DEPARTMENT OI	F HEALTH			D CERTIFIC	CATION	CENTERS FOR ME AND TRANSMITTAL	DICARE & MEDICAI ID:	D SERVICES P7U8
						TE SURVEY AGENCY		ility ID: 00375
<ol> <li>MEDICARE/MEDICA         <ul> <li>(L1) 245494</li> <li>2.STATE VENDOR OR N</li></ul></li></ol>			3. NAME AND AI (L3) ELIM HOM (L4) 701 FIRST S (L5) PRINCETO	IE STREET	LILT Y	(L6) <b>55371</b>	<ol> <li>TYPE OF ACTION:</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	<u>7 (L8)</u> 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CH (L9)	HANGE OF O	WNERSHIP	7. PROVIDER/SU 01 Hospital		GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other
<ol> <li>DATE OF SURVEY</li> <li>ACCREDITATION ST         <ol> <li>Unaccredited</li> <li>AOA</li> </ol> </li> </ol>	<b>10/26/</b> CATUS: 1 TJC 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 09/30	DATE: (L35)
11LTC PERIOD OF CEF	RTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:			
From (a): To (b):				nce With equirements ce Based On:		And/Or Approved Waivers O 2. Technical Personne 3. 24 Hour RN	<u>f The Following Requirements</u> <u>6</u> . Scope of Servic <u>7</u> . Medical Director	es Limit
12. Total Facility Beds		106 (L18)	1	cceptable POC		4. 7-Day RN (Rural S 5. Life Safety Code		
13.Total Certified Beds		<b>106</b> (L17)		npliance with Prog ents and/or Appli			(L12)	
14. LTC CERTIFIED BED	) BREAKDOW	VN				15. FACILITY MEETS		
18 SNF	18/19 SNF 106	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37)	(L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AG	ENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNAT	TURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Brenda Fisc	cher, Uni	it Supervisc	or 1	0/26/2015	(L19)	Kate JohnsTon, P	rogram Specialist	12/29/2015 (L20)
	PAR	T II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY	
<ol> <li>DETERMINATION (</li> <li>X_1. Facility is</li> <li>2. Facility is</li> </ol>				IPLIANCE WITI HTS ACT:	H CIVIL		ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HC /e :	2FA-1513)
22. ORIGINAL DATE		23. LTC AGREE	MENT 24	4. LTC AGREEN	<b>MENT</b>	26. TERMINATION ACTION	J: (L30	))
OF PARTICIPATION <b>08/01/1987</b>	1	BEGINNING	G DATE	ENDING DA	ΓE	<u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure		<u>RY</u> et Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimbur		et Agreement
25. LTC EXTENSION D	DATE:	27. ALTERNATI				03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	<u>OTHER</u>	tatus Change
	(L27)	-	n of Admissions: uspension Date:	(L44)			00-Active	latus Change
				(L45)				
28. TERMINATION DAT	ГE:	29	. INTERMEDIARY/	/CARRIER NO.		30. REMARKS		
			03001					
		(L28)			(L31)			
31. RO RECEIPT OF CM	IS-1539	32	2. DETERMINATION	I OF APPROVAL	DATE	Posted 12/29/2015 Co.		
		(L32)	10/28/2015		(L33)	DETERMINATION APP	PROVAL	



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

Minnesota Department of Health - Health Regulation Division • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer



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,

ate Comston

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

#### **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 245494	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/26/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
El	IM HOME		701 FIRST STREET PRINCETON, MN 55371	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix		Correction Completed 10/26/2015	ID Prefix			Correction Completed 10/26/2015		ID Prefix			Correction Completed 10/26/2015
Reg. # LSC	483.10(b)(5) - (	10), 483.10(t		483.10(n)					483.15(a)		_
ID Prefix Reg. # LSC	F0243 483.15(c)(1)-(5)	Correction Completed 10/26/2015	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed <b>10/26/2015</b>		ID Prefix Reg. # LSC	483.25(a)(2)		Correction Completed 10/26/2015
ID Prefix Reg. # LSC	F0312 483.25(a)(3)	Correction Completed 10/26/2015	ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 10/26/2015		ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 10/26/2015
	F0431 483.60(b), (d), (			F0441 483.65		Correction Completed 10/26/2015		Reg. #	F0465 483.70(h)		Correction Completed 10/26/2015
	F0520 483.75(o)(1)	Correction Completed 10/26/2015	Reg. #					D.a. #			
Reviewed I	Зу R	eviewed By	Date:	Signature	of Sur	veyor:				Date:	
State Agen	су	BF/KJ	11/09/20	015			1056	52		10/26	/2015
Reviewed I CMS RO	Зу R	eviewed By	Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Comp 9/17/20			Check for any Uncorrected					Summary of the Facility?	YES	NO

#### **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 245494	(Y2) Multiple Construction A. Building B. Wing 02 - BUI	LDING 2	(Y3) Date of Revisit 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).

		1		5) Date	(Y4)			(Y5)	Date
	Correction			Correction					Correction
	Completed 10/26/2015	ID Prefix		Completed 10/26/2015		ID Prefix			Completed 10/26/2015
		-				0			
K0050		LSC	K0054			LSC	K0062		
	Correction			Correction					Correction
	Completed <b>10/26/2015</b>	ID Prefix		Completed		ID Prefix			Completed
NFPA 101									
						LSC			
	Correction			Correction					Correction
	Completed	ID Drofiv		Completed					Completed
		Reg. #		_		Reg. # LSC			
	Correction			Correction					Correction
	Completed	ID Prefix		Completed		ID Prefix			Completed
		Reg. #				Reg. #			
		LSC		_		LSC			
	Correction			Correction					Correction
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						D //			
		LSC		_		LSC			
Ву	Reviewed By	Date:	Signature of Su	urveyor:				Date:	
су	TL/KJ	11/09/20	15	272	200			10/3	30/2015
Ву	Reviewed By	Date:	Signature of St	urveyor:				Date:	
-	-							YES	NO
	NFPA 101           K0050           NFPA 101           K0067	Completed 10/26/2015           NFPA 101           K0050           NFPA 101           K0067           Correction Completed 10/26/2015           NFPA 101           K0067           Correction Completed           Correction Completed           Correction Completed           Correction Completed           Correction Completed           Set           Reviewed By TL/KJ	Completed 10/26/2015     ID Prefix       NFPA 101     Reg. # LSC       Correction Completed 10/26/2015     ID Prefix       NFPA 101     Reg. # LSC       NFPA 101     Correction Completed        Correction Completed        Correction Completed        Correction Completed        Correction Completed        Correction Completed        D Prefix       Reg. # LSC        ID Prefix       Reg. # LSC	Completed 10/26/2015         ID Prefix         ID           NFPA 101         Reg. #         NFPA 101           K0050         Correction Completed 10/26/2015         ID Prefix         ID           NFPA 101         Reg. #         ID         ID           K0067         Correction Completed         ID Prefix         ID           Correction Completed         ID Prefix         ID         ID           ID         Correction Completed         ID Prefix         ID         ID           ID         Correction Completed         ID Prefix         ID         <	Completed 10/26/2015       ID Prefix       Completed 10/26/2015         NFPA 101       Correction Completed 10/26/2015       NFPA 101       Correction Completed 10/26/2015       Correction Completed         NFPA 101       Correction Completed       ID Prefix       Correction Completed       Correction Completed         NFPA 101       Correction Completed       Correction Completed       Correction Completed       Correction Completed	Completed 10/26/2015         Completed 10/26/2015           NFPA 101 K0050         Correction Completed 10/26/2015         KFPA 101 LSC         Correction Completed           NFPA 101 K0067         Correction Completed         Correction Completed         Correction Completed           NFPA 101 K0067         Correction Completed         Correction Completed         Correction Completed           Correction Completed         Correction Completed         Correction Completed         Correction Completed           Correction Completed         Correction Completed         Correction Completed         Correction Completed           Correction Completed         Correction Completed         Correction Completed         Correction Completed           Correction Completed         Correction Completed         Correction Completed         Correction Completed           Mey Mey Matcher         Correction Correction         Correction Correction Completed         Correction Correction Completed           Mey Mey Mey Matcher         Date:         Signature of Surveyor: Signature of Surveyor:         27200           By Mey Mey Completed on:         Date:         Signature of Surveyor:         27200	Completed 10/26/2015     ID Prefix     Completed 10/26/2015     ID Prefix       NFPA 101     Reg. #     NFPA 101     Reg. #       Correction Completed 10/26/2015     Correction Completed     Correction Completed     ID Prefix       NFPA 101     Correction Completed     ID Prefix     Reg. #       MFPA 101     Correction Completed     Correction Completed     ID Prefix       MFPA 101     Correction Completed     Correction Completed     ID Prefix       MFPA 101     Correction Completed     Correction Completed     Correction Completed       Correction Completed     Correction Completed     Correction Completed     ID Prefix       ID Prefix     Reg. #     LSC     ID Prefix       Correction Completed     Correction Completed     Correction Completed     ID Prefix       ID Prefix     Reg. #     LSC     ID Prefix       Meg. #     LSC     Correction Completed     ID Prefix       ID Prefix     Reg. #     LSC     ID Prefix       Meg. #     LSC     Signature of Surveyor:     Reg. #       ID Prefix     Signature of Surveyor:     Z7200       By     Reviewed By     Date:     Signature of Surveyor:       ID Survey Completed on:     Check for any Uncorrected Deficiencies. Was a	Completed 10/26/2015         ID Prefix         Completed 10/26/2015         ID Prefix         ID Prefix           NFPA 101         LSC         K0062         ID Prefix         Reg. #         NFPA 101         LSC         K0062           Correction Completed 10/26/2015         Correction Completed         Correction Completed         ID Prefix         ID Prefix         Reg. #         ID Prefix         ID	Completed 10/26/2015         ID Prefix         Completed 10/26/2015         ID Prefix         Reg. # NFPA 101           K0050         LSC         K0054         LSC         K0062         ID           Correction Completed 10/26/2015         Correction Completed         Correction Completed         ID Prefix         ID         ID           NFPA 101         Reg. #         Correction Completed         Correction Completed         ID Prefix         ID         ID

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					ND TRANSMITTAL E SURVEY AGENCY		ID: P7U8 Facility ID:	: 00375
1. MEDICARE/MEDICAID PROVIDER I         (L1)       245494         2.STATE VENDOR OR MEDICAID NO.         (L2)       615342900         5. EFFECTIVE DATE CHANGE OF OW		<ol> <li>NAME AND ADI (L3) ELIM HOME</li> <li>(L4) 701 FIRST ST (L5) PRINCETON</li> <li>PROVIDER/SUP</li> </ol>	E FREET N, MN		(L6) <b>55371</b>	4. TYPE 1. Initis 3. Tern 5. Valid 7. On-S	ination 4. CH lation 6. Con	ertification OW nplaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full	Survey After Complaint	
	<b>7/2015</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YI	EAR ENDING DATE:	(L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	0 15 ASC 16 HOSPICE		09/30	( )
2 AOA 3 Other		04 51 11	00 01 1/51	12 Kile	NUNCE IN NUMBER			
11LTC PERIOD OF CERTIFICATION		10. THE FACILITY	IS CERTIFIED AS:					
From (a):		X A. In Complian			And/Or Approved Waivers		quirements:	
To (b) :		Program Ree Compliance			2. Technical Persor 3. 24 Hour RN	_	Scope of Services Limit Medical Director	
12. Total Facility Beds	<b>106</b> (L18)		cceptable POC		5. 24 Hour RN 4. 7-Day RN (Rura 5. Life Safety Code	ll SNF)8.	Patient Room Size Beds/Room	
13.Total Certified Beds	<b>106</b> (L17)		pliance with Program ents and/or Applied V	Vaivers:	* Code: A1*	(L12)		
14. LTC CERTIFIED BED BREAKDOWN	۶				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):	I				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGEN	CY APPROVAL	Date	
Bruce Melc	hert HFE NE		10/13/2015	(L19)	Kate JohnsTor	n, Program S	Specialist 10	0/22/2015 (L20)
	PART II - TO	BE COMPLETEI	D BY HCFA RE	GIONAI	LOFFICE OR SINGLE	STATE AGENCY	Y	
19. DETERMINATION OF ELIGIBILIT          1. Facility is Eligible to Pa          2. Facility is not Eligible			PLIANCE WITH CI ITS ACT:	VIL	<ol> <li>1. Statement of</li> <li>2. Ownership/C</li> <li>3. Both of the A</li> </ol>	ontrol Interest Disclosu	CFA-2572) Ire Stmt (HCFA-1513)	
					1			
22. ORIGINAL DATE	23. LTC AGREEME		4. LTC AGREEME		26. TERMINATION ACTIO		(L30)	
OF PARTICIPATION 08/01/1987	BEGINNING I	DATE	ENDING DATE		<u>VOLUNTARY</u> 01-Merger, Closure	00	INVOLUNTARY 05-Fail to Meet Health/	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbu 03-Risk of Involuntary Termin		06-Fail to Meet Agreem	nent
25. LTC EXTENSION DATE:	27. ALTERNATIVE				04-Other Reason for Withdraw		<u>OTHER</u> 07 Provider Status Che	
	A. Suspension of	of Admissions:	(L44)				07-Provider Status Cha 00-Active	ange
(L27)	B. Rescind Susp	pension Date:	( )					
			(L45)					
28. TERMINATION DATE:	29.	INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION C	OF APPROVAL DAT	E	Posted 10/28/201	5 Co.		
	(L32)			(L33)	DETERMINATION AF	PPROVAL		



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:

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

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

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

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;

Elim Home October 2, 2015 Page 3

- 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

Elim Home October 2, 2015 Page 4

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

Elim Home October 2, 2015 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

		AND HUMAN SERVICES				FORM	APPROVED
							0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /				E SURVEY IPLETED
		245494	B. WING _			09/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HO	ME				11 FIRST STREET RINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00			
F 156 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa regulations has beet your verification. 483.10(b)(5) - (10), RIGHTS, RULES, S The facility must inf and in writing in a la understands of his regulations governin responsibilities duri facility must also prinotice (if any) of the §1919(e)(6) of the A made prior to or up resident's stay. Re- any amendments to writing. The facility must inf entitled to Medicaid of admission to the resident becomes e- items and services facility services und	of correction (POC) will serve of compliance upon the obtance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the e State developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in form each resident who is l benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing ler the State plan and for may not be charged; those	F 15	56			10/26/15
	other items and ser	vices that the facility offers					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

		AND HUMAN SERVICES				FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245494	B. WING _			09/ <sup>.</sup>	17/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				01 FIRST STREET RINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	and for which the re- the amount of charge inform each resider the items and servic (i)(A) and (B) of this The facility must inf at the time of admiss the resident's stay, facility and of charge including any charge under Medicare or M The facility must fur legal rights which in A description of the for establishing elige the right to request 1924(c) which deter non-exempt resource institutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid e A posting of names numbers of all perti groups such as the agency, the State life ombudsman progra	esident may be charged, and ges for those services; and nt when changes are made to ces specified in paragraphs (5) is section. Form each resident before, or asion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate. Trnish a written description of neludes: manner of protecting personal raph (c) of this section; requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending	F 1	56			

Facility ID: 00375

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 10/13/2015 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245494	B. WING		09	/17/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	agency concerning misappropriation of facility, and non-cor directives requiremed The facility must inf name, specialty, an physician responsite The facility must pro- written information, applicants for admis- information about h Medicare and Media receive refunds for such benefits. This REQUIREMEN- by: Based on observat review, the facility fa (R173), reviewed for charged for his medi- though it was cover Findings include: R173's Brief Intervie screening tool used 9/16/15, identified F R173's current phys- identified, "INSULIN PUMP KIT CHANG	<ul> <li>resident abuse, neglect, and resident property in the inpliance with the advance ents.</li> <li>orm each resident of the d way of contacting the ole for his or her care.</li> <li>ominently display in the facility and provide to residents and ssion oral and written ow to apply for and use caid benefits, and how to previous payments covered by</li> <li>NT is not met as evidenced ion, interview and document ailed to ensure 1 of 1 residents or insulin administration, was dication during his stay, even ed under his Medicare benefit.</li> <li>ew for Mental Status (BIMS, a to evaluate cognition), dated 8173 had intact cognition.</li> <li>sician orders dated 9/17/15, I INFUSION DISPOSABLE E EVERY DAY OR AS BRINGS IN CARTRIDGES</li> </ul>	F1	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	

Facility ID: 00375

If continuation sheet Page 3 of 50

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 **B** WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 156 Continued From page 3 F 156 R173's progress notes dated 9/11/15, identified, competence and continued compliance of "...[R173]'s primary insurance is U Care for the following plan: seniors ... admission agreement with arbitration clauses and patient privacy practices reviewed Regarding cited residents: F173¿s and signed willingly." medication was clarified by the nursing staff with family, pharmacy and MD, During observation of insulin administration on Pharmacy was unable to deliver insulin 9/17/15, at 11:18 a.m. registered nurse (RN)-B pump cartridges. Family updated staff that removed a plastic bag containing several V-GO the cartridges were filled with Humalog self-infusing cartridges of insulin (a device used insulin. Order clarified with MD and to inject insulin in doses set by the user) from a Humalog vial ordered from the pharmacy. refrigerator in the Turnaround Point medication Resident¿s family brought in receipts for room. The cartridges were branded by the Humalog insulin used to fill insulin pump manufacturer logo, "V-GO DISPOSABLE cartridges prior to clarification. They were INSULIN DELIVERY." At 11:22 a.m. RN-B reimbursed for the medication used while entered R173's room with the cartridge of insulin at the facility. Total amount paid to family and handed it to R173, and at 11:48 a.m. (26 was \$76.60. minutes later) R173 self administered the V-Go insulin delivery cartridges to himself. Actions taken to identify other potential residents having similar occurrences: When interviewed on 9/17/15, at 1:30 p.m. RN-C Medicare medication audits will be stated R173's insulin cartridges are supplied by completed to ensure that proper coverage R173's family member (FM)-H who brings them and reimbursement has been established into the facility from home. FM-H had been for Medicare benefit recipients. No paying for and supplying the insulin since R173 residents were identified as needing was admitted to the facility, but RN-C added she reimbursement. was not sure why, because R173 was at the facility for rehabilitation, and his payment source Measures put in place to ensure deficient was "Medicare Part A". Further, RN-C stated "the practice does not occur: Education facility" should be paying for his insulin, to comply provided to nursing staff on route of with Medicare coverage guidelines for R173. administration availability and the need to clarify orders. If route not currently available from the pharmacy, MD/GNP is During interview on 9/17/15, at 1:40 p.m. the dispensing pharmacist (DP) stated they received to be contacted to seek clarification. Order the admission orders for R173 on his day of changes will be made at the MD/NPs admission, but were unable to provide the discretion. Admission procedure on cartridges, so they (the pharmacy) faxed the Medicare coverage reviewed and updated facility seeking clarification on what supplies were to include information on reimbursement needed to fill the cartridges. However, the of medication expenses by facility.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00375

