and carrots]."

During interview on 9/16/15, at 1:11 p.m. RN-F stated R107 will "sometimes use her utensils" for eating, adding she did not feel rice was an appropriate meal choice for R107, given her history of mixing up and playing with her food. RN-F reviewed R107's care plan, and stated R107 "should have been re-approached, and offered cues and encouragement" to eat her meal. RN-F also said "We don't have anything different in place" if R107 is playing with her food and not accepting assistance.

A facility policy on activities of daily living was requested, but none was provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review and revise policies and procedures related to activities of daily living (ADLs), and provide staff education related to appropriate and timely

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2 915	Continued From page 11 provision of ADLs for residents. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff assisted residents with personal hygiene and grooming for 2 of 3 residents (R6, R8) who were dependent upon staff for their cares. Findings include: R6's annual Minimum Data Set (MDS) dated 6/16/15, identified R6 had intact cognition, and required "total dependence" on staff for his personal hygiene. During observation on 9/14/15, at 3:29 p.m. R6 was in his room in bed. R6 had long fingernails on both hands, with several of his nails having a dark-colored substance visible underneath the nail. In addition, R6 had visible white and gray facial hair on his upper lip and chin. R6 stated he	2 920	corrected	10/26/15

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2 920	Continued From page 12	2 920		

likes his nails kept "shorter" than they were, and did not want facial hair on his face. When subsequently observed on 9/15/15, at 1:31 p.m. R6 continued to have long, dirty fingernails and visible, uncut facial hair.

When observed for evening cares on 9/15/15, at 7:31 p.m. nursing assistant (NA)-E cleaned R6's face and eyes, and asked R6 "forget to shave today?" R6 responded that "nobody offered" to shave him, so it was not completed. NA-E finished R6's evening cares, however made no offer to shave him, or trim and clean his fingernails.

R6's care plan dated 6/18/15, identified R6 had an, "Alteration in ADLs of dressing, grooming and bathing..." Further, the care plan directed staff to complete, "Nail care as needed with bath..."

During interview on 9/16/15, at 8:44 a.m. NA-B stated R6 required total assistance to complete his personal hygiene and grooming, "[We] do all of that for him." Staff were expected to complete personal hygiene for residents "every morning and evening." NA-B observed R6's facial hair and long, dirty fingernails. NA-B stated R6 "needs to be shaved", and his fingernails "need to be clipped down."

When interviewed on 9/16/15, at 12:08 p.m. licensed practical nurse (LPN)-A stated R6 was "totally dependent" on staff for his care, and staff were expected to help him shave daily as R6 had a preference "to be clean shaven." Further, LPN-A was unaware of any preference to have long fingernails, and they should be clipped and cleaned, "They look like they could be cleaned underneath."

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2 920	Continued From page 13	2 920		

R8's quarterly MDS, dated 8/3/15, identified R8 was cognitively intact, had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of on side of the body), and required extensive assistance to complete personal hygiene.

During observation on 9/14/15, at 12:49 p.m. R8 was in his room and had long fingernails on both of his hands. R8 stated, "I think they are too long right now."

During observation on 9/15/15, at 6:56 p.m. R8 was lying on his back in his bed in his room. R8 had long fingernails noted on both of his hands. During a subsequent observation on 9/16/15, at 1:08 p.m. R8 continued to have long, untrimmed fingernails on both of his hands.

When interviewed on 9/15/15, at 6:45 p.m. R8 stated, "I think my fingernails are too long right now." He also stated his nails are trimmed pretty much when the staff "get around" to it. R8 stated, "I like my nails nice and short."

During interview on 9/16/15., at 1:10 p.m. nursing assistant (NA)-A stated that nursing assistant's trim resident's nails on their bath days. She further stated that R8's bath day was on Thursdays. NA-A also stated R8's nails "are long" and "they do need to be cut." In addition, NA-A was not sure when R8's nails were last trimmed or when staff had last offered to trim his nails.

When interviewed on 9/17/15, at 10:56 a.m. registered nurse (RN)-D stated she was not aware of R8 ever refusing nail care. RN-D also stated R8 received his baths on the night shift and it was the night shifts responsibility to

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2 920	Continued From page 14	2 920		

complete R8's nail care during his bath time.