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245494 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 156 Continued From page 4 F 156 pharmacy never obtained clarification from the Medicare medication audits will be facility. Furthermore, the facility should be paying completed weekly and prn. The DON/designee will report findings of for the medications to honor the Medicare A audits to the Quality Assurance coverage agreement. Committee who reviews for continued On 9/17/15, at 1:49 p.m. FM-H and R173 were compliance and further recommendations interviewed by RN-C and the surveyor. FM-H and approaches. stated the cartridges are filled with Humalog (a type of insulin) from a regular vial which she Effective implementation of actions will be brings from home. R173's payer source was monitored by: 10/26/15 Medicare and Ucare insurance, and the cost of the insulin was "expensive". FM-H was Those responsible to maintain compliance concerned with the cost of the medication and will be: DON or designee "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

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DEPARTMENT OF HEALTH AND HUMAN CENTERS FOR MEDICARE & MEDICAID				FORM	10/13/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/	SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
24	45494	B. WING		09/ <sup>-</sup>	17/2015
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HOME			01 FIRST STREET PRINCETON, MN 55371		
(X4) ID         SUMMARY STATEMENT OF DEF           PREFIX         (EACH DEFICIENCY MUST BE PRECI           TAG         REGULATORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
<ul> <li>F 156 Continued From page 5 plan have spent a certain amoun covered prescription drugs, you t all costs out-of-pocket for the me certain limit).</li> <li>When interviewed on 9/17/15, at director of nursing (DON) stated been billed for any services or me either the pharmacy or facility, bu added nobody in the facility was a potential concern until it had been the surveyor.</li> <li>F 176 483.10(n) RESIDENT SELF-ADM DRUGS IF DEEMED SAFE</li> <li>An individual resident may self-at the interdisciplinary team, as defit §483.20(d)(2)(ii), has determined practice is safe.</li> <li>This REQUIREMENT is not met by: Based on observation, interview review, the facility failed to compr assess for the safe self administr for 1 of 1 residents (R173) obser administer insulin during the surv</li> <li>Findings include: R173's Brief Interview for Mental screening tool used to evaluate of 9/16/15, identified R173 had intage During observation of medication on 9/17/15, at 11:18 a.m. register removed a plastic bag containing</li> </ul>	then have to pay edications, to a 3:43 p.m. the R173 had not yet edications by ut the DON aware of the n brought up by MINISTER dminister drugs if ined by 1 that this as evidenced and document rehensively ration of insulin ved to self /ey. Status (BIMS, a cognition), dated ct cognition. m administration red nurse (RN)-B	F 156	F-176 Resident self-administer dru deemed safe. Elim Care and Rehab Center has t 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 R17 9/18/15. He was able to safely demonstrate that he could accurate manage his own insulin pump and ta administration of insulin as per MD	the 73 on ely the	10/26/15

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 **B** WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 176 Continued From page 6 F 176 self infusing cartridges of insulin (a device used to Actions taken to identify other potential inject insulin in doses set by the user) from a residents having similar occurrences: refrigerator in the Turnaround Point medication Residents requesting to self-administer room. The cartridges were labeled, "V-GO medications were reviewed and assessed DISPOSABLE INSULIN DELIVERY", however did by nursing supervisor or designee. Facility not identify the medication inside the cartridge. will audit and review self-administration of the dosing of the medication R173 was to medications (SAM) assessments for receive, or directions for administration of the completion. medication. At 11:22 a.m., RN-B entered R173's room with the cartridge of insulin and handed it to Measures put in place to ensure deficient R173. RN-B asked R173 if the un-labeled practice does not occur: Education to be cartridge contained the "correct insulin" for him, provided to nursing staff on the and R173 replied, "I think so." R173 set the self-administration of medication (SAM) cartridge on a bedside table next to his recliner assessment completion. Weekly and prn chair, and stated he would apply it later after he SAM audits to be completed on residents let it "warm up a little bit." RN-B asked R173 if with new requests to self-administer, administering his insulin was "something you do admissions and readmission vourself, or we do [for him]?" R173 stated he requests/desire to self-administer does it himself because using the cartridge was medications. Daily stand up meeting "a new thing" and many of the staff do not know notes to now include any new SAM how to operate it. At 11:48 a.m. (26 minutes assessments to be reviewed by IDT. later) R173 removed a plastic cap from the The DON/designee will report findings of cartridge exposing a sticky surface used to attach audits to the Quality Assurance the cartridge to the skin, and affixed it to his right Committee who reviews for continued arm, inserting a needle and pumping a gray compliance and further recommendations trigger on the device seven times. R173 stated and approaches. his physician was still adjusting the dosing, and the times he engages the pump on the device Effective implementation of actions will be has been changing because of this. monitored by: 10/26/15 When interviewed on 9/17/15, at 11:31 a.m. RN-B Those responsible to maintain compliance stated R173 brought the V-GO cartridges from will be: DON or designee. 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245494	B. WING _			<b>09</b> / <sup>-</sup>	17/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				01 FIRST STREET RINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176 F 241 SS=E	included no indicati to safely self admin V-GO cartridge. During interview on stated R173's V-GO "don't know a whole R173 self administer insulin from the carr his ability to safely s had been complete sure they're doing it When interviewed of director of nursing ( have been assesse allowed to self adm the V-GO cartridge, [self administration completed." A facility Medication dated 6/2000, ident shall have their med facility staff, until an determine the ability self-administer their 483.15(a) DIGNITY INDIVIDUALITY The facility must pro- manner and in an e enhances each resi	on R173 had been assessed ister his insulin, using the 9/17/15, at 1:30 p.m. RN-C D cartridge was new, and staff e lot about it yet." RN-C stated ers different amounts of the tridge, but no assessment of self administer the medication d, but should have "to make t accurately and safely." on 9/17/15, at 3:43 p.m. the (DON) stated R173 should ed for safety before being inister his own insulin using , "[R173] should have the SAM of medication assessment] n - Self Administration policy ified, "All new admissions dications administered by n interdisciplinary team can y of the resident to	F 1		DEFICIENCY)		10/26/15
	This REQUIREMEN	NT is not met as evidenced					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 **B** WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 8 F 241 Based on observation, interview and document F ¿ 241: Dignity and respect of review, the facility failed to ensure for 2 of 3 individuality residents (R6, R107) reviewed for activities of Elim Care and Rehab Center has the daily living were found to be unshaven, had expectation that staff will show soiled/long fingernails and was not provided competence with the continued assistance to enhance their dignity. Furthermore, compliance of the following plan: the facility had not properly cleaned a commode Regarding cited residents: On 9/17/15, R6 and bath blanket with dried visible feces to was approached and agreed to nail care enhance a residents dignity for 2 of 2 residents (R165, R73) who had feces on their personal on only his right hand. He refused nail care equipment. care to his left hand. After much encouragement, he agreed to complete Findings include: the nail care. Resident was also approached and assisted with the removal LACK OF GROOMING: of unwanted facial hair. Staff continues to encourage his compliance with grooming R6's annual Minimum Data Set (MDS) dated assistance. He has a history of refusals of 6/16/15, identified R6 had intact cognition, and care; nursing is charting on his required "total dependence" on staff for his compliance. Care plan updated with his personal hygiene. preferences with grooming assistance. R107¿s diet was reviewed and changed to regular diet with finger foods, to ease During observation on 9/14/15, at 3:29 p.m. R6 was in his room in bed. R6 had long fingernails her ability and compliance with intake. Her on both hands, with several of his nails having a CP was reviewed and updated. dark colored substance visible underneath the R165 continued to be independent with nail. In addition, R6 had visible white and gray toileting. A new larger commode was facial hair on his upper lip and chin. R6 stated he ordered per resident preference, but likes his nails kept "shorter" than they were, and unfortunately it was not the height he did not want facial hair on his face. R6 stated he preferred. Facility to look into other "used to shave everyday" because he was a available options. Housekeeping to check salesman and "always was very clean." Further, bathroom daily and clean commode PRN. R6 stated not being kept as clean as he used to R73 re-assessed for bowel and bladder before coming to the nursing home this "don't in/continence. Nursing will also adjust the make me happy", and added, "What can I do appropriate incontinent product. Elimination CP updated with residents about it?" When subsequently observed on 9/15/15, at 1:31 p.m. R6 continued to have long, needs and preferences. dirty fingernails and visible facial hair on his face. Actions taken to identify other potential When observed for evening cares on 9/15/15, at residents having similar occurrences:

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00375

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 **B** WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 9 F 241 7:31 p.m. nursing assistant (NA)-E cleaned R6's Residents will continue to be groomed face and eyes, and asked R6 if he "forget to daily per their preferences. Shaving will be shave today?" R6 responded that "nobody offered, if facial hair is observed. Nail care offered" to shave him, so it was not completed. will be offered on bath days and prn. Staff NA-E finished R6's evening cares, however she will assist as per the care plan and PRN. did not offer to shave him, or trim and clean his Dining room audits will be conducted to fingernails despite even though R6 told NA-E he review assistance and dignity needs was not offered to get shaved. during meals. Bathrooms will continue to be observed daily with cares and R6's care plan dated 6/18/15, identified R6 had activities. Staff will clean an, "Alteration in ADLs of dressing, grooming and appliances/devices when appropriate bathing ... " Further, the care plan directed staff to and/or notify the appropriate personnel if complete, "Nail care as needed with bath ... " attention is needed. Residents noted to have a change in elimination will be During interview on 9/16/15, at 8:44 a.m. NA-B re-assessed and CP updated with stated R6 required total assistance to complete changes and preferences. his personal hygiene and grooming, "[We] do all of that for him." Staff were expected to complete Residents are offered a choice in their personal hygiene for residents "every morning plan of care. All efforts to meet the and evening." NA-B observed R6's facial hair individualized care needs are provided by and long, dirty fingernails. NA-B stated R6 nursing. "needs to be shaved", and his fingernails "need to be clipped down" adding, "It doesn't look good." Measures put in place to ensure deficient practice does not occur: When interviewed on 9/16/15, at 12:08 p.m. Policy and procedure for shaving a licensed practical nurse (LPN)-A stated R6 was resident reviewed/updated. Policy and "totally dependent" on staff for his care, and staff procedure for nail care reviewed/updated. were expected to help him shave daily as R6 had Nursing orders placed for nursing to a preference "to be clean shaven." Further, document compliance/refusals of cares q LPN-A was unaware of any preference to have shift. Care/grooming audits to be long fingernails, and they should be clipped and completed weekly and prn cleaned, "They look like they could be cleaned underneath." Audits to observe dining room activity will be done weekly and prn. Resident care On 9/17/15, at 8:31 a.m. family member (FM)-G equipment audits to be completed weekly and prn. Housekeeping routines will be was interviewed about R6's care in the facility. reviewed and updated to accommodate FM-G stated R6 used to clip his nails and shave "every single day." R6 used to be a salesman resident needs. Bathroom and equipment and appearance was very important to him. audits to be completed weekly and prn.

	RS FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES		IPLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245494	B. WING _			17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ELIM HC	OME			701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 241	being completed "a was concern for his feel better about the there scuzzie in beau LACK OF ASSISTA R107's annual Mini 6/17/15, identified F memory problems a understood", and re eating. During observation at 12:25 p.m. R107 one other resident R107 had a white of holding up from the contained diced ca steak. There were f contained a red juid in it, and a glass of over the outside of up spilled rice and eating it using her f in her hand. At 12: (NA)-C walked ove visited with her, how assistance to R107 from the table using 12:29 p.m. NA-C se food, and promptly to assist or re-direct spilled rice and car	ed R6's grooming was not as often as I would like", and it s well-being, "A person does emselves when not laying	F 24	<ul> <li>Staff is to be in-serviced on importance of dignity/groom resident in a timely manner, observation/cleaning of soils resident care equipment. T designee will report findings the Quality Assurance Comp further recommendations ar approaches.</li> <li>Effective implementation of monitored by: 10/26/15</li> <li>Those responsible to maintawill be: DON or designee.</li> </ul>	ing, assisting and the ed linens and he DON / of audits to mittee who liance and nd actions will be	

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 B. WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 11 F 241 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.

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PRINTED: 10/13/2015 FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/13/2015 APPROVED . 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED			
		245494	B. WING _			09/	17/2015			
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•				
ELIM HO				701 FIRST STREET PRINCETON, MN 55371						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 241	don't have anything playing with her foo assistance. Further and visitors were we food and it "looks be SOILED COMMOD R165's MDS, dated cognitively intact, an During observation was noted that in R shared by another r room, a commode s R165's commode h designed with a cut existing bathroom to side hand rails. The between the seat an layer of dried, dark extending around th of the commode. The lingering, malodoro During observation 9:24 a.m., R165's c positioned over the inside of the commode with dried feces still odor. In an interview on 9 stated that when the	should have been offered cues and eat her meal, and added, "We different in place" if R107 is d and not accepting r, RN-F stated other residents atching R107 play with her ad."	F 24	41						

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		AND HUMAN SERVICES			FORM	: 10/13/2015 APPROVED : 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245494	B. WING		09/	17/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
ELIM HO	ELIM HOME			701 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 241	bathroom." R165 s should be cleansed disgusting." R165 a not the first time he bathroom, and add floor, and toilet "car cleanings." R165 s came to do a thoro In an interview on 9 registered nurse (R had been cleaned. were responsible for the resident rooms, commode. RN-E s commode be clean cleaned sooner." During an interview the assistant direct charge of infection present on any surf right away," and tha concern." The ADC clean up bodily fluid is all our responsible would expect reside cleaned." SOILED BLANKET R73's MDS dated 7 mobility, continent of incontinent of bowe movements).	aid when it gets dirty, "It dright away, and not left. "It is also stated that "today" was e encountered an unclean ed he felt the bathroom, the n get very dirty between said the housekeeper only ugh cleaning "once a week." 0/16/2015 at 1:50 p.m., RN)-E stated R165's commode RN-E said the nursing staff or the "day-to-day cleaning" in , including things like the said she would "expect" R165's h, and that it "should have been of on 9/17/2015 at 1:53 p.m., or of nursing (ADON) in control, stated that if feces is face, "It should be cleaned at this was "an infection control DN stated the responsibility to ds falls on "whoever sees it, it ility." The ADON also said she ent commodes "to be always	F 241				

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		AND HUMAN SERVICES				FORM	): 10/13/2015 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245494	B. WING			09	/17/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 241	required assistance hygiene, and "Staff episodes" During observation R73 was seated in a white blanket. R7 bathroom exposing discoloration, dried measuring approxir inch in size. During 9/16/15 at 8:14 a.m her recliner with sev size of the stain had four inches by 2 inc When interviewed of nursing assistant (N her recliner chair wa [bowel movement].' the soiled blanket wa approximately 1:50 R73 soiling her blar was "kind of a regu R73's blanket was "ch During a subsequen 9:15 a.m., R73's ha with visible, dark, ta feces, measuring a two inches in size. During interview on member (FM)-K sta to perform her own FM-K said R73 had blankets with feces	on 9/14/15, at 11:51 a.m., a recliner chair in her room on 73 stood up and walked to the a visible, dark-tan feces, on the blanket, mately three inches by one g a subsequent observation on 0., R73's white blanket was in veral stuffed animals. The d increased to approximately thes in size. on 9/16/15, at 1:43 p.m. NA)-D stated R73's blanket in as soiled, and "looks like BM " NA-D proceeded to change with a new blanket. At p.m. on 9/16/15, NA-G stated nket in the chair with feces lar thing." NA-G also said often stained "with bowel" and	F2	241			

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	10/13/2015 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245494	B. WING			09/17/2015		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ELIM HO	ME		701 FIRST STREET PRINCETON, MN 55371					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 241 F 243 SS=E	stated this was upsime, but it also make stated (R73) had ex- before as well, and someone else" was on her chair. FM-K time she sees it, an has done that." A facility policy rega- but none was provid 483.15(c)(1)-(5) RIC RESIDENT/FAMILY A resident has the r participate in reside resident's family has facility with the famil facility; the facility m family group, if one staff or visitors may group's invitation; a designated staff per assistance and resp that result from group This REQUIREMEN by: Based on observat	a was incontinent. FM-K etting to (R73), and "It annoys es me sad." Further, FM-K cpressed concerns with it also said R73 "thinks putting the blanket with feces said "It bothers [R73] every d [R73] thinks someone else arding dignity was requested, ded. GHT TO PARTICIPATE IN ' GROUP ight to organize and nt groups in the facility; a s the right to meet in the lies of other residents in the nust provide a resident or exists, with private space; attend meetings at the nd the facility must provide a rson responsible for providing ponding to written requests	F 2		F -243 Right to participate in resident/family group		10/26/15	
	care units (Turnarou unit), were provided in resident council a	und Point,a short term care I an opportunity to be involved activities. This had the I 15 residents (R172) who			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 residen			

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	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATI	00000000000000000000000000000000000000	
	OF CONTRECTION		A. BUILDIN	G	COM		
		245494	B. WING				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DΕ		
ELIM HC	ME			701 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 243	Findings include: During the initial tou at 1:27 p.m., reside were posted on sev three floors of the fa only pertained to se councils, which tool third floors. The 2nd separate resident c but contained no in Turnaround Point re When interviewed of registered nurse (R Turnaround Point u the facility" for an e could also reside in several weeks or m residents progress During interview on stated she had bee Point Unit for a cou of any Resident Co or posting of the mi if she was able to a meetings. When interviewed of worker (SW)-A stat minutes "are posted residents," and that council" meeting of residents. SW-A s would not be intere	ur of the facility on 9/14/2015, ent council meeting minutes veral bulletin boards on all acility. However, the minutes eparate meetings of resident k place on the second and d and 3rd floor each had councils, and meeting minutes, put from, or mention of, the	F 24	<ul> <li>Who reside on our short term turn around point, will be offer participate in their own unit's council every month. Informatic change to these meetings is a monthly activity calendar and reminded by the nursing staff.</li> <li>Actions taken to identify other residents having similar occur residents on our short term st Around Point) will be updated activity staff upon admission/r of their option for attending a resident council meeting. This will be provided to the new/ret resident verbally and in writing activity calendar.</li> <li>Measures put in place to ensur practice does not occur: Com as to the time and place of all council meetings will be addee activity calendars and posted the facility. Residents are enc attend. Attendance of particip collected at each resident cour meeting.</li> <li>The DON/designee will report audits to the Quality Assurance Committee who reviews for compliance and further recom and approaches.</li> <li>Effective implementation of admonitored by: 10/26/15</li> </ul>	ed to resident ion for the added to the residents potential rences: All ay unit (Turn by the e-admission monthly information urning y via the ure deficient munication resident d to the throughout ouraged to bants will be incil findings of e ontinued imendations		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	10/13/2015 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DATI	E SURVEY PLETED			
		245494	B. WING		09/	17/2015			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
ELIM HO	ME				01 FIRST STREET RINCETON, MN 55371				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 243 F 282 SS=D	requested, but none	e was provided. RVICES BY QUALIFIED		243 282	will be: DON or designee.	10/26/15			
33-0	The services provid must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of							
	by: Based on observat review, the facility fa the plan of care for residents (R107) re incontinence. Findings include: R107's annual Minii 6/17/15, identified F memory problems, understood", require toileting, and was fr bladder. R107's care plan da to be incontinent of having "no skin bu Further, the care pla every 2 - [to] 3 hour needed." During an observati 9:45 a.m., nursing a registered nurse (R	mum Data Set (MDS) dated 107 had long and short-term			<ul> <li>F -282: Services by qualified person/per care plan</li> <li>Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan:</li> <li>Regarding cited residents:</li> <li>R 107 was reviewed and reassessed for her elimination patterns. CP and NAR assignment sheets updated with residents needs/preferences.</li> <li>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.</li> <li>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</li> </ul>				

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 B. WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 18 F 282 a mechanical lift, and her pants removed leadership. Toileting program audits being exposing a white incontinence pad that was done weekly and prn. visibly saturated with dark yellow urine. NA-B removed the incontinence pad and disposed of it The DON/designee will report findings of in the trash can, however a lingering odor or urine audits to the Quality Assurance remained in the room with NA-B adding the Committee who reviews for continued incontinence pad was "very" saturated. R107 compliance and further recommendations was seated on the toilet but did not urinate. At and approaches. 10:00 a.m. R107 was assisted to stand, and NA-B performed perineal cares before a new Effective implementation of actions will be incontinence product was placed and R107 was monitored by: 10/26/15 assisted back into her wheelchair. Those responsible to maintain compliance When interviewed on 9/17/15, at 10:03 a.m. NA-B will be: DON or designee. 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 10/13/2015 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245494	B. WING			17/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HOME					01 FIRST STREET RINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From pa When interviewed of stated the care plan our nursing assess direct the resident of have been assisted three hours" as dire A facility policy on c but none was provid 483.25(a)(2) TREAT IMPROVE/MAINTA A resident is given t services to maintair specified in paragra This REQUIREMEN by: Based on observat review, the facility fa (R107), reviewed for	ge 19 on 9/17/15, at 10:17 a.m. RN-F i is "a way for us to manifest ments", and they are used "to care." Further, R107 should with toileting "every two to cted by her plan of care. are planning was requested, ded. IMENT/SERVICES TO	F 2	311		10/26/15	
	6/17/15, identified F memory problems, understood", and re eating. R107's care plan da required "encourage	mum Data Set (MDS) dated R107 had long and short term was "rarely/never equired supervision with ated 9/10/15, identified R107 ement with eating", and asist with feeding as res.			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		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL			SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING		COMPLETED	
		245494	B. WING			09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 311	Continued From pa	ae 20	F 3	311			
	During observation	of the lunch meal on 9/16/15, was seated at a table with			during meals.		
	R107 had a white of holding up from the contained diced can steak, along with tw contained a red juid in it, and a glass of over the outside of up spilled rice and of eating it using her f At 12:27 p.m. nursi over to R107's table however made no of who continued to p using her fingers. A R107's tablemate h table making no off who was still eating from the table top u p.m. R107 continue on her table until 12 her a piece of bana made no offer to as meal, as she contin the table and plate	in the Skyview dining room. bolored lipped plate she was a table in her left hand which rrots, rice, and country fried to glasses on the table, one ce with pieces of diced carrot water with food smeared all the glass. R107 was picking carrots from the table and ingers while holding her plate. Ing assistant (NA)-C walked emate and visited with her, offer of assistance to R107 ick up food from the table At 12:29 p.m. NA-C served her food, and promptly left the er to assist or re-direct R107 the spilled rice and carrots using her fingers. At 12:31 ed to play with the spilled food 2:39 p.m. when NA-C served ina cake in a small dish. NA-C esist R107 to eat the cake or using her fingers. At 12:42			Measures put in place to ensure de practice does not occur: Audits to o dining room activity will be done we and prn. Staff is to be in-serviced o importance of dignity/grooming and assisting resident in a timely manne The DON/designee will report findin audits to the Quality Assurance Committee who reviews for continu compliance and further recommend and approaches. Effective implementation of actions monitored by: 10/26/15 Those responsible to maintain com will be: DON or designee.	bbserve eekly on the ar. ngs of dations will be	
	room and offered F with eating, but did R107 as she contin fingers. At 12:46 p the table and asked and R107 responde RN-F cut up R107's dish using a fork ar get this rice off of y clothing and onto th	se (RN)-F entered the dining R107's tablemate assistance not offer any assistance to used to eat food using her .m. RN-F approached R107 at d, "How are you doing?" to her, ed with non-sensical speech. s banana cake in the small nd asked her, "Do you mind if I ou?", as she brushed it off her ne floor. RN-F then picked up ce and removed it from the					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	10/13/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245494	B. WING		09/	17/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	_	
ELIM HO	ME			01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 311	got a carrot in it" an remained seated at and eating using he amounts on the floo (26 minutes later) w away from herself of clothing protector. When interviewed of NA-D stated R107 t [food]" when she is without any assistan her when they bring she would often refil leave her alone to " food (referring to he NA-D stated staff "s food" so she could of her preference addi alternative offered [ During interview on stated R107 will "so eating, adding she of appropriate meal of history of mixing up RN-F reviewed R10 R107 "should have offered cues and er meal. RN-F also sa different in place" if and not accepting a	he was removing it "since you d left the table. R107 the table pushing food around er fingers, spilling large or and herself until 12:51 p.m. when she pushed the plate on the table using her soiled on 9/16/15, at 12:57 p.m. typically "wears a lot of it left alone to eat by herself nce. The staff often try to help g her a plate of food, however use assistance so staff just do what she does" with the er playing with it). Further, should give her more finger eat with her hands if that was ing, "I wonder why there is no versus rice and carrots]." 9/16/15, at 1:11 p.m. RN-F ometimes use her utensils" for did not feel rice was an noice for R107, given her and playing with her food. 07's care plan, and stated been re-approached, and noouragement" to eat her aid "We don't have anything R107 is playing with her food assistance. 	F 311			
F 312 SS=D		ARE PROVIDED FOR	F 312			10/26/15

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			С	FORM MB NO.	10/13/2015 APPROVED 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245494	B. WING	i		09/-	17/2015
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	daily living receives maintain good nutri and oral hygiene. This REQUIREMEN by: Based on observat review, the facility for residents with perso 2 of 3 residents (Re upon staff for their of Findings include: R6's annual Minimu 6/16/15, identified F required "total deper personal hygiene. During observation was in his room in to on both hands, with dark-colored substa nail. In addition, Re facial hair on his up likes his nails kept " did not want facial for subsequently observation	AT is not met as evidenced tion, grooming, and personal NT is not met as evidenced tion, interview and document ailed to ensure staff assisted onal hygiene and grooming for 5, R8) who were dependent cares. AT Data Set (MDS) dated R6 had intact cognition, and endence" on staff for his on 9/14/15, at 3:29 p.m. R6 bed. R6 had long fingernails a several of his nails having a ance visible underneath the 5 had visible white and gray oper lip and chin. R6 stated he 'shorter" than they were, and nair on his face. When rved on 9/15/15, at 1:31 p.m. ve long, dirty fingernails and	F	312		the and at hand. d. After to was also removal nues to poming usals of ed with istance. to allow th days	
	7:31 p.m. nursing a face and eyes, and	evening cares on 9/15/15, at ssistant (NA)-E cleaned R6's asked R6 "forget to shave ded that "nobody offered" to			and NAR assignment sheet update his preferences with grooming/hyg preferences. Actions taken to identify other pote	liene	

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245494 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 312 Continued From page 23 F 312 shave him, so it was not completed. NA-E residents having similar occurrences: finished R6's evening cares, however made no Residents will continue to be groomed offer to shave him, or trim and clean his daily per their preferences. Shaving will be offered, if facial hair is observed. Nail care fingernails. will be offered on bath days and prn. Staff R6's care plan dated 6/18/15, identified R6 had will assist as per the care plan and PRN. an, "Alteration in ADLs of dressing, grooming and bathing..." Further, the care plan directed staff to Measures put in place to ensure deficient complete, "Nail care as needed with bath ... " practice does not occur: Policy and procedure for shaving a During interview on 9/16/15, at 8:44 a.m. NA-B resident reviewed/updated. Policy and stated R6 required total assistance to complete procedure for nail care reviewed/updated. his personal hygiene and grooming, "[We] do all Nursing orders placed for nursing to of that for him." Staff were expected to complete document compliance/refusals of cares q personal hygiene for residents "every morning shift. Care/grooming audits to be and evening." NA-B observed R6's facial hair completed weekly and prn and long, dirty fingernails. NA-B stated R6 "needs to be shaved", and his fingernails "need to The DON/designee will report findings of be clipped down." audits to the Quality Assurance Committee who reviews for continued When interviewed on 9/16/15, at 12:08 p.m. compliance and further recommendations licensed practical nurse (LPN)-A stated R6 was and approaches. "totally dependent" on staff for his care, and staff were expected to help him shave daily as R6 had Effective implementation of actions will be a preference "to be clean shaven." Further, monitored by: 10/26/15 LPN-A was unaware of any preference to have long fingernails, and they should be clipped and Those responsible to maintain compliance cleaned, "They look like they could be cleaned will be: DON or designee. underneath." R8's guarterly 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

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245494	B. WING			09/	17/2015
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 312	right now." During observation was lying on his back had long fingernails During a subsequent 1:08 p.m. R8 contin fingernails on both of When interviewed of stated, "I think my finow." He also state much when the stat "I like my nails nice During interview on assistant (NA)-A stat trim resident's nails further stated that F Thursdays. NA-A along" and "they do r NA-A was not sure trimmed or when st nails. When interviewed of registered nurse (R aware of R8 ever re stated R8 received and it was the night complete R8's nail of A facility Standards	ated, "I think they are too long on 9/15/15, at 6:56 p.m. R8 ck in his bed in his room. R8 noted on both of his hands. nt observation on 9/16/15, at ued to have long, untrimmed of his hands. on 9/15/15, at 6:45 p.m. R8 ingernails are too long right ed his nails are trimmed pretty ff "get around" to it. R8 stated,	F	312			
F 315	residents" on a daily "completed on bath	y basis, and for nail care to be	F:	315			10/26/15

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM	): 10/13/2015 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245494	B. WING		/17/2015
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC 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 315 SS=D	RESTORE BLADD Based on the reside	-	F 315		
	resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder			
	by: Based on observat review, the facility fa assistance with toile continence for 1 of dependent upon sta Findings include: R107's annual Mini 6/17/15, identified F memory problems, understood", requir toileting, and was fr bladder. During observation R107 was seated in Skyview dining roor odor present to her R107's Nursing Obs	mum Data Set (MDS) dated R107 had long and short-term was "rarely/never ed extensive assistance with equently incontinent of on 9/14/15, at 12:14 p.m. her wheelchair in the n, and had a distinct urine servations assessment dated		<ul> <li>F - 315 No catheter, prevent UTI, restore bladder</li> <li>Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan:</li> <li>Regarding cited residents:</li> <li>R 107 was reviewed and reassessed for her elimination patterns. CP and NAR assignment sheets updated with residents needs/preferences.</li> <li>Actions taken to identify other potential residents having similar occurrences: Resident; s with toileting plans were observed for compliance. Changes to individual CP and NAR assignment sheet updated PRN.</li> </ul>	5
	6/18/15, identified F	107 had frequent episodes of continence (incontinence		Measures put in place to ensure deficient practice does not occur: Education	

Facility ID: 00375

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 B. WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 315 Continued From page 26 F 315 resulted from being unable to toilet themselves provided to nursing staff on timely toileting, following the CP and reporting for mental or physical reasons). R107 was "at risk for incontinence r/t [related to] DX [diagnosis] any elimination pattern changes to nursing of Alzheimer [sic], impaired mobility and leadership. Toileting program audits being medications", and directed staff to, "see care plan done weekly and prn. for current interventions." The DON/designee will report findings of audits to the Quality Assurance R107's care plan dated 6/27/15, identified R107 to be incontinent of bladder with a goal of R107 Committee who reviews for continued having "...no skin breakdown r/t incontinence." compliance and further recommendations Further, the care plan directed staff to, "Toilet and approaches. every 2 - [to] 3 hours during the day and as needed." Effective implementation of actions will be monitored by: 10/26/15 During an observation of toileting on 9/17/15, at 9:45 a.m. nursing assistant (NA)-B and registered Those responsible to maintain compliance nurse (RN)-F assisted R107 into the Skyview will be: DON or designee. 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES			FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245494	B. WING		09/	17/2015
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HO	ME			01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315 F 323 SS=D	desk, and stated th assisted since bein morning (three hou During interview on stated she was NA- particular day, and with toileting since stated R107 should and helped with toil hours." R107's Vitals Repo identified the last tir with toileting as "05 had been incontine assisted. When interviewed of stated R107 is freq should be assisted three hours." A facility policy on u requested, but none 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	e last time R107 had been g dressed was 5:52 a.m. that rs and 53 minutes prior). 9/17/15, at 10:11 a.m. NA-C -B's partner for the shift that R107 had not been assisted 5:42 a.m Further, NA-C I be assisted to the bathroom eting every "two to three rt dated 9/16/15 to 9/17/15, me R107 had been assisted 5:52 [5:52 a.m.]", and R107 nt of urine at that time when on 9/17/15, at 10:17 a.m. RN-F uently incontinent of urine and with toileting "every two to urinary incontinence was e was provided. F ACCIDENT	F 315			10/26/15
	This REQUIREMEN	NT is not met as evidenced				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	10/13/2015 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION (X3) DAT	E SURVEY IPLETED			
		245494	B. WING	ì		17/2015			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 323	review, the facility fa not have a large ga the Food and Drug Bed System Dimen prevent potential er (R8) reviewed in the bars attached to his Findings include: The FDA Hospital E Assessment Guidar dated 3/10/06, inclu reduce entrapment equipped with side result in death or se identified vulnerable problems with mem pain, uncontrolled b out of bed unsafely patients most often confused." Zone 3 between the inside mattress, compress head." The FDA re less than 4 3/4" (inc could become entra R8's quarterly Minin 8/3/15, indicated he diagnoses of hemip the body) and hemi of the body). The M required supervision staff member for be	ion, interview and document ailed to ensure a grab bar did p in Zone 3, as identified by Administration (FDA) Hospital sional, dated 3/10/06, to atrapment, for 1 of 1 residents e sample, who utilzed grab bed. Bed System Dimensional and nce to Reduce Entrapment, ided information for facilities to risks of patients beds, rails/assist rails, which may erious injury. The guidance e patients as those who have ory, sleeping, incontinence, body movements, or who get without assistance. "These have been frail, elderly or is defined as "the space surface of the rail and the sed by the weight of a patient's commended this space be ches), a space where a head apped. num Data Set (MDS) dated e was cognitively intact, had blegia (paralysis of one side of paresis (weakness of on side ADS also indicated R8 n and the assistance of one ad mobility, due to weakness	F	323	<ul> <li>F-323</li> <li>Free of accident hazards/supervision/devices</li> <li>Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan:</li> <li>Regarding cited residents:</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul>				
	staff member for be	ed mobility, due to weakness ver extremities on one side,			The DON/designee will report findings of audits to the Quality Assurance				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0									
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245494	B. WING _			09/ <sup>.</sup>	17/2015		
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE				
ELIM HC	ME				1 FIRST STREET RINCETON, MN 55371				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 323	During observation grab bar, which was wide and 18 inches bed frame on the ex- the rail was grasped away from the bed, eight-inch gap betw bar (Zone 3). R8's moved back and fo not securely fastene During interview on stated he uses his g repositioning. R8 ft my left side is shak me" that my grab ba R8's facility Reposit Rail Assessment, d Zone 3 measurement the rail device and t assessment did not utilize the grab bars to ensure this was r R8. During interview on environmental serving rab bars on the reac checked," or on a m further stated staff of me" if a grab bar ne replaced, or a work maintenance depar grab bar at this time	on 9/15/15, at 6:56 p.m. R8's s approximately six inches in height, was fastened to the xit (left) side of the bed. When d, it could easily be pulled creating an approximately veen the mattress and the grab loose grab-bar rail could be rth with little effort, and was ed to the bed frame. 9/15/15, at 6:45 p.m., R8 grab bar "over and over" for urther stated the grab bar "on y" and it "scare me and worry ar is loose. tion Device/Grab Bar/ Side lated 8/11/15, indicated the ents as 2 1/2 inches between	F 32	23	Committee who reviews for continu- compliance and further recommend and approaches. Effective implementation of actions monitored by: 10/26/15 Those responsible to maintain com- will be: DON or designee.	dations			