A facility Standards of Care / Expectations policy, dated 10/3/14, identified staff should "shave male residents" on a daily basis, and for nail care to be "completed on bath day..."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review and revise policies and procedures related to activities of daily living (ADLs), and could provide staff education related to appropriate and timely provision of ADLs for residents who require extensive assistance. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		10/26/15

Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure staff cleaned and sanitized a blood glucose meter in between resident use, which had potential to affect 6 of 6 residents (R173, R172, R169, R20, R174, R175) who shared a glucometer; ensure staff properly handled soiled incontinence products and linens

Provider's plan of correction: corrected

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to reduce the potential spread of infection, which affected 2 of 5 residents (R117, R68) observed during cares; ensure staff washed hands after providing perineal care for 1 of 5 residents (R68) observed during cares, and; maintain clean resident care equipment for 1 of 1 residents (R165) who utilized a commode.

Findings include:

LACK OF CLEANING BLOOD GLUCOSE METER:

R173 was observed during a blood glucose monitoring on 9/17/15, at 11:18 a.m. with registered nurse (RN)-B who pierced R173's finger using a lancet, and placed a large drop of blood on the collection strip of the Assure Platinum blood glucose meter to measure R173's blood glucose level. At 11:29 a.m. RN-B finished administering R173 medication and returned to the mobile medication cart in the hallway, placing the soiled blood glucose meter on top of the cart without disinfecting the meter after obtaining a sample of R173's blood. At 11:57 a.m. RN-B washed her hands in the medication room, and picked up the soiled blood glucose meter from the medication cart. RN-B approached another resident, R174 in the dining room and assisted her to the Turnaround Point spa to check her blood glucose. RN-B placed a new collection strip into the machine and instructed R174 to hold out her finger to get a blood sample. RN-B was stopped by the surveyor before she used the soiled blood glucose meter.

When interviewed on 9/17/15, at 11:57 a.m. RN-B stated she did not disinfect the blood glucose meter after using it to obtain R173's blood glucose reading, "You're right, I didn't", and added

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the meter should have been disinfected with a hydrogen peroxide wipe between each resident use.

A Turnaround Point Diabetics form dated 9/17/15, identified R173, R172, R169, R20, R174, R175 currently resided on the unit, and were all using the same Assure blood glucose meter.

During interview on 9/17/15, at 1:30 p.m. RN-C stated the glucometer was for community use (meaning all residents on the unit used it), and it should be disinfected between each resident, "After they [staff] use it, they clean it." Further, RN-C stated it needed to be cleaned for "infection control purposes."

During in interview on 9/17/15 at 1:55 p.m., the assistant director of nursing (ADON) stated the protocol for shared glucometer included "cleansing it with disinfecting wipes" between resident use. Further, the ADON said, the glucometer was to be left in the disinfectant towel for "at least two minutes" before going on to the next resident. "That is the protocol," the ADON said.

A Cleaning and Disinfecting your Assure Platinum Blood Glucose Meter manufacture manual dated 12/14, identified, "CMS [Centers for Medicare and Medicaid Services] guidelines read that blood glucose meters need to be cleaned and disinfected after each use", and staff should be cleaning the meters in between each resident as "...meters are at high risk of becoming contaminated with bloodborne pathogens such as Hepatitis B Virus [HBV], Hepatitis C Virus [HCV], and Human Immunodeficiency Virus [HIV]."

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IMPROPER HANDLING OF SOILED INCONTINENCE PRODUCTS AND LINENS:

R117's quarterly Minimum Data Set (MDS) dated 6/17/15, identified R117 had severe cognitive impairment, and was "occasionally incontinent" of urine.

During observation of morning care on 9/16/15, at 9:15 a.m. nursing assistant (NA)-F assisted R117 into the restroom. NA-F assisted R117 to take down her pants, exposing a urine soiled incontinence brief. NA-F removed R117's soiled incontinence pad using her bare hands, and threw it on the floor next to the toilet and a small trash can. NA-F applied a new incontinence pad to R117, and then washed her hands in the sink before completing R117's morning cares.

When interviewed on 9/16/15, at 9:42 a.m. NA-F stated she did not have gloves on when she removed the urine soiled brief from R117, but "should have worn gloves" in case the urine from the soiled pad would have gotten on her hands.