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		MB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	( )	à		PLETED
		245494	B. WING		09/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HC	ME			701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIND DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 323	A facility policy on a rails/side rails was provided.	assistance devices/bed requested, but none was	F 323	3		
F 431 SS=D	483.60(b), (d), (e) LABEL/STORE DF	DRUG RECORDS, RUGS & BIOLOGICALS	F 431			10/26/15
	a licensed pharma of records of receip controlled drugs in accurate reconcilia records are in orde	mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug er and that an account of all maintained and periodically				
	labeled in accordat professional princip appropriate access	als used in the facility must be nce with currently accepted bles, and include the sory and cautionary he expiration date when				
	facility must store a locked compartme	State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys.				
	permanently affixe controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distr	rovide separately locked, d compartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to n the facility uses single unit ibution systems in which the ninimal and a missing dose can I.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	0938-039 SURVEY PLETED
		245494			00/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/	1/2015
ELIM HO				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 431	Continued From pa	age 31	F 43	1		
	by: Based on observa review, the facility f properly labeled to for 1 of 1 residents insulin during the s Findings include: R173's Brief Intervi screening tool used 9/16/15, identified I During observation on 9/17/15, at 11:14 (RN)-B removed a V-GO [a trademark of insulin (a device set by the user) fro Turnaround Point r cartridges were bra "V-GO DISPOSAB did not, however, ic the cartridge, the d was to receive, or of the medication. At R173's room with t handed it to R173. un-labeled cartridg insulin" for him, and 11:48 a.m. (26 min administered the un	NT is not met as evidenced tion, interview and document failed to ensure insulin was ensure its safe administration (R173), observed to use urvey. iew for Mental Status (BIMS, a d to evaluate cognition), dated R173 had intact cognition. of medication administration 8 a.m., registered nurse plastic bag containing several a name] self-infusing cartridges used to inject insulin in doses m a refrigerator in the nedication room. The anded by the manufacturer, LE INSULIN DELIVERY", but dentify the medication inside osing of the medication R173 directions for administration of 11:22 a.m., RN-B entered he cartridge of insulin and RN-B asked R173 if the e contained the "correct d R173 replied, "I think so." At utes later) R173 self n-labeled insulin to himself.		<ul> <li>F ¿ 431: Drug records, labels/stor &amp; Biologicals</li> <li>Elim Care and Rehab Center has expectation that staff will show competence with the continued compliance of the following plan:</li> <li>Regarding cited residents: R 173¿ was clarified with MD to identify th cartridge for his V-GO insulin pum indeed, Humalog insulin. A new via proper pharmacy labeling was ord and delivered to the facility. After t self-administration of medication assessment was completed, resid able to fill cartridge from provided no issues noted. Resident was ab independently manage his insulin as per MD order and assessment indicated.</li> <li>Actions taken to identify other pote residents having similar occurrence rooms and med carts were audited check for improper labeling of medications. Updated policy and procedures were requested from contracted pharmacy. This policy a procedure was reviewed and updated Measures put in place to ensure d practice does not occur: Nursing s receive education on proper labeling</li> </ul>	the s order e p, was al with ered he ent was vial with le to pump also ential ees: Med d to and ated. eficient taff to	

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 **B** WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 431 Continued From page 32 F 431 he's [R173] telling me" regarding the contents procedures. Staff will review the updated inside the cartridges. Further, RN-B allowed labeling policy and procedure provided by R173 to use the un-labeled insulin because she pharmacy. Med pass audits to also be "didn't have a choice", and using un-labeled conducted weekly and prn. medications for administration "makes me [RN-B] nervous." The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued When interviewed on 9/17/15, at 1:30 p.m. RN-C stated R173's family member was bringing the compliance and further recommendations medication in from home to use, and it was and approaches. "supposed to be labeled" with the current medication, dose, and expiration date. Effective implementation of actions will be monitored by: 10/26/15 During interview on 9/17/15, at 1:40 p.m. the dispensing pharmacist (DP) stated medications Those responsible to maintain compliance being administered in the facility should be will be: DON or designee. 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· /	E SURVEY
		245494	B. WING		00/17/0015	
NAME OF I	PROVIDER OR SUPPLIER	243434		STREET ADDRESS, CITY, STATE, ZIP CODE	09	/17/2015
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 431	Continued From pa	ge 33	F 43 <sup>-</sup>	1		
F 441 SS=E	medication." 483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	F 44	1		10/26/15
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				
	<ul> <li>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</li> <li>(1) Investigates, controls, and prevents infections in the facility;</li> <li>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</li> <li>(3) Maintains a record of incidents and corrective actions related to infections.</li> </ul>					
	determines that a ruprevent the spread isolate the resident. (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus	ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted				
		ndle, store, process and as to prevent the spread of				

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		AND HUMAN SERVICES	I OTWINT THOUED					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED		
			A. DOILDIN	····				
		245494	B. WING _		<b>09</b> /1	7/2015		
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE				
ELIM HO				701 FIRST STREET				
				PRINCETON, MN 55371				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE		
				DEFICIENCY)				
			ri I					
F 441	Continued From pa	ge 34	F 44	1				
		NT is not met as evidenced						
	by: Based on observation, interview and document review, the facility failed to ensure staff cleaned							
				F-441 Infection control, prevent sp	read,			
				linens				
	and sanitized a blood glucose meter in between			Elim Care and Rehab Center has t	he			
	resident use, which had potential to affect 6 of 6 residents (R173, R172, R169, R20, R174, R175)			expectation that staff will show				
		meter; ensure staff properly		competence with the continued compliance of the following plan:				
		ntinence products and linens		compliance of the following plan.				
		tial spread of infection, which		Regarding cited residents:				
		lents (R117, R68) observed		Registered Nurse (RN-B) was in-se				
		re staff washed hands after		on the proper glucose cleaning pro				
		are for 1 of 5 residents (R68)		The certified nursing assistant (NA				
		res, and; maintain clean ment for 1 of 1 residents		was in-serviced on proper hand wa procedures and the handling of soil				
	(R165) who utilized			linens.	cu			
	(,			The certified nursing assistant (NA	R-F			
	Findings include:			and NAR-B) were in-serviced on do				
				gloves, universal precautions and t				
	METER:	NG BLOOD GLUCOSE		proper handling of soiled incontiner products/ linens.	ice			
				R165 continued to be independent	with			
	R173 was observed	d during a blood glucose		toileting. A new larger commode wa				
		15, at 11:18 a.m. with		ordered per resident preference, bu				
		N)-B who pierced R173's		unfortunately it was not the height h				
		t, and placed a large drop of		preferred. Facility to look into other				
		ion strip of the Assure		available options that meet his	reina			
		cose meter to measure R173's . At 11:29 a.m. RN-B finished		preferences. Housekeeping and nu to check bathroom daily and clean	ising			
		medication and returned to		commode PRN.				
		on cart in the hallway, placing						
		cose meter on top of the cart		Actions taken to identify other poter				
		the meter after obtaining a		residents having similar occurrence				
		lood. At 11:57 a.m. RN-B		All resident; s that require the use of				
		in the medication room, and defined blood glucose meter from		shared glucometer are at risk have potential to be affected. All licensed				
			1					

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 **B** WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 441 Continued From page 35 F 441 the medication cart. RN-B approached another will be in-serviced on the facility¿s policy resident, R174 in the dining room and assisted for the performance and cleaning of the her to the Turnaround Point spa to check her glucose machines between residents. blood glucose. RN-B placed a new collection All staff will be in-serviced on the facility; policy for hand washing. In-service strip into the machine and instructed R174 to hold out her finger to get a blood sample. RN-B was training includes random observation of stopped by the surveyor before she used the personnel performing hand washing soiled blood glucose meter. procedures according to facility policy and also the handling of soiled linens. When interviewed on 9/17/15, at 11:57 a.m. RN-B In-service training includes observation of stated she did not disinfect the blood glucose each NAR changing bed linen and meter after using it to obtain R173's blood handling other soiled linens. Findings are glucose reading, "You're right, I didn't", and added reviewed with all personnel. Corrective the meter should have been disinfected with a action is provided as needed. hydrogen peroxide wipe between each resident Bathrooms will continue to be observed use. daily with cares and activities. Staff will clean appliances/devices when A Turnaround Point Diabetics form dated 9/17/15, appropriate and/or notify the appropriate identified R173, R172, R169, R20, R174, R175 personnel if attention is needed. currently resided on the unit, and were all using Residents noted to have a change in the same Assure blood glucose meter. elimination will be re-assessed and CP updated with changes and preferences. During interview on 9/17/15, at 1:30 p.m. RN-C stated the glucometer was for community use Measures put in place to ensure deficient (meaning all residents on the unit used it), and it practice does not occur: The Director of Nursing Services (DNS), should be disinfected between each resident, "After they [staff] use it, they clean it." Further, or designee will do the following; RN-C stated it needed to be cleaned for "infection Glucometer audits will be conducted control purposes." randomly every week for the next 4 weeks and PRN to ensure compliance from staff. During in interview on 9/17/15 at 1:55 p.m., the Hand washing audits will be done assistant director of nursing (ADON) stated the randomly every week for 4 weeks and protocol for shared glucometer included then prn. "cleansing it with disinfecting wipes" between Cleanliness of residents and resident care resident use. Further, the ADON said, the equipment audits will be done randomly glucometer was to be left in the disinfectant towel every week for 4 weeks and then prn for "at least two minutes" before going on to the Resident care equipment audits to be next resident. "That is the protocol," the ADON completed weekly and prn. Housekeeping said. routines will be reviewed and updated to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FRUIT F								
							0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY PLETED	
		245494	B. WING _			<b>09</b> /1	17/2015	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ELIM HO	ME				01 FIRST STREET			
				Р	RINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	Continued From pa	ge 36	F 44	41				
					accommodate resident needs.			
		infecting your Assure Platinum er manufacture manual dated			The DON/designed will report find			
		MS [Centers for Medicare and			The DON/designee will report findir audits to the Quality Assurance	igs of		
		guidelines read that blood			Committee who reviews for continu	ed		
		ed to be cleaned and			compliance and further recommend	dations		
		ch use", and staff should be in between each resident as			and approaches.			
	"meters are at hig				Effective implementation of actions	will be		
	contaminated with	bloodborne pathogens such as			monitored by: 10/26/15			
	Hepatitis B Virus [HBV], Hepatitis C Virus [HCV], and Human Immunodeficiency Virus [HIV]."				Those responsible to maintain com will be: DON or designee.	pliance		
	IMPROPER HAND	LING OF SOILED RODUCTS AND LINENS:						
	6/17/15, identified F	nimum Data Set (MDS) dated R117 had severe cognitive as "occasionally incontinent" of						
	9:15 a.m. nursing a into the restroom. I down her pants, exp incontinence brief. incontinence pad us threw it on the floor trash can. NA-F ap to R117, and then w	of morning care on 9/16/15, at ssistant (NA)-F assisted R117 NA-F assisted R117 to take posing a urine soiled NA-F removed R117's soiled sing her bare hands, and next to the toilet and a small oplied a new incontinence pad vashed her hands in the sink R117's morning cares.						
	stated she did not h removed the urine s "should have worn	on 9/16/15, at 9:42 a.m. NA-F have gloves on when she soiled brief from R117, but gloves" in case the urine from d have gotten on her hands.						

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		AND HUMAN SERVICES			FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245494	B. WING		<b>09</b> /-	17/2015
NAME OF I	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 37	F 441			
	registered nurse (R followed standard p R117's soiled brief a RN-F stated gloves soiled incontinence of infection." R68's annual MDS,	9/16/15, at 12:04 p.m. N)-F stated NA-F should have precautions when handling and had gloves on. Further, are used when handling briefs to help "break the chain dated 5/29/2015, indicated pairment. The MDS further				
	indicated R68 requi activities of daily live	ired extensive assistance with ing (ADLs), including al assist with personal hygiene.				
	nursing assistant (N routine morning car basin, filled it with w and before returning gloves. NA-B did n glove placement. F face, hands, arms, provided R68 with p incontinent brief wa and also had a sma gloves still on, NA-E into the bathroom, f removed and dispo the basin to the dra denture cup into the rinsed off the dentu gloves, and placed NA-B did not wash changes, after havi for R68. After remo NA-B completed gr	on 9/16/2015 at 9:16 a.m., NA)-B provided R68 with res. NA-B retrieved a plastic varm water from the bathroom, g to R68's bedside, donned ot wash her hands prior to the Following the washing of R68's and upper body, NA-B berineal care. R68 was as moderately urine soaked, all amount of feces With B took the plastic wash basin flushed and rinsed the basin, sed her gloves, then returned aver. NA-B then took R68's e bathroom, drained and arres, donned a new pair of the teeth into R68's mouth. her hands between the glove ng just provided perineal care bying the 2nd pair of gloves, ooming for R68. Exiting the returned to R68's room with IA-B relined the wastebasket				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245494	B. WING	i		09/-	17/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	used gloves and Re other bag, NA-B ga R68's gown from the articles. NA-B then room in the wheel cha wheel chair into the dining room, plastic in the soiled utility a utility area, NA-B ag During an interview NA-B stated "I did r providing perineal of she "should have w inserting R68's den bring a bag into R6 towels, gown and s placed in the bag" a also said she "shou water" after complet the laundry, before In an interview on 9 assistant director of staff" were trained to after donning glove providing personal the staff were trained bags into resident r garbage can liners, laundry, and one fo stated three had be training in July," and	ng shut the bag containing 58's soiled brief. With the thered the soiled linens and e floor, and bagged the pushed R68 out from her hair, the plastic bags swinging ir handles as she pushed the dining room. NA-B exited the bags in had, and placed them trea. After emerging from the pplied sanitizer to her hands. on 9/16/2015 at 9:56 a.m., not wash my hands" after cares for R68. NA-B stated vashed my hands" before tures. NA-B said she forgot to 8's room, and the soiled oaker pad "should have been and not on the floor. NA-B ld have washed with soap and ting cares and dropping off assisting another resident. /17/2015 at 1:53 p.m., the f nursing (ADON) stated "all o wash hands "before and s," especially if staff were cares. The ADON also said ed to bring in three plastic ooms, to replace the existing and "one for personal r linens." The ADON also en "infection control (IC) d all nursing staff get training ew hires" receive IC training	F	441			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245494	B. WING	i		09/ <sup>.</sup>	17/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HC	)ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	SOILED RESIDEN R165's MDS, dated cognitively intact, an During observation was noted that in R shared by another n room, a commode commode was used designed with a cut existing bathroom s side hand rails, whi and a place to grip, independently on a the plastic bowl, be covered with a laye feces, extending ar circumference of th produced a malodo bathroom. During observation 9:24 a.m., R165's co over the stool in the commode bowl rem feces present, and noticeable. In an interview on 9 stated that when th and dirty like that, I bathroom." R165 s should be cleansed disgusting." R165 a not the first time he bathroom, and add floor, and toilet "car	age 39 T BATHROOM EQUIPMENT d 8/13/2015, indicated he was nd independent with toileting. on 9/15/2015 at 7:20 p.m., it 8165's bathroom, which was male resident in the adjoining stood over the stool. R165's d as a raised toilet seat, t out bottom, placed over the stool, and was equipped with ich provided R165 stability, allowing him to transfer nd off the seat. The inside of tween the seat and toilet, was er of dried, dark brown-colored round the entire inside he bowl. The dried feces brous scent in R165's shared the next day, on 9/16/2015 at commode remained positioned e bathroom. The inside of the nained unclean, with the dried the odor was still present and 0/16/2015 at 12:53 p.m., R165 he commode bowl was"soiled didn't even want to use the said when it gets dirty, "It d right away, and not left. "It is also stated that "today" was he encountered an unclean led he felt the bathroom, the in get very dirty between said the housekeeper only	F	441			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245494	B. WING			09/	17/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HC	ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441 F 465 SS=D	the assistant director charge of infection of present on any surf right away," and that concern." The ADC clean up bodily fluic is all our responsibit would expect reside cleaned." A facility document, Housekeeping," rev "Routine cleaning p table, chair, floors, soiling or spills occur indicated "Surfacess fluids shall be clear established procedus splashes of blood of A facility "Infection ( August 2009, indica "to keep the envir microbiologically sa resident, staff and v 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro-	e a week." on 9/17/2015 at 1:53 p.m., or of nursing (ADON) in control, stated that if feces is ace, "It should be cleaned at it was "an infection control ON stated the responsibility to ds falls on "whoever sees it, it lity." The ADON also said she ent commodes "to be always "Infection Control, rised August 2009, directed: rocedures for bed, bedside etc, shall be followed when ur" Further, the policy soiled with blood or body hed in accordance with ures for cleaning up spills or or body fluids." Control" document, updated ated it was the facility policy onment clean an ifeTo prevent infection in risitors."	F 4	441			10/26/15