During interview on 9/16/15, at 12:04 p.m. registered nurse (RN)-F stated NA-F should have followed standard precautions when handling R117's soiled brief and had gloves on. Further, RN-F stated gloves are used when handling soiled incontinence briefs to help "break the chain of infection."

R68's annual MDS, dated 5/29/2015, indicated severe cognitive impairment. The MDS further indicated R68 required extensive assistance with activities of daily living (ADLs), including one-person physical assist with personal hygiene.

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During observation on 9/16/2015 at 9:16 a.m., nursing assistant (NA)-B provided R68 with routine morning cares. NA-B retrieved a plastic basin, filled it with warm water from the bathroom, and before returning to R68's bedside, donned gloves. NA-B did not wash her hands prior to the glove placement. Following the washing of R68's face, hands, arms, and upper body, NA-B provided R68 with perineal care. R68 was incontinent brief was moderately urine soaked, and also had a small amount of feces.. With gloves still on, NA-B took the plastic wash basin into the bathroom, flushed and rinsed the basin, removed and disposed her gloves, then returned the basin to the drawer. NA-B then took R68's denture cup into the bathroom, drained and rinsed off the dentures, donned a new pair of gloves, and placed the teeth into R68's mouth. NA-B did not wash her hands between the glove changes, after having just provided perineal care for R68. After removing the 2nd pair of gloves, NA-B completed grooming for R68. Exiting the room briefly, NA-B returned to R68's room with two plastic bags. NA-B relined the wastebasket with a new liner, tying shut the bag containing used gloves and R68's soiled brief. With the other bag, NA-B gathered the soiled linens and R68's gown from the floor, and bagged the articles. NA-B then pushed R68 out from her room in the wheelchair, the plastic bags swinging near the wheel chair handles as she pushed the wheel chair into the dining room. NA-B exited the dining room, plastic bags in had, and placed them in the soiled utility area. After emerging from the utility area, NA-B applied sanitizer to her hands.

During an interview on 9/16/2015 at 9:56 a.m., NA-B stated "I did not wash my hands" after providing perineal cares for R68. NA-B stated she "should have washed my hands" before

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inserting R68's dentures. NA-B said she forgot to bring a bag into R68's room, and the soiled towels, gown and soaker pad "should have been placed in the bag" and not on the floor. NA-B also said she "should have washed with soap and water" after completing cares and dropping off the laundry, before assisting another resident.

In an interview on 9/17/2015 at 1:53 p.m., the assistant director of nursing (ADON) stated "all staff" were trained to wash hands "before and after donning gloves," especially if staff were providing personal cares. The ADON also said the staff were trained to bring in three plastic bags into resident rooms, to replace the existing garbage can liners, and "one for personal laundry, and one for linens." The ADON also stated three had been "infection control (IC) training in July," and all nursing staff get training annually, and "all new hires" receive IC training "before going on the floor."

SOILED RESIDENT BATHROOM EQUIPMENT

R165's MDS, dated 8/13/2015, indicated he was cognitively intact, and independent with toileting.

During observation on 9/15/2015 at 7:20 p.m., it was noted that in R165's bathroom, which was shared by another male resident in the adjoining room, a commode stood over the stool. R165's commode was used as a raised toilet seat, designed with a cut out bottom, placed over the existing bathroom stool, and was equipped with side hand rails, which provided R165 stability, and a place to grip, allowing him to transfer independently on and off the seat. The inside of the plastic bowl, between the seat and toilet, was covered with a layer of dried, dark brown-colored

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feces, extending around the entire inside circumference of the bowl. The dried feces produced a malodorous scent in R165's shared bathroom.

During observation the next day, on 9/16/2015 at 9:24 a.m., R165's commode remained positioned over the stool in the bathroom. The inside of the commode bowl remained unclean, with the dried feces present, and the odor was still present and noticeable.

In an interview on 9/16/2015 at 12:53 p.m., R165 stated that when the commode bowl was"soiled and dirty like that, I didn't even want to use the bathroom." R165 said when it gets dirty, "It should be cleansed right away, and not left. "It is disgusting." R165 also stated that "today" was not the first time he encountered an unclean bathroom, and added he felt the bathroom, the floor, and toilet "can get very dirty between cleanings." R165 said the housekeeper only came through "once a week."