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		AND HUMAN SERVICES			PRINTED: 10/13/2015 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245494	B. WING _		09/17/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 701 FIRST STREET	•	
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI> TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO		
F 465	This REQUIREMEI by: Based on observative review, the facility f bathroom device for whose raised-seat unclean. Findings include: R165's admission M dated 8/13/2015, in intact. During observation was noted in R165' by another male rest commode stood ov was a raised toilet s bottom, placed over and was equipped by provided R165 state allowing him to trant the seat. The inside the seat and toilet, dried, dark brown-of around the entire in bowl. The dried feet scent in R165's shate During observation 9:24 a.m., R165's of the stool in the bath and the inside of th with the dried feetes In an interview on S stated that when th	NT is not met as evidenced tion, interview and document ailed to maintain a clean r 1 of 1 residents (R165) commode was observed Minimum Data Set (MDS), dicated he was cognitively on 9/15/2015 at 7:20 p.m., it s bathroom, which was shared sident in the adjoining room, a er the stool. R165's commode seat, designed with a cut out r the existing bathroom stool, with side hand rails, which bility, and a place to grip, isfer independently on and off e of the plastic bowl, between was covered with a layer of colored feces, extending iside circumference of the ces produced a malodorous ared bathroom. the next day, on 9/16/2015 at commode, still positioned over nroom, had a noticeable odor, e bowl remained unlearned,	F 4	<ul> <li>F - 465</li> <li>Safe/functional/sanitary/comforenvironment</li> <li>Elim Care and Rehab Centerexpectation that staff will show competence with the continue compliance of the following plates</li> <li>Regarding cited residents:</li> <li>R165 continued to be indepentioned to be indepentioned per resident preference unfortunately it was not the heip preferred. Facility to look into available options that meet his preferences. Housekeeping a to check bathroom daily and commode PRN.</li> <li>Actions taken to identify other residents having similar occur Bathrooms will continue to be daily with cares and activities. clean appliances/devices whe appropriate and/or notify the apersonnel if attention is needed Residents noted to have a char elimination will be re-assessed updated with changes and presented to have a char elimination will be re-assessed updated with changes and presented weekly and print Horizon to the completed weekly and</li></ul>	has the v d an: hdent with de was ce, but height he other s nd nursing clean potential rences: observed Staff will n uppropriate ed. ange in d and CP eferences. ure deficient its to be pousekeeping	

Facility ID: 00375

If continuation sheet Page 42 of 50

		AND HUMAN SERVICES				FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245494	B. WING _			09/1	17/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				1 FIRST STREET RINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465 F 520 SS=E	bathroom." R165 s should be cleansed disgusting." R165 a not the first time he bathroom, and adda floor, and toilet "car cleanings." R165 s came through "once In an interview on 9 registered nurse (R had been cleaned. were responsible for the resident rooms, commode. RN-E s commode be clean cleaned sooner." During an interview the assistant directo charge of infection of present on any surf right away," and tha concern." The ADC clean up bodily fluid is all our responsibi would expect reside cleaned." A facility document, Cleaning/Disinfection indicated the facility environment clean a and "To prevent infe visitors." 483.75(o)(1) QAA COMMITTEE-MEM	aid when it gets dirty, "It right away, and not left. "It is also stated that "today" was encountered an unclean ed he felt the bathroom, the n get very dirty between aid the housekeeper only e a week." 0/16/2015 at 1:50 p.m., N)-E stated R165's commode RN-E said the nursing staff or the "day-to-day cleaning" in including things like the aid she would "expect" R165's , and that it "should have been or on 9/17/2015 at 1:53 p.m., or of nursing (ADON) in control, stated that if feces is iace, "It should be cleaned at it was "an infection control DN stated the responsibility to ds falls on "whoever sees it, it lity." The ADON also said she ent commodes "to be always , "Infection Control, on," updated August 2009, y policy was to "keep the and microbiologically safe," ection in resident, staff and IBERS/MEET	F 4		accommodate resident needs. The DON/designee will report findir audits to the Quality Assurance Committee who reviews for continu- compliance and further recommend and approaches. Effective implementation of actions monitored by: 10/26/15 Those responsible to maintain com will be: DON or designee.	ed dations will be pliance	10/26/15
	Cleaning/Disinfection indicated the facility environment clean and "To prevent infe- visitors." 483.75(o)(1) QAA	on," updated August 2009, policy was to "keep the and microbiologically safe," action in resident, staff and IBERS/MEET	F 52	20			10/26/15

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		AND HUMAN SERVICES		FORM	: 10/13/2015 APPROVED . 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DAT	(X3) DATE SURVEY COMPLETED			
		245494	B. WING		17/2015			
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
ELIM HOME			701 FIRST STREET PRINCETON, MN 55371					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 520	Continued From pa	ge 43	F 520					
	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.							
	committee meets a issues with respect and assurance acti- develops and imple	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies.						
	disclosure of the re except insofar as si	retary may not require cords of such committee uch disclosure is related to the committee with the s section.						
		s by the committee to identify deficiencies will not be used as is.						
	by: Based on interview facility failed to ens Assurance (QA&A) implemented, and r address identified of completion of activit the facility. This aff R6 and R8) in the s	NT is not met as evidenced y and document review, the ure the Quality Assessment & committee developed, re-evaluated actions plans to concerns regarding the ties of daily living (ADLs) in rected 3 of 3 residents (R107, cample identified as not having et, but had the potential to		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				
	affect all residents	who required staff assistance ving, and personal hygiene.		condition and/or ADL status are discussed daily at the IDT meeting. R107, R6 and				

Facility ID: 00375

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			E CONSTRUCTION	MB NO. 0938-03 (X3) DATE SURVEY COMPLETED
			A. BUILDII	NG _		
		245494	B. WING _			09/17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
ELIM HC	ME				D1 FIRST STREET RINCETON, MN 55371	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTIC
F 520	Continued From pa	age 44	F 52	20		
				_ •	R8¿s change in their ADL status w	ere
	Findings include:				discussed at the October QAPI me	eting
					held on 10/12/15. Concerns with th	
		imum Data Set (MDS) dated R107 had long and short term			status discussed with IDT. Action p place. CP and NAR assignment sh	
	memory problems,				updated.	
		equired supervision with			upualeu.	
	eating.				R107¿s diet was reviewed and cha	anged
	-				to regular diet with finger foods, to	ease
		ated 9/10/15, identified R107			her ability and compliance with inta	ake. Her
		gement with eating", and			CP was reviewed and updated.	
	-	directed staff to, "Assist with feeding as res. [resident] allows."			On 9/17/15, R6 was approached a	nd
	[resident] allows.				agreed to nail care on only his righ	
	During observation	of the lunch meal on 9/16/15,			He refused nail care to his left han	
	at 12:25 p.m. R107	was seated at a table with			much encouragement, he agreed	to
		in the Skyview dining room.			complete the nail care. Resident v	
		colored lipped plate she was			approached and assisted with the	
		e table in her left hand which			of unwanted facial hair. Staff contin	
		rrots, rice, and country fried wo glasses on the table, one			encourage his compliance with gro assistance. He has a history of ref	
		ce with pieces of diced carrot			care, nursing is charting on his	
		water with food smeared all			compliance daily. Care plan update	ed with
		the glass. R107 was picking carrots from the table and			his preferences with grooming ass	
		fingers while holding her plate.			R8 will continue to be encouraged	to allow
		ing assistant (NA)-C walked			staff to perform nail care on his ba	
		emate and visited with her,			and PRN. Any refusals will be	5
		offer of assistance to R107			documented in his medical record.	
		ick up food from the table			and NAR assignment sheet update	
		At 12:29 p.m. NA-C served			his preferences with grooming/hyg preferences.	iene
		ner food, and promptly left the fer to assist or re-direct R107				
		g the spilled rice and carrots			Actions taken to identify other pote	ential
		using her fingers. At 12:31			residents having similar occurrenc	
	p.m. R107 continue	ed to play with the spilled food			Facility will continue to discuss cha	anges in
		2:39 p.m. when NA-C served			condition and/or ADL status daily a	t the
		ana cake in a small dish. NA-C			IDT meeting.	
	made no offer to as	ssist R107 to eat the cake or			Dining room audits will be conduct	ea 10

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245494 **B** WING 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 520 Continued From page 45 F 520 meal, as she continued to push food around on review assistance and dignity needs the table and plate using her fingers. At 12:42 during meals. p.m. registered nurse (RN)-F entered the dining Residents will continue to be groomed room and offered R107's tablemate assistance daily per their preferences. Shaving will be with eating, but did not offer any assistance to offered, if facial hair is observed. Nail care R107 as she continued to eat food using her will be offered on bath days and prn. fingers. At 12:46 p.m. RN-F approached R107 at the table and asked, "How are you doing?" to her, Measures put in place to ensure deficient and R107 responded with non-sensical speech. practice does not occur: RN-F cut up R107's banana cake in the small Audits to observe dining room activity will dish using a fork and asked her, "Do you mind if I be done weekly and prn. Staff is to be get this rice off of you?", as she brushed it off her in-serviced on the importance of clothing and onto the floor. RN-F then picked up dignity/grooming, assisting resident in a the glass of red juice and removed it from the timely manner, and the table telling R107 she was removing it "since you observation/cleaning of soiled linens and got a carrot in it" and left the table. R107 resident care equipment. remained seated at the table pushing food around Policy and procedure for shaving a and eating using her fingers, spilling large resident reviewed/updated. Policy and amounts on the floor and herself until 12:51 p.m. procedure for nail care reviewed/updated. (26 minutes later) when she pushed the plate Nursing orders placed for nursing to away from herself on the table using her soiled document compliance/refusals of cares g shift. Care/grooming audits to be clothing protector. completed weekly and prn When interviewed on 9/16/15, at 12:57 p.m. NA-D stated R107 typically "wears a lot of it The DON/designee will report findings of [food]" when she is left alone to eat by herself audits, daily IDT change in ADL without any assistance. The staff often try to help status/Change of condition to the Quality her when they bring her a plate of food, however Assurance Committee who reviews for she would often refuse assistance so staff just continued compliance and further leave her alone to "do what she does" with the recommendations and approaches. food (referring to her playing with it). Further, NA-D stated staff "should give her more finger Effective implementation of actions will be food" so she could eat with her hands if that was monitored by: 10/26/15 her preference adding, "I wonder why there is no alternative offered [versus rice and carrots]." Those responsible to maintain compliance will be: DON or designee. 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES				FORM	: 10/13/2015 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245494	B. WING	ì		09/17/2015		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 520	history of mixing up RN-F reviewed R10 R107 "should have offered cues and er meal. RN-F also sa different in place" if and not accepting a R6's annual Minimu 6/16/15, identified F required "total deper personal hygiene. During observation was in his room in k on both hands, with dark-colored substa nail. In addition, R6 facial hair on his up likes his nails kept ' did not want facial f subsequently obser R6 continued to hav visible, uncut facial When observed for 7:31 p.m. nursing a face and eyes, and today?" R6 respon shave him, so it wa finished R6's evenin offer to shave him, fingernails. R6's care plan date	noice for R107, given her o and playing with her food. D7's care plan, and stated been re-approached, and ncouragement" to eat her aid "We don't have anything R107 is playing with her food assistance. um Data Set (MDS) dated R6 had intact cognition, and endence" on staff for his on 9/14/15, at 3:29 p.m. R6 bed. R6 had long fingernails aseveral of his nails having a ance visible underneath the b had visible white and gray oper lip and chin. R6 stated he "shorter" than they were, and nair on his face. When rved on 9/15/15, at 1:31 p.m. ve long, dirty fingernails and hair. r evening cares on 9/15/15, at asked R6 "forget to shave ded that "nobody offered" to s not completed. NA-E ing cares, however made no or trim and clean his	F	520				
		DLs of dressing, grooming and the care plan directed staff to						

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		AND HUMAN SERVICES			FORM	10/13/2015 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245494	B. WING		09/17/2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ELIM HOME				701 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 520	During interview on stated R6 required his personal hygien of that for him." Sta personal hygiene for and evening." NA-I and long, dirty finge "needs to be shave be clipped down." When interviewed of licensed practical n "totally dependent" were expected to h a preference "to be LPN-A was unawar long fingernails, and cleaned, "They look underneath." R8's quarterly MDS was cognitively inta hemiplegia (paralys hemiparesis (weak and required extens personal hygiene. During observations 9/16/15 throughout having long fingern When interviewed of stated, "I think my finow." He also state	e as needed with bath" 9/16/15, at 8:44 a.m. NA-B total assistance to complete e and grooming, "[We] do all aff were expected to complete or residents "every morning B observed R6's facial hair ernails. NA-B stated R6 d", and his fingernails "need to on 9/16/15, at 12:08 p.m. urse (LPN)-A stated R6 was on staff for his care, and staff elp him shave daily as R6 had clean shaven." Further, e of any preference to have d they should be clipped and c like they could be cleaned 6, dated 8/3/15, identified R8 ct, had diagnoses of sis of one side of the body) and ness of on side of the body), sive assistance to complete s on 9/14/15, 9/15/15 and the survey, R8 was noted ails on both of his hands. on 9/15/15, at 6:45 p.m. R8 ingernails are trimmed pretty ff "get around" to it. R8 stated,	F 520				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245494	B. WING	i		<b>09</b> / <sup>.</sup>	17/2015
NAME OF	PROVIDER OR SUPPLIER	•	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HC	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 520	Continued From pa	ige 48	F؛	520			
	During interview on assistant (NA)-A sta trim resident's nails further stated that F Thursdays. NA-A a long" and "they do n NA-A was not sure trimmed or when st nails. When interviewed of registered nurse (R aware of R8 ever re stated R8 received and it was the night complete R8's nail During an interview the administrator and discussed current ta assurance (QA) con emphasized that "a reviewed each mon The DON stated that a review of "incident adult), incidents, fal issues, and our hos DON stated one PI program) that was a past year dealt with the facility had been addressing skin con especially based "p other current QA pr addressing" infectio "improve residents"	a 9/16/15., at 1:10 p.m. nursing ated that nursing assistant's s on their bath days. She R8's bath day was on also stated R8's nails "are need to be cut." In addition, when R8's nails were last taff had last offered to trim his on 9/17/15, at 10:56 a.m. RN)-D stated she was not efusing nail care. RN-D also his baths on the night shift t shifts responsibility to care during his bath time. on 9/17/2015, at 4:03 p.m. nd director of nursing (DON) topics of the facility's quality mmittee. The administrator all issues in the building" were nth during the QA meetings. e QA agenda typically included nt reports, VAs (vulnerable lls, complaints, any ethical spital readmission rates." The P (process improvement a major focus of the QA this n "skin issues." The DON said n "very proactive" in ncerns/pressure ulcers, prior surveys." The DON said rojects included "always on control, a program to 's leep," and a "hospitality se resident overall satisfaction					

Facility ID: 00375

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/13/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245494	B. WING	·····	<b>09</b> / <sup>.</sup>	17/2015
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HOME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 520	Continued From pa during their stay in There was no ment program addressing resident activities of was again identified In continuing the im- personal grooming, discussed a lot abor grooming" and mak- they need for ADLs personal grooming conversation," but t formal part" of the f facility was aware to proper assistance of there was no formal plan developed or m committee. The DO	age 49	F 520			

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		AND HUMAN SERVICES & MEDICAID SERVICES	FSI	494023		APPROVED 0. 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mult A. Buildi	TIPLE CONSTRUCTION NG <b>01</b>	(X3) DATE SURVEY COMPLETED	
		245494	B. WING		09	/21/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ELIM HC	DME			701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S	K 0(	00		
	FIRE SAFETY					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.			ч.	
	ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE .S BEEN ATTAINED IN TH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio Elim Home Princeto compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the ent of Public Safety, State in. At the time of this survey, on was found not in substantial requirements for participation id at 42 CFR, Subpart ity from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), Health Care.		EPC		
0.	PLEASE RETURN CORRECTION FOR DEFICIENCIES (K	R THE FIRE SAFETY				
	HEALTH CARE FIR STATE FIRE MARS 445 MINNESOTA S	HAL DIVISION				
		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE 10/12/2015
Electron	ically Signed					10/12/2013

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

PRINTED: 10/20/2015

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

						. 0000 0001	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245494	B. WING _		09	/21/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ELIM HC	DME			701 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficient 2. The actual, or pro 3. The name and/or responsible for corr	D1-5145, or tate.mn.us @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE RMATION: what has been, or will be, done ency.	K 0(	00			
	basement. The orig in 1971 and was de construction. An ac the same constructi building was inspec building also has an that is properly sepa The building is fully facility has a fire ala detection in the corr corridors that is mon department notificat have either heat det that are on the fire a	on is a 3 story building with no inal building was constructed termined to be of Type II(111) Iditions was built on in 1989 of on type,. Therefore the ted as one building. The apartment complex attached arated. sprinklered throughout, the rm system with smoke idors and spaces open to the hitored for automatic fire ion. Other hazardous areas section or smoke detection alarm system in accordance State Fire Code. The facility					

FORM CMS-2567(02-99) Previous Versions Obsolete

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DEPARTMENT	OF	HEALTH	AND	HUMAN	SERVICES
CENTERS FOR	R ME	EDICARE	& ME	EDICAID	SERVICES

CENTERS FOR MEDICA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	(X3) DATE SURVEY COMPLETED	
AND FLAN C	of contention		A. BUILDING		
		245494	B. WING		09/21/2015
NAME OF I	PROVIDER OR SUPPLIER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 01 FIRST STREET PRINCETON, MN 55371	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIC
K 000	97 at the time of the The requirement at	beds and had a census of	K 000		
K 029 SS=D	One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 prot the approved autom option is used, the a other spaces by sm doors. Doors are s field-applied protect	FETY CODE STANDARD construction (with <sup>3</sup> / <sub>4</sub> hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When hatic fire extinguishing system areas are separated from loke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are .1	K 029		10/26/15
	Based on observat revealed that the fa proper protection fo areas located throu accordance with NF section 19.3.2.1. The in the event of a fire spread throughout the areas making them	PA Life Safety Code 101 (00) his deficient conditions could a, allow smoke and flames to the effected corridors and untenable, which could a exiting capabilities for		K029 ¿ Door closers will be installe these doors and storage removed f against the electrical panel, all by 10-26-15. Jim Knutson, plant oper- assistant, will be responsible for correction and monitoring to prever recurrence.	rom up ations
	Findings include:				