During an interview on 9/17/2015 at 1:53 p.m., the assistant director of nursing (ADON) in charge of infection control, stated that if feces is present on any surface, "It should be cleaned right away," and that it was "an infection control concern." The ADON stated the responsibility to clean up bodily fluids falls on "whoever sees it, it is all our responsibility." The ADON also said she would expect resident commodes "to be always cleaned."

A facility document, "Infection Control, Housekeeping," revised August 2009, directed: "Routine cleaning procedures for bed, bedside table, chair, floors, etc, shall be followed when

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21375	Continued From page 21 soiling or spills occur..." Further, the policy indicated "Surfaces soiled with blood or body fluids shall be cleaned in accordance with established procedures for cleaning up spills or splashes of blood or body fluids." A facility "Infection Control" document, updated August 2009, indicated it was the facility policy "...to keep the environment clean an microbiologically safe...To prevent infection in resident, staff and visitors." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to infection control, and provide staff education related to: appropriate cleansing of shared glucometers; appropriate handling of soiled linen and incontinence products; appropriate hand washing; and timely cleaning of resident care equipment. The director of nursing or designee could develop an audit tool to ensure appropriate infection control techniques are consistently applied. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced	21565		10/26/15

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21565	Continued From page 22 by: Based on observation, interview and document review, the facility failed to comprehensively assess for the safe self administration of insulin for 1 of 1 residents (R173) observed to self administer insulin during the survey. Findings include: R173's Brief Interview for Mental Status (BIMS, a screening tool used to evaluate cognition), dated 9/16/15, identified R173 had intact cognition. During observation of medication administration on 9/17/15, at 11:18 a.m. registered nurse (RN)-B removed a plastic bag containing several V-GO self infusing cartridges of insulin (a device used to inject insulin in doses set by the user) from a refrigerator in the Turnaround Point medication room. The cartridges were labeled, "V-GO DISPOSABLE INSULIN DELIVERY", however did not identify the medication inside the cartridge, the dosing of the medication R173 was to receive, or directions for administration of the medication. At 11:22 a.m., RN-B entered R173's room with the cartridge of insulin and handed it to R173. RN-B asked R173 if the un-labeled cartridge contained the "correct insulin" for him, and R173 replied, "I think so." R173 set the cartridge on a bedside table next to his recliner chair, and stated he would apply it later after he let it "warm up a little bit." RN-B asked R173 if administering his insulin was "something you do yourself, or we do [for him]?" R173 stated he does it himself because using the cartridge was "a new thing" and many of the staff do not know how to operate it. At 11:48 a.m. (26 minutes later) R173 removed a plastic cap from the cartridge exposing a sticky surface used to attach the cartridge to the skin, and affixed it to his right	21565	corrected	

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arm, inserting a needle and pumping a gray trigger on the device seven times. R173 stated his physician was still adjusting the dosing, and the times he engages the pump on the device has been changing because of this.

When interviewed on 9/17/15, at 11:31 a.m. RN-B stated R173 brought the V-GO cartridges from home when he admitted to the facility. RN-B had reviewed the Medication Administration Record, and the type of insulin R173 was to receive was not identified, but he was "able to use it properly by himself."

R173's medical record was reviewed and included no indication R173 had been assessed to safely self administer his insulin, using the V-GO cartridge.

During interview on 9/17/15, at 1:30 p.m. RN-C stated R173's V-GO cartridge was new, and staff "don't know a whole lot about it yet." RN-C stated R173 self administers different amounts of the insulin from the cartridge, but no assessment of his ability to safely self administer the medication had been completed, but should have "to make sure they're doing it accurately and safely."

When interviewed on 9/17/15, at 3:43 p.m. the director of nursing (DON) stated R173 should have been assessed for safety before being allowed to self administer his own insulin using the V-GO cartridge, "[R173] should have the SAM [self administration of medication assessment] completed."