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

ſ					(Y3) DATE 9	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245494	B. WING		09/21	1/2015
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME			01 FIRST STREET RINCETON, MN 55371		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029	On facility tour betw 09/21/2015, observ following deficient of rooms throughout th 1. Resident rooms rooms that were co and are not equipped 2. There was storage panels that are loca	veen 3:00 PM to 6:00 PM on ation revealed, that the conditions hazardous storage the facility: 350 and 352 are resident nverted into storage rooms ad with self closing doors. ge up against the electrical	К 029			
K 050 SS=F	Administrator (TL). NFPA 101 LIFE SAI Fire drills are held a varying conditions, a The staff is familiar that drills are part of Responsibility for pl assigned only to con qualified to exercise conducted between	tion was verified by the Facility FETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. anning and conducting drills is mpetent persons who are leadership. Where drills are 9 PM and 6 AM a coded be used instead of audible	K 050		1	0/26/15
	Based on review of interview, it was det to conduct fire drills Safety Code 101(00 12-month period. Th	a not met as evidenced by: reports, records and staff ermined that the facility failed in accordance with NFPA Life 0), 19.7.1.2, during the last his deficient practice could bt in the event of a fire.		K050 ¿ Fire drill did take place du day shift on 4¿28¿15 however com documentation wasn¿t available at time of survey. Documentation nov been found and is in our life safety ring binder. Jim Knutson, plant	plete the w has	

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

VENIC		& MEDICAID SERVICES			VID 110. 0000-00	<u> </u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245494	B. WING		09/21/2015	ŀ
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 01 FIRST STREET		
ELIM HO	ME			RINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	
K 050		ge 4 y staff would affect the safety	K 050	operations assistant, will be respor for correction and monitoring to pre recurrence.		
	09/21/2015, during maintenance docun the Facility Administ the facility failed to p	veen 3:00 PM to 6:00 PM on the review of all available mentation and interview with trator (TL) it was revealed that provide a day shift fire drill in of the calendar year.				
K 054 SS=F	Administrator (TL). NFPA 101 LIFE SAI All required smoke activating door hold	tion was verified by the Facility FETY CODE STANDARD detectors, including those -open devices, are approved, ed and tested in accordance rer's specifications. 9.6.1.3	K 054		10/26/1	5
	Based on staff inter available document conducted that requ smoke detectors on accordance with NF Code (99), Sec. 7-3	s not met as evidenced by: rview and a review of the ation, the facility has not irred sensitivity testing of the the fire alarm system in PA 72 National Fire Alarm .2.1. This deficient practice lents, visitors, and staff.		K054 ¿ Smoke Detector sensitivity testing document ¿ will be printed a provided by our vendor by 10 ¿ 26	and	
	Findings include:					
	09/21/2015, a revie	een 3:00 PM to 6:00 PM on w of the facility's available fire and testing documentation for				

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES				C	<u>MB NO. 093</u>	8-0391
	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SUI COMPLET	
		245494	B. WING _		09/21/2	015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO	DBE CON	(X5) MPLETION DATE
K 054	Facility Administrat time of the inspecti any current docum completion of the r	age 5 , and an interview with the or (TL) revealed that at the on the facility could not provide entation verifying the equired sensitivity testing of for located throughout the	K 05	4		
K 056 SS=D	Administrator (TL). NFPA 101 LIFE SA If there is an autom installed in accorda for the Installation of provide complete of building. The syste accordance with NI Inspection, Testing Water-Based Fire I supervised. There supply for the syste systems are equipt	FETY CODE STANDARD natic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the em is properly maintained in FPA 25, Standard for the , and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler bed with water flow and tamper e electrically connected to the	K 05	6	10/	26/15
	Based on observa found that the auto installed and maint NFPA 13 the Stand Sprinkler Systems the sprinkler syster	s not met as evidenced by: tions and staff interview, it was matic sprinkler system is not ained in accordance with lard for the Installation of (99). The failure to maintain n in compliance with NFPA 13 stem being place out of service		K056 ¿ Sprinkler heads will be re to be the same type in the same department ¿ vendor Viking Sprin do the work by 10-16-15. Jim Knu plant operations assistant, will be responsible for correction and mo to prevent recurrence.	kler to utson,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: P7U821

			AND HUMAN SERVICES & MEDICAID SERVICES		FC	ED: 10/20/2015 RM APPROVED NO: 0938-0391
	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		DATE SURVEY COMPLETED
		245494		B. WING		09/21/2015
	NAME OF I	PROVIDER OR SUPPLIER		r	STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 056	capability in the even would affect the res facility. Findings include: On facility tour betw 09/21/2015, observenthere are two different mixed in the same of	in the fire protection system ont of an emergency that idents, visitors and staff of the reen 3:00 PM to 6:00 PM on ations have revealed that ent types of sprinkler head compartment, there are 2	K 05	6	
	K 062 SS=F	type heads located and in the 2nd floor This deficient condi Administrator (TL). NFPA 101 LIFE SAI Required automatic continuously mainta condition and are in	tion was verified by the Facility FETY CODE STANDARD sprinkler systems are ined in reliable operating	K 06	2	10/26/15
		This STANDARD is Based on documer with staff, the facility and maintain the au accordance with NF Section 19.7.6, and of Sprinkler System for the Inspection, T Water Based Fire P	a not met as evidenced by: Intation review and interview has failed to properly inspect tomatic sprinkler system in PA 101 Life Safety Code (00), 4.6.12, NFPA 13 Installation s (99), and NFPA 25 Standard Testing and Maintenance of rotection Systems, (98). This bes not ensure that the fire		K062 ¿ Annual Sprinkler test was completed on 9¿25¿15. Terri at Vikin Sprinkler will schedule our inspections less than 52 weeks in the future. Paul Whitcomb, plant operations director, w be responsible for correction and monitoring to prevent recurrence	in a
L		e7/00.00) Braviaua Margiana	Obsoloto Event ID: P71821		acility ID: 00375 If continuation	sheet Page 7 of 10

Facility ID: 00375

If continuation sheet Page 7 of 10

PRINTED: 10/20/2015

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245494	B. WING			21/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 701 FIRST STREET PRINCETON, MN 55371	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO	I SHOULD BE	(X5) COMPLETION DATE
K 062 K 067 SS=F	sprinkler system is fully operational in the negatively affect read Findings include: On facility tour betwn 09/21/2015, a revie interview with the F revealed that at the facility failed to provide the facility failed to provide the current annual fire standard the facility failed to provide the facility facility	functioning properly and is the event of a fire and could sidents, staff and visitors. ween 3:00 PM to 6:00 PM on w of documentation and acility Administrator (TL) time of the inspection the vide any documentation for a sprinkler test having been tion was verified by the Facility FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed	К0			10/26/15
	Based on document interview, the fire/st been maintained in requirements of NF deficient practice do operation of the fire allow smoke migrat	s not met as evidenced by: ntation review and staff moke damper system has not accordance with the PA 90(99) section 3-4.7. This bes not ensure the proper /smoke dampers and could ion to negatively affect the ts, staff and visitors in the		K067 ¿ Fire & Smoke Dar inspection documentation - and provided by our vendor 15.	will be printed	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245494	B. WING			09/2	21/2015
NAME OF I	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
					DI FIRST STREET RINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 067	Continued From pa	ge 8	ĸ	)67			
, K 147 SS=D	REGULATORY OR LSC IDENTIFYING INFORMATION)         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).         NFPA 101 LIFE SAFETY CODE STANDARD		Κı	47	K147 ¿ Storage will be removed fro against the left panel, all by Octobe Jim Knutson, plant operations assis will be responsible for correction and monitoring to prevent recurrence.	r 26. tant,	10/26/15
	09/21/2015, observa	een 3:00 PM to 6:00 PM on ations revealed that there was nt of combustible items being					

Facility ID: 00375

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	MENT OF HEALTH		FORM APPROVE OMB NO. 0938-039			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY
		245494	B. WING _		09	21/2015
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 147		up against the electrical anels that are located in the	K 14	47		
	This deficient condi Administrator (TL).	tion was verified by the Facility				

Event ID: P7U821

Facility ID: 00375

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G <b>02 - BUILDING 2</b>		TE SURVEY MPLETED
		245494	B. WING		09	/21/2015
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
	ME			701 FIRST STREET		
				PRINCETON, MN 55371 PROVIDER'S PLAN OF CORRE	CTION	(1)(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMENT	ſS	K 000	0		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
15	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio Elim Home Princeto compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, on was found not in substantial e requirements for participation id at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), ealth Care.		EPOC		
	DEFICIENCIES (K	R THE FIRE SAFETY TAGS) TO:		Ervu		8
	HEALTH CARE FIR STATE FIRE MARS 445 MINNESOTA S					

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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DEPARTMENT	OF HEALTH AND HUMA	<b>N SERVICES</b>
CENTERS FOR	MEDICARE & MEDICAL	D SERVICES

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			(	<u> WR NO</u>	0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION 02 - BUILDING 2		e survey IPleted
		245494	B. WING	i		09/	21/2015
NAME OF	PROVIDER OR SUPPLIER	•		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HC	ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/o responsible for corr	01-5145, or state.mn.us n@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency.	K	000			
	Elim Home Princett basement. The buil been determined to inspection only refle 11-4-03. It is proper building constructed The building is fully facility has a fire all detection in the cor corridors that is more department notificat have either heat det that are on the fire with the Minnesota	on is a 3 story building with no ding construction type has be Type II(442). This ects the building that opened rly separated from the original d in 1971. sprinklered throughout, the arm system with smoke ridors and spaces open to the initored for automatic fire tion. Other hazardous areas tection or smoke detection alarm system in accordance State Fire Code. The facility 06 beds and had a census of					

Facility ID: 00375

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

			1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		CONSTRUCTION - BUILDING 2		E SURVEY PLETED
		245494	B. WING			09/:	21/2015
NAME OF I	PROVIDER OR SUPPLIER	L	L		EET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				FIRST STREET NCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 2	КO	000			
K 050 SS=F	NOT MET. NFPA 101 LIFE SAM Fire drills are held a varying conditions, i The staff is familiar that drills are part o Responsibility for pl assigned only to co qualified to exercise conducted between	42 CFR Subpart 483.70(a) is FETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. anning and conducting drills is mpetent persons who are e leadership. Where drills are 9 PM and 6 AM a coded y be used instead of audible	κo	950			10/26/15
	Based on review of interview, it was det to conduct fire drills Safety Code 101(00 12-month period. Th affect how staff read Improper reaction b of all residents. Findings include: On facility tour betw 09/21/2015, during maintenance docum the Facility Administ the facility failed to p	s not met as evidenced by: f reports, records and staff ermined that the facility failed in accordance with NFPA Life 0), 18.7.1.2, during the last his deficient practice could ct in the event of a fire. by staff would affect the safety reen 3:00 PM to 6:00 PM on the review of all available mentation and interview with trator (TL) it was revealed that provide a day shift fire drill in of the calendar year.		t t t f	K050 ¿ Fire drill did take place dur day shift on 4¿28¿15 however com documentation wasn¿t available at time of survey. Documentation now been found and is in our life safety of ring binder. Jim Knutson, plant operations assistant, will be respon- for correction and monitoring to pre recurrence.	plete the v has code 3 sible	

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Facility ID: 00375

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FORM /	APPROVED
OMB NO.	0938-0391

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 02 - BUILDING 2	(X3) DATE SURVEY COMPLETED
		245494	B. WING		09/21/2015
NAME OF	PROVIDER OR SUPPLIER	£	70	TREET ADDRESS, CITY, STATE, ZIP CODE 01 FI <b>RST STREET</b> RINCETON, MN 55371	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
K 050	Continued From pa	ige 3	K 050		
K 054 SS=F	Administrator (TL). NFPA 101 LIFE SA All required smoke activating door hold maintained, inspect	ition was verified by the Facility FETY CODE STANDARD detectors, including those l-open devices, are approved, ted and tested in accordance rer's specifications. 9.6.1.3	K 054		10/26/15
	Based on staff inter available document conducted that requisitions or accordance with NF Code (99), Sec. 7-3	s not met as evidenced by: rview and a review of the tation, the facility has not uired sensitivity testing of the n the fire alarm system in FPA 72 National Fire Alarm 8.2.1. This deficient practice dents, visitors, and staff.		K054 ¿ Smoke Detector sensitivity testing document ¿ will be printed a provided by our vendor by 10 ¿ 26	and
	09/21/2015, a revie alarm maintenance the last 12 months, Facility Administrate time of the inspection any current docume completion of the re	veen 3:00 PM to 6:00 PM on ew of the facility's available fire and testing documentation for and an interview with the or (TL) revealed that at the on the facility could not provide entation verifying the equired sensitivity testing of or located throughout the			
K 062	Administrator (TL).	tion was verified by the Facility FETY CODE STANDARD	K 062		10/26/15

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		245494	B. WING		09/	21/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 062 SS=F	continuously mainta condition and are in	ige 4 c sprinkler systems are ained in reliable operating hspected and tested 5, 4.6.12, NFPA 13, NFPA 25,	K 062	2		
	Based on docume with staff, the facilit and maintain the au accordance with NI Section 18.7.6, and of Sprinkler System for the Inspection, Water Based Fire F deficient practice do sprinkler system is fully operational in	s not met as evidenced by: ntation review and interview y has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), I 4.6.12, NFPA 13 Installation hs (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This bes not ensure that the fire functioning properly and is the event of a fire and could sidents, staff and visitors.		K062 ¿ Annual Sprinkler test wa completed on 9¿25¿15. Terri Sprinkler will schedule our inspe- less than 52 weeks in the future Whitcomb, plant operations dire be responsible for correction an monitoring to prevent recurrence	at Viking ections in a . Paul ctor, will d	
	09/21/2015, a revie interview with the F revealed that at the facility failed to prov	veen 3:00 PM to 6:00 PM on w of documentation and Facility Administrator (TL) time of the inspection the vide any documentation for a sprinkler test having been				
K 067 SS=F	Administrator (TL).	ition was verified by the Facility FETY CODE STANDARD	K 06	7		10/26/15

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - BUILDING 2		E SURVEY PLETED
		245494	B. WING			09/	21/2015
NAME OF F	Provider or supplier			70	TREET ADDRESS, CITY, STATE, ZIP CODE D1 FIRST STREET RINCETON, MN 55371	0.00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 067	with the provisions in accordance with	, and air conditioning comply of section 9.2 and are installed	КO	67			
	Based on document interview, the fire/sr been maintained in requirements of NF deficient practice do operation of the fire allow smoke migrat	s not met as evidenced by: ntation review and staff moke damper system has not accordance with the PA 90(99) section 3-4.7. This bes not ensure the proper /smoke dampers and could ion to negatively affect the ts, staff and visitors in the			K067 ¿ Fire & Smoke Damper ter inspection documentation - will be and provided by our vendor by 10 15.	printed	
	09/21/2015, it was the facility's fire and test/inspection docu by interview with the that the facility had documentation verif dampers have been last 4 years.	Imentation and was confirmed e Facility Administrator (TL),					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00375

If continuation sheet Page 6 of 6



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.

Elim Home October 2, 2015 Page 2

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,

ale Compton

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

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00375	B. WING		09/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HO	ME	701 FIRST PRINCET	T STREET ON, MN 553 <sup>-</sup>	71		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 10/12/15

STATE FORM

If continuation sheet 1 of 40

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ELIM HC	ME		T STREET ON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proo completion date, th corrected prior to e Minnesota Departm On September 14t Department's staff, the following correct Please indicate in y correction that you and identify the date	h-17th, 2015, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed.				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow	umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED
		00375	B. WING		09/17/2015
			DRESS, CITY, <b>T STREET</b>	STATE, ZIP CODE	
ELIM HO	ME	PRINCET	ON, MN 553	371	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		10/26/15
		omprehensive plan of care personnel involved in the .			
	by: Based on observati review, the facility fa	ent is not met as evidenced on. interview and document ailed to ensure staff followed toileting assistance for 1 of 3 viewed for urinary		corrected	
	Findings include:				
	6/17/15, identified F memory problems, understood", require	mum Data Set (MDS) dated R107 had long and short-term was "rarely/never ed extensive assistance with equently incontinent of			
	to be incontinent of having "no skin be Further, the care pla	ated 6/27/15, identified R107 bladder with a goal of R107 reakdown r/t incontinence." an directed staff to, "Toilet s during the day and as			

P7U811

If continuation sheet 3 of 40

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00375	B. WING		09/	09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
ELIM HO	ME		T STREET ON, MN 5537	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
	9:45 a.m., nursing a registered nurse (R Skyview Spa. R10 a mechanical lift, an exposing a white in visibly saturated wit	ion of toileting on 9/17/15, at assistant (NA)-B and N)-F assisted R107 into the 7 was assisted to stand using nd her pants removed continence pad that was th dark yellow urine. NA-B					
	in the trash can, ho remained in the roc incontinence pad w was seated on the 10:00 a.m. R107 w NA-B performed per	inence pad and disposed of it wever a lingering odor or urine om with NA-B adding the vas "very" saturated. R107 toilet but did not urinate. At as assisted to stand, and erineal cares before a new ct was placed and R107 was her wheelchair.					
	stated R107 has ur time", and should b "two to three hours with morning cares shift "about 6 o'cloc last time she was c incontinence. Furth Time Touched docu the last time R107	on 9/17/15, at 10:03 a.m. NA-B inary incontinence "most of the be assisted to the toilet every ." R107 had been assisted and dressing by the previous ck" that morning. This was the hecked/toileted for her, NA-B reviewed a Last ument at the desk, and stated had been assisted since being a.m. that morning, three hours dier.					
	stated she was NA particular day, and with toileting since stated R107 should	9/17/15, at 10:11 a.m. NA-C -B's partner for the shift that R107 had not been assisted 5:42 a.m Further, NA-C be assisted to the bathroom leting every "two to three					
		rt dated 9/16/15 to 9/17/15, me R107 had been assisted					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING			
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
ELIM HO	ME		ST STREET TON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
		5:52 [5:52 a.m.]", and R107 Int of urine at that time when				
	stated the care plat our nursing assess direct the resident have been assisted	on 9/17/15, at 10:17 a.m. RN-F n is "a way for us to manifest ments", and they are used "to care." Further, R107 should d with toileting "every two to ected by her plan of care.				
	A facility policy on o but none was provi	care planning was requested, ded.				
	The director of nurs review and revise p to ensuring the car resident is followed designee could dev and develop a mor	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related e plan for each individual I. The director of nursing or velop a system to educate staff itoring system to ensure staff as directed by the written plan				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			10/26/1
	have a continuous management to red unnecessary use o comprehensive res home must ensure A. a resident w	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized				