A facility Medication - Self Administration policy dated 6/2000, identified, "All new admissions shall have their medications administered by facility staff, until an interdisciplinary team can

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21565	Continued From page 24 determine the ability of the resident to self-administer their medications." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for assessments, including self-administration of medication. The DON or designee could develop a system to educate staff, and develop a monitoring system to ensure staff complete all needed resident assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin was properly labeled to ensure its safe administration for 1 of 1 residents (R173), observed to use insulin during the survey. Findings include: R173's Brief Interview for Mental Status (BIMS, a screening tool used to evaluate cognition), dated 9/16/15, identified R173 had intact cognition. During observation of medication administration on 9/17/15, at 11:18 a.m., registered nurse (RN)-B removed a plastic bag containing several V-GO [a trademark name] self-infusing cartridges	21620	corrected	10/26/15

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of insulin (a device used to inject insulin in doses set by the user) from a refrigerator in the Turnaround Point medication room. The cartridges were branded by the manufacturer, "V-GO DISPOSABLE INSULIN DELIVERY", but did not, however, identify the medication inside the cartridge, the dosing of the medication R173 was to receive, or directions for administration of the medication. At 11:22 a.m., RN-B entered R173's room with the cartridge of insulin and handed it to R173. RN-B asked R173 if the un-labeled cartridge contained the "correct insulin" for him, and R173 replied, "I think so." At 11:48 a.m. (26 minutes later) R173 self administered the un-labeled insulin to himself.

During interview on 9/17/15, at 11:30 a.m. RN-B stated R173 brought the un-labeled insulin cartridges from home, and she was "trusting what he's [R173] telling me" regarding the contents inside the cartridges. Further, RN-B allowed R173 to use the un-labeled insulin because she "didn't have a choice", and using un-labeled medications for administration "makes me [RN-B] nervous."

When interviewed on 9/17/15, at 1:30 p.m. RN-C stated R173's family member was bringing the medication in from home to use, and it was "supposed to be labeled" with the current medication, dose, and expiration date.

During interview on 9/17/15, at 1:40 p.m. the dispensing pharmacist (DP) stated medications being administered in the facility should be labeled accurately to include the medication name, dosage, directions for administration, and the date it was filled. Further, DP stated all medications should be labeled correctly so nursing staff could verify the "accuracy and

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correct dose" of the medication being administered.

When interviewed on 9/17/15, at 3:43 p.m. the director of nursing (DON) stated she had observed R173's insulin cartridges and "didn't see any proper labeling on it." Further, the DON added R173's insulin cartridges should have been labeled to ensure safe administration of the medication.

An undated facility Medication Labels policy identified, "Medications are labeled in accordance with facility requirements and state and federal laws." Further, the policy identified the following information must be present on a medication label to include, "Patient's name", "Specific directions for use...", and "Strength of medication."

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage and labeling of medications. Nursing staff could be educated, as necessary, on the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.

21665	MN Rule 4658.1400 Physical Environment	21665		10/26/15

A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use

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21665	Continued From page 27 personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean bathroom device for 1 of 1 residents (R165) whose raised-seat commode was observed unclean. Findings include: R165's admission Minimum Data Set (MDS), dated 8/13/2015, indicated he was cognitively intact. During observation on 9/15/2015 at 7:20 p.m., it was noted in R165's bathroom, which was shared by another male resident in the adjoining room, a commode stood over the stool. R165's commode was a raised toilet seat, designed with a cut out bottom, placed over the existing bathroom stool, and was equipped with side hand rails, which provided R165 stability, and a place to grip, allowing him to transfer independently on and off the seat. The inside of the plastic bowl, between the seat and toilet, was covered with a layer of dried, dark brown-colored feces, extending around the entire inside circumference of the bowl. The dried feces produced a malodorous scent in R165's shared bathroom. During observation the next day, on 9/16/2015 at 9:24 a.m., R165's commode, still positioned over the stool in the bathroom, had a noticeable odor, and the inside of the bowl remained unlearned, with the dried feces present. In an interview on 9/16/2015 at 12:53 p.m., R165	21665	corrected	

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stated that when the commode bowl was"soiled and dirty like that, I didn't even want to use the bathroom." R165 said when it gets dirty, "It should be cleansed right away, and not left. "It is disgusting." R165 also stated that "today" was not the first time he encountered an unclean bathroom, and added he felt the bathroom, the floor, and toilet "can get very dirty between cleanings." R165 said the housekeeper only came through "once a week."

In an interview on 9/16/2015 at 1:50 p.m., registered nurse (RN)-E stated R165's commode had been cleaned. RN-E said the nursing staff were responsible for the "day-to-day cleaning" in the resident rooms, including things like the commode. RN-E said she would "expect" R165's commode be clean, and that it "should have been cleaned sooner."

During an interview on 9/17/2015 at 1:53 p.m., the assistant director of nursing (ADON) in charge of infection control, stated that if feces is present on any surface, "It should be cleaned right away," and that it was "an infection control concern." The ADON stated the responsibility to clean up bodily fluids falls on "whoever sees it, it is all our responsibility." The ADON also said she would expect resident commodes "to be always cleaned."

A facility document, "Infection Control, Cleaning/Disinfection," updated August 2009, indicated the facility policy was to "keep the environment clean and microbiologically safe," and "To prevent infection in resident, staff and visitors."

SUGGESTED METHOD OF CORRECTION:

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The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping and conduct periodic audits of resident care equipment, to ensure a safe, clean, functional and homelike environment is maintained in the facility.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights	21805		10/26/15

Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure for 2 of 3 residents (R6, R107) reviewed for activities of daily living were found to be unshaven, had soiled/long fingernails and was not provided assistance to enhance their dignity. Furthermore, the facility had not properly cleaned a commode and bath blanket with dried visible feces to enhance a residents dignity for 2 of 2 residents (R165, R73) who had feces on their personal care equipment.

corrected

Findings include:

LACK OF GROOMING:

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R6's annual Minimum Data Set (MDS) dated 6/16/15, identified R6 had intact cognition, and required "total dependence" on staff for his personal hygiene.

During observation on 9/14/15, at 3:29 p.m. R6 was in his room in bed. R6 had long fingernails on both hands, with several of his nails having a dark colored substance visible underneath the nail. In addition, R6 had visible white and gray facial hair on his upper lip and chin. R6 stated he likes his nails kept "shorter" than they were, and did not want facial hair on his face. R6 stated he "used to shave everyday" because he was a salesman and "always was very clean." Further, R6 stated not being kept as clean as he used to before coming to the nursing home this "don't make me happy", and added, "What can I do about it?" When subsequently observed on 9/15/15, at 1:31 p.m. R6 continued to have long, dirty fingernails and visible facial hair on his face.

When observed for evening cares on 9/15/15, at 7:31 p.m. nursing assistant (NA)-E cleaned R6's face and eyes, and asked R6 if he "forget to shave today?" R6 responded that "nobody offered" to shave him, so it was not completed. NA-E finished R6's evening cares, however she did not offer to shave him, or trim and clean his fingernails despite even though R6 told NA-E he was not offered to get shaved.

R6's care plan dated 6/18/15, identified R6 had an, "Alteration in ADLs of dressing, grooming and bathing..." Further, the care plan directed staff to complete, "Nail care as needed with bath..."

During interview on 9/16/15, at 8:44 a.m. NA-B stated R6 required total assistance to complete

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his personal hygiene and grooming, "[We] do all of that for him." Staff were expected to complete personal hygiene for residents "every morning and evening." NA-B observed R6's facial hair and long, dirty fingernails. NA-B stated R6 "needs to be shaved", and his fingernails "need to be clipped down" adding, "It doesn't look good."

When interviewed on 9/16/15, at 12:08 p.m. licensed practical nurse (LPN)-A stated R6 was "totally dependent" on staff for his care, and staff were expected to help him shave daily as R6 had a preference "to be clean shaven." Further, LPN-A was unaware of any preference to have long fingernails, and they should be clipped and cleaned, "They look like they could be cleaned underneath."

On 9/17/15, at 8:31 a.m. family member (FM)-G was interviewed about R6's care in the facility. FM-G stated R6 used to clip his nails and shave "every single day." R6 used to be a salesman and appearance was very important to him. Further, FM-G stated R6's grooming was not being completed "as often as I would like", and it was concern for his well-being, "A person does feel better about themselves when not laying there scuzzie in bed."

LACK OF ASSISTANCE WITH EATING:

R107's annual Minimum Data Set (MDS) dated 6/17/15, identified R107 had long and short term memory problems as she was "rarely/never understood", and required supervision with eating.