STATEMEN	DIT DEPARTMENT OF HE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00375	B. WING		09/	17/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ELIM HO	OME		T STREET	371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLET DATE
2 910	Continued From pa	age 5	2 910			
	that catheterization B. a resident wireceives appropriate prevent urinary trace	's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as ler function as possible.				
	by: Based on observat review, the facility f assistance with toil	ent is not met as evidenced ion. interview and document ailed to provide timely eting to promote urinary 3 residents (R107), who was aff for toileting		corrected		
	Findings include:					
	6/17/15, identified I memory problems, understood", requir	imum Data Set (MDS) dated R107 had long and short-term was "rarely/never red extensive assistance with requently incontinent of				
	R107 was seated in	on 9/14/15, at 12:14 p.m. n her wheelchair in the m, and had a distinct urine				
	6/18/15, identified I functional urinary in resulted from being for mental or physic risk for incontinenc of Alzheimer [sic], i	servations assessment dated R107 had frequent episodes of acontinence (incontinence g unable to toilet themselves cal reasons). R107 was "at e r/t [related to] DX [diagnosis] mpaired mobility and directed staff to, "see care plan				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		- 09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ige 6	2 910			
	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."					
	9:45 a.m. nursing a nurse (RN)-F assis Spa. R107 was as mechanical lift, and a white incontinence saturated with dark the incontinence pat trash can, however remained in the roo incontinence pad w was seated on the own. At 10:00 a.m and NA-B performed	ion of toileting on 9/17/15, at issistant (NA)-B and registered ted R107 into the Skyview sisted to stand using a I her pants removed exposing e pad that was visibly yellow urine. NA-B removed ad and disposed of it in the a lingering odor or urine om with NA-B adding the ras "very" saturated. R107 toilet but did not void on her . R107 was assisted to stand, ed perineal cares before a new ct was placed and R107 was her wheelchair.				
	stated R107 has ur time", and should b "two to three hours with am cares and "about 6 o'clock" th last time she was c reviewed a Last Tir desk, and stated th assisted since bein	on 9/17/15, at 10:03 a.m. NA-E inary incontinence "most of the e assisted to the toilet every "R107 had been assisted dressing by the previous shift at morning, and that was the hecked. Further, NA-B ne Touched document at the e last time R107 had been g dressed was 5:52 a.m. that rs and 53 minutes prior).				
		9/17/15, at 10:11 a.m. NA-C B's partner for the shift that				

TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       DATE         2 910       Continued From page 7       2 910       2 910       2 910       2 910         articular 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."       2 910         R107's Vitals Report dated 9/16/15 to 9/17/15, identified the last time R107 had been assisted with noileting ar 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 review and revise papropriate and timely incontinence care, and provide staff education related to the care of residents with urinary incontinence. The director of nursing or designee could review and revise papropriate and timely incontinence care is provided.         TIME PERIOD FOR CORRECTION: Twenty-one (21) days.       TIME PERIOD FOR CORRECTION: Twenty-one	Minnesc	ta Department of He	alth			FORM	APPROVED
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           PLAN         TOT FIRST STREET         PRINCETON, MN 55371           PMERY TA         SUMMARY STATEMENT OF DEFICIENCIES ECONDECTION NUM TO EPRICEDED OF THE SUMMARY STATEMENT OF DEFICIENCIES TA         PROVIDERS PLAN OF CORRECTION ENCONDENSION NUM TO EPRICEDED OF THE SUMMARY STATEMENT OF DEFICIENCIES TA         PROVIDERS PLAN OF CORRECTION ENCONDENSION NUM TO EPRICEDED OF THE SUMMARY STATEMENT OF DEFICIENCIES TA         PROVIDERS PLAN OF CORRECTION ENCONDENSION NUM TO EPRICEDED OF THE STATE         PROVIDERS PLAN OF CORRECTION ENCONDENSION NUM TO EPRICEDED OF THE STATE         PROVIDERS PLAN OF CORRECTION ENCONDENSION NUM TO EPRICE DEFICENCY         COUNT STATE           2 910         Continued From page 7 particular day, and R107 had not been assisted with tolleting since 5.42 a.m Further, NA-C stated R107 Should be assisted to the bathroom and helped with tolleting every two to three hours."         2 910           R1075 Vitals Report dated 9/16/15 to 9/17/15, identified the last time R107 had been assisted with tolleting as '05.52 (55.2 m.g. 'n, and R107 had been incontinent of urine at that time when assisted.         SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to monitoring and provide staff education related to the care of of nursing or designee, could review and revise policies and procedures related to the ensure appropriate and timely incontinence care is provided.         2 915         10/26/1           2 915         MN Rule 4658.0525 Subp. 6 A Rehab - ADLs         2 915         10/26/1							
ELIM HOME         D1 FIRST STREET PRINCETON, MUST BE PRECIDENCY           VMI ID PRECISION         SUMMARY STATEMENT OF DEFCIENCE (EACH OPERCISING AND STATEMENT OF DEFCIENCE) (EACH OPERCISING AND STATEMENT OF DEFCIENCE) (CROSS-REFERENCE) TO THE APPROPRIATE (CROSS-REFERENCE) TO THE APPROPRIATE (CROSS-REFERENCE) TO THE APPROPRIATE (CROSS-REFERENCE) TO THE APPROPRIATE (CROSS-REFERENCE)			00375	B. WING		09/	17/2015
ELM MOME         PRINCETON, MN 55371           VM10 Trad         SUMMERY SIXTEMENT OF DESCRIPTION (ESUMATION OR LISO DENTIFYING INFORMATION)         ID PREFX Trad         PROVIDERS PLAN OF CORRECTION (ESUMATION OR LISO DENTIFYING INFORMATION)         ID PREFX TRAS         PROVIDERS PLAN OF CORRECTION (ESUMATION OR LISO DENTIFYING INFORMATION)         ID PREFX TRAS         DENOTORIES TO BENDIFYING (EDUCATION OR LISO DENTIFYING INFORMATION)         ID PREFX TRAS         DENOTORIES TO THE APPROPRIATE (EDUCATION OR LISO DENTIFYING INFORMATION)         ID PREFX TRAS         DEFICIENCY)           2 910         Continued From page 7 particular day, and R107 had not been assisted with toileting sec 524 a.m. Further, NA-C stated R107 should be assisted to the bathroom and helped with toileting every 'two to three hours."         2 910           R1075 Vitals Report dated 9/16/15 to 9/17/15, identified the last time R107 had been assisted with toileting as "05:52 [552 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 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 the care is provided.         SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to to care is provided.         2 915         10/26/1           2 915 MN Rule 4658.0525 Subp. 6 A Rehab - ADLs         2 915         2 915         10/26/1           Subp. 6. Activities of daily living. Based on the care is	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PREFIX TAG       IEACH DEPRICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)       PREFX TAG       IEACH CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE       Continued From page 7         2910       Continued From page 7       2910         particular day, and R107 had not been assisted with tolleting since 5:42 a.m., Further, NA-C stated R107 should be assisted to the bathroom and helped with tolleting every "two to three hours."       2910         R107's Vitals Report dated 9/16/15 to 9/17/15, identified the last time R107 had been assisted with tolleting 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 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.       2 915         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	ELIM HO	ME		-	371		
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. 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. 2 915 MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing timesota Department of Health	PRÉFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETE
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 incontinence was         requested, but none was provided.         SUGGESTED METHOD OF CORRECTION:         The director of nursing, or designee, could review         and provide staff education related to the care of         resident with uninary incontinence care,         and provide staff education related to the care of         resident with uninary 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.       2 915         Subp. 6. Activities of daily living. Based on the         comprehensive resident assessment, a nursing         timeeda Department of Health	2 910	Continued From pa	ge 7	2 910			
identified the last time R107 had been assisted with tolleting 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 tolleting "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.       2 915         IME PERIOD FOR CORRECTION: TIME PERIOD FOR CORRECTION: Twenty-one (21) days.       10/26/1         2 915       MN Rule 4658.0525 Subp. 6 A Rehab - ADLs       2 915         Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing       2 915		with toileting since stated R107 should and helped with toil	5:42 a.m Further, NA-C be assisted to the bathroom				
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.         2 915       MN Rule 4658.0525 Subp. 6 A Rehab - ADLs       2 915         Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing       2 915		identified the last tir with toileting as "05 had been incontine	ne R107 had been assisted :52 [5:52 a.m.]", and R107				
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.       2 915         MN Rule 4658.0525 Subp. 6 A Rehab - ADLs       2 915         Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing       2 915		stated R107 is freq should be assisted	uently incontinent of urine and				
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.       10/26/1         Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing       2 915							
(21) days. 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 Innesota Department of Health		The director of nurs and revise policies monitoring and pro- and provide staff ec residents with urina of nursing or design to ensure appropria	sing, or designee, could review and procedures related to vision of incontinence care, ducation related to the care of ry incontinence. The director nee could develop an audit tool				
Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing			R CORRECTION: Twenty-one				
comprehensive resident assessment, a nursing	2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			10/26/15
		-		6899	D7U011	If continue	tion short 9 of 41

	a Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	ME			774		
		TEMENT OF DEFICIENCIES	FON, MN 553	PROVIDER'S PLAN OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 915	Continued From pa	ge 8	2 915			
	treatments and serv abilities in activities deterioration is a not the resident's condi part, activities of da resident's ability to: (1) bathe, dres (2) transfer and (3) use the toil (4) eat; and (5) use speech	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this ily living includes the ss, and groom; d ambulate;				
	by: Based on observati review, the facility fa (R107), reviewed fo	ent is not met as evidenced on, interview and document ailed to ensure 1 of 5 residents or activities of daily living, was a with eating when required.	6	corrected		
	6/17/15, identified F memory problems, understood", and re eating. R107's care plan da	equired supervision with ated 9/10/15, identified R107				
	directed staff to, "As [resident] allows."	ement with eating", and ssist with feeding as res.				
	During observation	of the lunch meal on 9/16/15,				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HC	DME		F STREET ON, MN 5537	71		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 915	Continued From pa	ge 9	2 915			
nnesota D	R107 had a white c holding up from the contained diced can steak, along with tw contained a red juic in it, and a glass of over the outside of up spilled rice and c eating it using her f At 12:27 p.m. nursi over to R107's table however made no of who continued to pi using her fingers. A R107's tablemate h table making no off who was still eating from the table top u p.m. R107 continue on her table until 12 her a piece of bana made no offer to as meal, as she contin the table and plate p.m. registered nurs room and offered R with eating, but did R107 as she contin fingers. At 12:46 p the table and asked and R107 responde RN-F cut up R107's dish using a fork ar get this rice off of y clothing and onto th the glass of red juic table telling R107 s	n the Skyview dining room. olored lipped plate she was table in her left hand which rrots, rice, and country fried to glasses on the table, one ee with pieces of diced carrot water with food smeared all the glass. R107 was picking carrots from the table and ingers while holding her plate. ng assistant (NA)-C walked emate and visited with her, offer of assistance to R107 ck up food from the table At 12:29 p.m. NA-C served er food, and promptly left the er to assist or re-direct R107 the spilled rice and carrots using her fingers. At 12:31 ed to play with the spilled food 2:39 p.m. when NA-C served na cake in a small dish. NA-C ssist R107 to eat the cake or ued to push food around on using her fingers. At 12:42 se (RN)-F entered the dining 107's tablemate assistance not offer any assistance to ued to eat food using her .m. RN-F approached R107 at d, "How are you doing?" to her, ed with non-sensical speech. a banana cake in the small ind asked her, "Do you mind if I ou?", as she brushed it off her he floor. RN-F then picked up ee and removed it from the he was removing it "since you d left the table. R107				

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HC	OME		T STREET ON, MN 5537	71		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 915	Continued From pa	ge 10	2 915			
	and eating using he amounts on the floo (26 minutes later) w away from herself of clothing protector. When interviewed of NA-D stated R107 [food]" when she is without any assista her when they bring she would often ref leave her alone to " food (referring to he NA-D stated staff "s food" so she could her preference add alternative offered [ During interview on stated R107 will "so eating, adding she appropriate meal ch history of mixing up RN-F reviewed R10 R107 "should have offered cues and er meal. RN-F also sa different in place" if and not accepting a A facility policy on a requested, but none SUGGESTED MET The director of nurs and revise policies activities of daily liv	ctivities of daily living was				

STATE FORM

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3	) DATE SURVEY COMPLETED
		00375	B. WING		09/17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
ELIM HO	ME	701 FIRST PRINCETO	STREET ON, MN 553	71	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 915	Continued From pa	ge 11	2 915		
		or residents. The director of e could develop an audit tool to care is provided.			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920		10/26/15
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,			
	by: Based on observati review, the facility fa residents with perso	ent is not met as evidenced on, interview and document ailed to ensure staff assisted onal hygiene and grooming for 5, R8) who were dependent cares.		corrected	
	Findings include:				
	6/16/15, identified F	Im Data Set (MDS) dated R6 had intact cognition, and endence" on staff for his			
	was in his room in h on both hands, with dark-colored substanail. In addition, Re	on 9/14/15, at 3:29 p.m. R6 bed. R6 had long fingernails several of his nails having a ance visible underneath the b had visible white and gray per lip and chin. R6 stated he			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 920	Continued From pa	ge 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.					
	an, "Alteration in AD bathing" Further,	d 6/18/15, identified R6 had DLs of dressing, grooming and the care plan directed staff to a as needed with bath"				
	stated R6 required his personal hygien of that for him." Sta personal hygiene for and evening." NA-R and long, dirty finge	9/16/15, at 8:44 a.m. NA-B total assistance to complete e and grooming, "[We] do all aff were expected to complete or residents "every morning B observed R6's facial hair ernails. NA-B stated R6 d", and his fingernails "need to				
	licensed practical n "totally dependent" were expected to he a preference "to be LPN-A was unawar long fingernails, and	on 9/16/15, at 12:08 p.m. urse (LPN)-A stated R6 was on staff for his care, and staff elp him shave daily as R6 had clean shaven." Further, e of any preference to have d they should be clipped and a like they could be cleaned				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/	17/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
ELIM HO	ME		F STREET ON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ige 13	2 920			
	was cognitively inta hemiplegia (paralys hemiparesis (weak and required extens personal hygiene. During observation was in his room and	5, dated 8/3/15, identified R8 lict, had diagnoses of sis of one side of the body) and ness of on side of the body), sive assistance to complete on 9/14/15, at 12:49 p.m. R8 d had long fingernails on both tated, "I think they are too long				
	was lying on his ba had long fingernails During a subseque 1:08 p.m. R8 contir fingernails on both When interviewed o stated, "I think my f	on 9/15/15, at 6:45 p.m. R8 ingernails are too long right				
	much when the sta "I like my nails nice					
	assistant (NA)-A sta trim resident's nails further stated that F Thursdays. NA-A a long" and "they do NA-A was not sure	9/16/15., at 1:10 p.m. nursing ated that nursing assistant's on their bath days. She R8's bath day was on also stated R8's nails "are need to be cut." In addition, when R8's nails were last taff had last offered to trim his				
	registered nurse (R aware of R8 ever re stated R8 received	on 9/17/15, at 10:56 a.m. N)-D stated she was not efusing nail care. RN-D also his baths on the night shift t shifts responsibility to				

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
ELIM HC	DME		T STREET ON, MN 553	71		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	ige 14	2 920			
	complete R8's nail	care during his bath time.				
	dated 10/3/14, iden	s of Care / Expectations policy, tified staff should "shave male y basis, and for nail care to be a day"				
	The director of nurs and revise policies activities of daily liv staff education rela provision of ADLs for extensive assistance	THOD OF CORRECTION: sing or designee, could review and procedures related to ing (ADLs), and could provide ted to appropriate and timely or residents who require ce. The director of nursing or velop an audit tool to ensure provided.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			10/26/15
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review, the facility f and sanitized a bloc resident use, which residents (R173, R who shared a gluco	ent is not met as evidenced ion, interview and document ailed to ensure staff cleaned od glucose meter in between had potential to affect 6 of 6 172, R169, R20, R174, R175) ometer; ensure staff properly ontinence products and linens		corrected		

Minnesota Department of Health STATE FORM

6899

P7U811

If continuation sheet 15 of 40

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	OME		T STREET ON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 15	21375			
	affected 2 of 5 resid during cares; ensu providing perineal c observed during ca resident care equip (R165) who utilized Findings include:	tial spread of infection, which dents (R117, R68) observed re staff washed hands after care for 1 of 5 residents (R68) res, and; maintain clean ment for 1 of 1 residents a commode.				
	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.					
	stated she did not o meter after using it	on 9/17/15, at 11:57 a.m. RN-E disinfect the blood glucose to obtain R173's blood ou're right, I didn't", and addec				

If continuation sheet 16 of 40

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00375	B. WING			17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ME		T STREET TON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 16	21375			
		ave been disinfected with a wipe between each resident				
	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.					
	stated the glucome (meaning all reside should be disinfecte "After they [staff] us	9/17/15, at 1:30 p.m. RN-C ter was for community use nts on the unit used it), and it ed between each resident, se it, they clean it." Further, ded to be cleaned for "infection	I.			
	assistant director or protocol for shared "cleansing it with di resident use. Furth glucometer was to for "at least two mir	on 9/17/15 at 1:55 p.m., the f nursing (ADON) stated the glucometer included sinfecting wipes" between her, the ADON said, the be left in the disinfectant towel hutes" before going on to the tt is the protocol," the ADON				
	Blood Glucose Met 12/14, identified, "C Medicaid Services] glucose meters nee disinfected after ea cleaning the meters "meters are at hig contaminated with I Hepatitis B Virus [H	infecting your Assure Platinum er manufacture manual dated MS [Centers for Medicare and guidelines read that blood ed to be cleaned and ch use", and staff should be s in between each resident as gh risk of becoming bloodborne pathogens such as IBV], Hepatitis C Virus [HCV], odeficiency Virus [HIV]."	1			