During observation of the lunch meal on 9/16/15,

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21805	Continued From page 32 at 12:25 p.m. R107 was seated at a table with one other resident in the Skyview dining room. R107 had a white colored lipped plate she was holding up from the table in her left hand which contained diced carrots, rice, and country fried steak. There were two glasses on the table, one contained a red juice with pieces of diced carrot in it, and a glass of water with food smeared all over the outside of the glass. R107 was picking up spilled rice and carrots from the table and eating it using her fingers while holding her plate in her hand. At 12:27 p.m. nursing assistant (NA)-C walked over to R107's tablemate and visited with her, however made no offer of assistance to R107 who continued to pick up food from the table using her fingers and eating it. At 12:29 p.m. NA-C served R107's tablemate her food, and promptly left the table making no offer to assist or re-direct R107 who was still eating the spilled rice and carrots from the table top using her fingers. At 12:31 p.m. R107 continued to play with the spilled food on her table until 12:39 p.m. when NA-C served her a piece of banana cake in a small dish. NA-C made no offer to assist R107 to eat the cake or meal, as R107 continued to push food around on the table and plate using her fingers. At 12:42 p.m. registered nurse (RN)-F entered the dining room and offered R107's tablemate assistance with eating, but did not offer any assistance to R107 as she continued to eat food using her fingers. At 12:46 p.m. RN-F approached R107 at the table and asked, "How are you doing?", R107 responded with non-sensical speech. RN-F cut up R107's banana cake in the small dish using a fork and asked her, "Do you mind if I get this rice off of you?", as she brushed it off her clothing and onto the floor. RN-F then picked up the glass of red juice and removed it from the table telling R107 she was removing it "since you got a carrot in it"	21805		

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and left the table. R107 remained seated at the table pushing food around and eating using her fingers, spilling large amounts on the floor and herself until 12:51 p.m. (26 minutes later) when she pushed the plate away from herself on the table using her soiled clothing protector.

When interviewed on 9/16/15, at 12:57 p.m. NA-D stated R107 typically "wears a lot of it [food]" when she is left alone to eat by herself without any assistance. The staff often try to help her when they bring her a plate of food, however she would often refuse assistance so staff just leave her alone to "do what she does" with the food (referring to her playing with it).

During interview on 9/16/15, at 1:11 p.m. RN-F stated R107 will "sometimes use her utensils" for eating, adding she did not feel rice was an appropriate meal choice for R107 given her history of mixing up and playing with her food. RN-F stated R107 should have been re-approached and offered cues and encouragement to eat her meal, and added, "We don't have anything different in place" if R107 is playing with her food and not accepting assistance. Further, RN-F stated other residents and visitors were watching R107 play with her food and it "looks bad."

SOILED COMMODE WITH FECES

R165's MDS, dated 8/13/2015, indicated he was cognitively intact, and independent with toileting.

During observation on 9/15/2015 at 7:20 p.m., it was noted that in R165's bathroom, which was shared by another male resident in the adjoining room, a commode stood was over the toilet. R165's commode had a raised toilet seat,

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designed with a cut out bottom, placed over the existing bathroom toilet, and was equipped with side hand rails. The inside of the plastic bowl, between the seat and toilet, was covered with a layer of dried, dark brown-colored feces, extending around the entire inside circumference of the commode. The dried feces produced a lingering, malodorous scent in R165's bathroom.

During observation the next day, on 9/16/2015 at 9:24 a.m., R165's commode was again positioned over the toilet in the bathroom. The inside of the commode bowl remained unclean, with dried feces still present and a noticeable odor.

In an interview on 9/16/2015 at 12:53 p.m., R165 stated that when the commode bowl was "soiled and dirty like that, I don't even want to use the bathroom." R165 said when it gets dirty, "It should be cleansed right away, and not left. "It is disgusting." R165 also stated that "today" was not the first time he encountered an unclean bathroom, and added he felt the bathroom, the floor, and toilet "can get very dirty between cleanings." R165 said the housekeeper only came to do a thorough cleaning "once a week."

In an interview on 9/16/2015 at 1:50 p.m., registered nurse (RN)-E stated R165's commode had been cleaned. RN-E said the nursing staff were responsible for the "day-to-day cleaning" in the resident rooms, including things like the commode. RN-E said she would "expect" R165's commode be clean, and that it "should have been cleaned sooner."

During an interview on 9/17/2015 at 1:53 p.m., the assistant director of nursing (ADON) in charge of infection control, stated that if feces is

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present on any surface, "It should be cleaned right away," and that this was "an infection control concern." The ADON stated the responsibility to clean up bodily fluids falls on "whoever sees it, it is all our responsibility." The ADON also said she would expect resident commodes "to be always cleaned."

SOILED BLANKET WITH FECES

R73's MDS dated 7/14/15, was independent with mobility, continent of bladder, and frequently incontinent of bowels (unable to control bowel movements).

R73's care plan, dated 7/14/15, identified R73 required assistance to complete personal hygiene, and "Staff to clean up after incontinent episodes..."

During observation on 9/14/15, at 11:51 a.m., R73 was seated in a recliner chair in her room on a white blanket. R73 stood up and walked to the bathroom exposing a visible, dark-tan discoloration, dried feces, on the blanket, measuring approximately three inches by one inch in size. During a subsequent observation on 9/16/15 at 8:14 a.m., R73's white blanket was in her recliner with several stuffed animals. The size of the stain had increased to approximately four inches by 2 inches in size.

When interviewed on 9/16/15, at 1:43 p.m. nursing assistant (NA)-D stated R73's blanket in her recliner chair was soiled, and "looks like BM [bowel movement]." NA-D proceeded to change the soiled blanket with a new blanket. At approximately 1:50 p.m. on 9/16/15, NA-G stated R73 soiling her blanket in the chair with feces

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was "kind of a regular thing." NA-G also said R73's blanket was often stained "with bowel" and the blanket was "changed as needed."

During a subsequent observation on 9/17/15, at 9:15 a.m., R73's had another white blanket again with visible, dark, tan-colored stain, possible feces, measuring approximately three inches by two inches in size.

During interview on 9/17/15, at 11:04 a.m. family member (FM)-K stated R73 was not always able to perform her own cares due to her dementia. FM-K said R73 had "previous instances" of a blankets with feces left in her chair, sometimes for up to "several days without being changed, " which identifies R73 was incontinent. FM-K stated this was upsetting to (R73), and "It annoys me, but it also makes me sad." Further, FM-K stated (R73) had expressed concerns with it before as well, and also said R73 "thinks someone else" was putting the blanket with feces on her chair. FM-K said "It bothers [R73] every time she sees it, and [R73] thinks someone else has done that."

A facility policy regarding dignity was requested, but none was provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review/revise policies and procedures related to the provision of dignified resident care and services. Employees could be re-educated on these policies. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.

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21805	Continued From page 37 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 6 facility care units (Turnaround Point,a short term care unit), were provided an opportunity to be involved in resident council activities. This had the potential to affect all 15 residents (R172) who resided in the Turnaround Point unit. Findings include: During the initial tour of the facility on 9/14/2015, at 1:27 p.m., resident council meeting minutes were posted on several bulletin boards on all three floors of the facility. However, the minutes only pertained to separate meetings of resident councils, which took place on the second and	21942	corrected	10/26/15

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third floors. The 2nd and 3rd floor each had separate resident councils, and meeting minutes, but contained no input from, or mention of, the Turnaround Point resident unit.

When interviewed on 9/16/15, at 9:59 a.m. registered nurse (RN)-C stated residents on the Turnaround Point unit they were "typically not in the facility" for an extended period of time, but could also reside in the Turnaround Point unit for several weeks or months, depending on how the residents progress with their therapies.

During interview on 9/17/15, at 1:36 p.m. R172 stated she had been residing on the Turnaround Point Unit for a couple weeks, and was "unaware of any Resident Council" for the short term unit, or posting of the minutes from the other floors, or if she was able to attend resident council meetings.

When interviewed on 9/17/15, at 2:00 p.m., social worker (SW)-A stated the resident council minutes "are posted for the Turnaround Point residents," and that " there was no resident council" meeting offered to the Turnaround Point residents. SW-A stated, he felt the residents would not be interested, and that "They don't want to think about themselves as part of a unit."

A facility policy on resident council meetings was requested, but none was provided.

SUGGESTED METHOD OF CORRECTION:
The Administrator, Director of Nursing (DON) or designee, could review/revise policies and procedures related resident rights. The Administrator, DON or designee could work with social services and/or activities to promote,

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21942	Continued From page 39 encourage and provide opportunity for all residents to meet and organize. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		