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 17	21375			
	R117's quarterly Mi 6/17/15, identified F	LING OF SOILED RODUCTS AND LINENS: nimum Data Set (MDS) dated R117 had severe cognitive as "occasionally incontinent" of				
	9:15 a.m. nursing a into the restroom. I down her pants, ex incontinence brief. incontinence pad us threw it on the floor trash can. NA-F ap to R117, and then v	of morning care on 9/16/15, a ssistant (NA)-F assisted R117 NA-F assisted R117 to take posing a urine soiled NA-F removed R117's soiled sing her bare hands, and next to the toilet and a small oplied a new incontinence pad vashed her hands in the sink R117's morning cares.				
	stated she did not h removed the urine s "should have worn	on 9/16/15, at 9:42 a.m. NA-F have gloves on when she soiled brief from R117, but gloves" in case the urine from d have gotten on her hands.				
	registered nurse (R followed standard p R117's soiled brief RN-F stated gloves	9/16/15, at 12:04 p.m. N)-F stated NA-F should have precautions when handling and had gloves on. Further, are used when handling briefs to help "break the chain				
	severe cognitive im indicated R68 requi activities of daily liv	dated 5/29/2015, indicated pairment. The MDS further ired extensive assistance with ing (ADLs), including al assist with personal hygiene.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:			E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ELIM HO	OME		ST STREET FON, MN 55371			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21375	Continued From pa	ge 18	21375			
	nursing assistant (N routine morning car basin, filled it with w and before returning gloves. NA-B did n glove placement. F face, hands, arms, provided R68 with p incontinent brief wa and also had a sma gloves still on, NA-E into the bathroom, f removed and dispo the basin to the dra denture cup into the rinsed off the dentu gloves, and placed NA-B did not wash changes, after havi for R68. After remo NA-B completed gr room briefly, NA-B two plastic bags. N with a new liner, tyi used gloves and R6 other bag, NA-B ga R68's gown from th articles. NA-B then room in the wheelch in the soiled utility a utility area, NA-B ap During an interview NA-B stated "I did r	on 9/16/2015 at 9:16 a.m., NA)-B provided R68 with res. NA-B retrieved a plastic varm water from the bathroom g to R68's bedside, donned ot wash her hands prior to the following the washing of R68's and upper body, NA-B berineal care. R68 was s moderately urine soaked, all amount of feces With B took the plastic wash basin flushed and rinsed the basin, sed her gloves, then returned wer. NA-B then took R68's bathroom, drained and res, donned a new pair of the teeth into R68's mouth. her hands between the glove ng just provided perineal care bying the 2nd pair of gloves, ooming for R68. Exiting the returned to R68's room with IA-B relined the wastebasket ng shut the bag containing 58's soiled brief. With the thered the soiled linens and the floor, and bagged the pushed R68 out from her hair, the plastic bags swinging ir handles as she pushed the dining room. NA-B exited the bags in had, and placed them the bags				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	71		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	OBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	COMPLET DATE
21375	Continued From pa	ge 19	21375			
	bring a bag into R6 towels, gown and s placed in the bag" a also said she "shou water" after comple the laundry, before In an interview on 9 assistant director of staff" were trained t after donning glove providing personal the staff were trained bags into resident r garbage can liners, laundry, and one fo stated three had be training in July," and	tures. NA-B said she forgot to 8's room, and the soiled oaker pad "should have been and not on the floor. NA-B and have washed with soap and thing cares and dropping off assisting another resident. 0/17/2015 at 1:53 p.m., the f nursing (ADON) stated "all to wash hands "before and s," especially if staff were cares. The ADON also said ed to bring in three plastic tooms, to replace the existing and "one for personal r linens." The ADON also een "infection control (IC) d all nursing staff get training ew hires" receive IC training e floor."				
	SOILED RESIDEN	T BATHROOM EQUIPMENT				
		8/13/2015, indicated he was nd independent with toileting.				
	was noted that in R shared by another r room, a commode s commode was used designed with a cut existing bathroom s side hand rails, whi and a place to grip,	on 9/15/2015 at 7:20 p.m., it 165's bathroom, which was male resident in the adjoining stood over the stool. R165's d as a raised toilet seat, out bottom, placed over the stool, and was equipped with ch provided R165 stability, allowing him to transfer				
	the plastic bowl, be	nd off the seat. The inside of tween the seat and toilet, was r of dried, dark brown-colored				

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ELIM HC	DME		ST STREET FON, MN 5537	<b>'</b> 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 20	21375			
	circumference of th	round the entire inside he bowl. The dried feces prous scent in R165's shared				
	9:24 a.m., R165's c over the stool in the commode bowl rem	the next day, on 9/16/2015 at commode remained positioned e bathroom. The inside of the nained unclean, with the dried the odor was still present and				ULD BE COMPLE
	stated that when th and dirty like that, I bathroom." R165 s should be cleansed disgusting." R165 not the first time he bathroom, and add floor, and toilet "car	9/16/2015 at 12:53 p.m., R165 e commode bowl was"soiled didn't even want to use the said when it gets dirty, "It d right away, and not left. "It is also stated that "today" was e encountered an unclean ed he felt the bathroom, the n get very dirty between said the housekeeper only e a week."				
	the assistant direct charge of infection present on any surf right away," and tha concern." The ADC clean up bodily fluid is all our responsible	on 9/17/2015 at 1:53 p.m., or of nursing (ADON) in control, stated that if feces is face, "It should be cleaned at it was "an infection control DN stated the responsibility to ds falls on "whoever sees it, it ility." The ADON also said she ent commodes "to be always				
	"Routine cleaning p	, "Infection Control, vised August 2009, directed: procedures for bed, bedside etc, shall be followed when				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ME		ST STREET TON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	age 21	21375			
	indicated "Surfaces fluids shall be clear	ur" Further, the policy s soiled with blood or body ned in accordance with ures for cleaning up spills or or body fluids."				
	August 2009, indica "to keep the envir	afeTo prevent infection in				
	The director of nurs and revise policies infection control, ar related to: appropr glucometers; appro and incontinence p washing; and timely equipment. The dir could develop an a	THOD OF CORRECTION: sing or designee, could review and procedures related to nd provide staff education iate cleansing of shared opriate handling of soiled linen roducts; appropriate hand y cleaning of resident care ector of nursing or designee udit tool to ensure appropriate chniques are consistently				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21565	MN Rule 4658.132 Medications Self Ad	5 Subp. 4 Administration of dmin	21565			10/26/15
	self-administer med resident assessme care as required in 4658.0405 indicate	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				
	This MN Requirem	ent is not met as evidenced				

STATE FORM

P7U811

If continuation sheet 22 of 40

ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00375	B. WING		09/17/2015	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ME			371		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLET DATE
Continued From pa	ge 22	21565			
review, the facility fassess for the safe for 1 of 1 residents	ailed to comprehensively self administration of insulin (R173) observed to self		corrected		
Findings include:					
screening tool used	I to evaluate cognition), dated				
on 9/17/15, at 11:18 removed a plastic b self infusing cartride inject insulin in dose refrigerator in the T room. The cartridg DISPOSABLE INSU not identify the medication. At 11:2 room with the cartri R173. RN-B asked cartridge contained and R173 replied, " cartridge on a beds chair, and stated he let it "warm up a litt administering his in yourself, or we do [ does it himself beca "a new thing" and n how to operate it.	3 a.m. registered nurse (RN)-B bag containing several V-GO ges of insulin (a device used to es set by the user) from a urnaround Point medication es were labeled, "V-GO JLIN DELIVERY", however did dication inside the cartridge, edication R173 was to is for administration of the 22 a.m., RN-B entered R173's dge of insulin and handed it to I R173 if the un-labeled the "correct insulin" for him, I think so." R173 set the ide table next to his recliner e would apply it later after he le bit." RN-B asked R173 if sulin was "something you do for him]?" R173 stated he ause using the cartridge was nany of the staff do not know At 11:48 a.m. (26 minutes				
cartridge exposing	a sticky surface used to attach				
	T OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER ME SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa by: Based on observati review, the facility fr assess for the safe for 1 of 1 residents administer insulin d Findings include: R173's Brief Intervis screening tool used 9/16/15, identified F During observation on 9/17/15, at 11:18 removed a plastic b self infusing cartridg inject insulin in dos refrigerator in the T room. The cartridg DISPOSABLE INSU not identify the med the dosing of the m receive, or direction medication. At 11:2 room with the cartri R173. RN-B asked cartridge on a beds chair, and stated he let it "warm up a litt administering his in yourself, or we do [ does it himself beca "a new thing" and n how to operate it. A later) R173 remove cartridge exposing	TOF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00375       00375         PROVIDER OR SUPPLIER       STREET AD ME         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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 cartridge were labeled, "V-GO DISPOSABLE INSULIN DELIVERY", however did not identify 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	TO F DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPI A. BUILDING         00375       B. WING	TOF DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLA       D2 MULTIPLE CONSTRUCTION         DOG75       B. WING         INCOVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         TOT FIRST STREET       PROVIDERS OF DEFICIENCIES         IROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       D         IROVIDER FOR DAMARY STATEMENT OF DEFICIENCIES       D         IREGULATORY OR LSC IDENTIFYING INFORMATION)       D         RESULATORY OR LSC IDENTIFYING INFORMATION       D         RESULATORY OR LSC IDENTIFYING INFORMATION       D         Continued From page 22       21565         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 administration of insulin for 1 of 1 residents (R173) abserved to self administration of insulin of the valuate cognition), dated 9/16/15, identified R173 had intact cognition.         During observation of medication administration or insulin in doses set by the user) from a refrigerator in the Turnaround Point medication room. The cartridge were labeled, "V-GO Self insulin adpatis bag containing several V-GO Self insulin and handed it to R173. RN-B asked R173 if the un-labeled cartridge. INSULIN NO." R173 set 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 or insulin and handed it to R173	TOP DEPROENCES       (M) PROVIDERSUPPLIENCLA DENTFICATION NUMBER:       (M) PROVIDERSUPPLIENCLA A BUILDING: 

STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21565	Continued From pa	age 23	21565			
	trigger on the devic his physician was s	edle and pumping a gray e seven times. R173 stated still adjusting the dosing, and les the pump on the device because of this.				
	stated R173 brough home when he adm reviewed the Medic and the type of inst	on 9/17/15, at 11:31 a.m. RN-E ht the V-GO cartridges from nitted to the facility. RN-B had cation Administration Record, ulin R173 was to receive was e was "able to use it properly				
	included no indicati	ord was reviewed and on R173 had been assessed hister his insulin, using the				
	stated R173's V-G0 "don't know a whole R173 self administe insulin from the car his ability to safely s had been complete	9/17/15, at 1:30 p.m. RN-C O cartridge was new, and staff e lot about it yet." RN-C stated ers different amounts of the tridge, but no assessment of self administer the medication ed, but should have "to make t accurately and safely."				
	director of nursing ( have been assesse allowed to self adm the V-GO cartridge	on 9/17/15, at 3:43 p.m. the (DON) stated R173 should ed for safety before being inister his own insulin using , "[R173] should have the SAN of medication assessment]				
	dated 6/2000, ident shall have their me	n - Self Administration policy tified, "All new admissions dications administered by n interdisciplinary team can				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	X3) DATE SURVEY COMPLETED	
		00375	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 553	371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	
21565	Continued From pa	ge 24	21565			
	determine the abilit self-administer thei					
	The director of nurs review and revise p assessments, inclu medication. The DC a system to educate	THOD OF CORRECTION: sing (DON) or designee could olicies and procedures for ding self-administration of DN or designee could develop e staff, and develop a to ensure staff complete all sessments.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21620	MN Rule 4658.134	5 Labeling of Drugs	21620		10/26/1	
	Drugs used in the r in accordance with	nursing home must be labeled part 6800.6300.				
	by: Based on observati review, the facility f properly labeled to	ent is not met as evidenced on, interview and document ailed to ensure insulin was ensure its safe administration (R173), observed to use urvey.		corrected		
	Findings include:					
	screening tool used	ew for Mental Status (BIMS, a I to evaluate cognition), dated R173 had intact cognition.				
	on 9/17/15, at 11:18 (RN)-B removed a	of medication administration 3 a.m., registered nurse plastic bag containing several name] self-infusing cartridges				

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	NT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00375	B. WING		09/	09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
ELIM HO	DME		T STREET ON, MN 5537	'1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21620	of insulin (a device set by the user) from Turnaround Point m cartridges were bra "V-GO DISPOSABI did not, however, id the cartridge, the do was to receive, or of the medication. At R173's room with th handed it to R173. un-labeled cartridge insulin" for him, and 11:48 a.m. (26 minu administered the ur During interview on stated R173 brough cartridges from hom he's [R173] telling r inside the cartridge R173 to use the un "didn't have a choic medications for adr nervous." When interviewed of stated R173's famil medication in from "supposed to be lat medication, dose, a During interview on dispensing pharma being administered labeled accurately to name, dosage, dire the date it was filled	used to inject insulin in doses m a refrigerator in the nedication room. The unded by the manufacturer, LE INSULIN DELIVERY", but lentify the medication inside osing of the medication R173 directions for administration of 11:22 a.m., RN-B entered ne cartridge of insulin and RN-B asked R173 if the e contained the "correct d R173 replied, "I think so." At utes later) R173 self n-labeled insulin to himself. 9/17/15, at 11:30 a.m. RN-B nt the un-labeled insulin ne, and she was "trusting what ne" regarding the contents s. Further, RN-B allowed -labeled insulin because she ee", and using un-labeled ministration "makes me [RN-B] on 9/17/15, at 1:30 p.m. RN-C y member was bringing the home to use, and it was peled" with the current		DEFIGIENC	;γ)		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			E SURVEY PLETED
		00375	B. WING	B. WING		17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME		ST STREET FON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21620	Continued From pa	age 26	21620			
	correct dose" of the administered.	e medication being				
	director of nursing observed R173's in any proper labeling added R173's insu	on 9/17/15, at 3:43 p.m. the (DON) stated she had isulin cartridges and "didn't see on it." Further, the DON lin cartridges should have been afe administration of the				
	identified, "Medicat with facility required laws." Further, the information must b	Medication Labels policy ions are labeled in accordance ments and state and federal policy identified the following e present on a medication atient's name", "Specific .", and "Strength of	;			
	administrator, direct consulting pharmatic policies and proceed labeling of medicate educated, as necess labeling medication designee, along with	THOD OF CORRECTION: The stor of nursing (DON) and cist could review and revise dures for proper storage and ions. Nursing staff could be ssary, on the importance of as properly. The DON or th the pharmacist, could audit egular basis to ensure				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty one				
21665	MN Rule 4658.140	0 Physical Environment	21665			10/26/1
	functional, comforta	ust provide a safe, clean, able, and homelike physical ing the resident to use				

IAME OF P ELIM HOI (X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY	701 FIRS	B. WING		09/17/2015	
(X4) ID PREFIX	ME SUMMARY STA (EACH DEFICIENCY	701 FIRS	DRESS, CITY,		09/17/2015	
(X4) ID PREFIX	SUMMARY STA (EACH DEFICIENCY			STATE, ZIP CODE		
PRÉFIX	(EACH DEFICIENCY		T STREET ON, MN 553	371		
	REGULATORY OR L	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETI	
21665	Continued From pa	ge 27	21665			
	personal belonging	s to the extent possible.				
	by: Based on observati review, the facility fa bathroom device fo	ent is not met as evidenced on, interview and document ailed to maintain a clean r 1 of 1 residents (R165) commode was observed		corrected		
	Findings include:					
		/linimum Data Set (MDS), dicated he was cognitively				
	was noted in R165' by another male rescommode stood ov was a raised toilet so bottom, placed ove and was equipped with provided R165 stab allowing him to tran the seat. The inside the seat and toilet, dried, dark brown-caround the entire in	on 9/15/2015 at 7:20 p.m., it s bathroom, which was shared sident in the adjoining room, a er the stool. R165's commode seat, designed with a cut out r the existing bathroom stool, with side hand rails, which sility, and a place to grip, sfer independently on and off e of the plastic bowl, between was covered with a layer of olored feces, extending side circumference of the ces produced a malodorous ared bathroom.				
	9:24 a.m., R165's c the stool in the bath	the next day, on 9/16/2015 at commode, still positioned over proom, had a noticeable odor, e bowl remained unlearned, present.				
	In an interview on 9 partment of Health	/16/2015 at 12:53 p.m., R165				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ME		ST STREET FON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 28	21665			
	and dirty like that, I bathroom." R165 s should be cleansed disgusting." R165 not the first time he bathroom, and add floor, and toilet "car cleanings." R165 s came through "onc In an interview on 9 registered nurse (F had been cleaned. were responsible for the resident rooms commode. RN-E s	e commode bowl was"soiled didn't even want to use the said when it gets dirty, "It d right away, and not left. "It is also stated that "today" was e encountered an unclean ed he felt the bathroom, the n get very dirty between said the housekeeper only e a week." D/16/2015 at 1:50 p.m., RN)-E stated R165's commode RN-E said the nursing staff or the "day-to-day cleaning" in , including things like the said she would "expect" R165's a and that it "should have beer	5			
	the assistant direct charge of infection present on any surf right away," and tha concern." The ADO clean up bodily fluid is all our responsib would expect reside cleaned."	on 9/17/2015 at 1:53 p.m., or of nursing (ADON) in control, stated that if feces is face, "It should be cleaned at it was "an infection control DN stated the responsibility to ds falls on "whoever sees it, it ility." The ADON also said she ent commodes "to be always				
	indicated the facility environment clean	, "Infection Control, on," updated August 2009, y policy was to "keep the and microbiologically safe," ection in resident, staff and				
	SUGGESTED MET	THOD OF CORRECTION:				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00075	B. WING		09/17/2015		
	PROVIDER OR SUPPLIER	00375 STREET AI	ADDRESS, CITY, STATE, ZIP CODE 09/17				
			T STREET				
		PRINCE	ON, MN 553	371			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
21665	Continued From pa	ge 29	21665				
	educate staff regard clean, functional an DON or designee, of maintenance and h periodic audits of re ensure a safe, clear	sing (DON) or designee, could ding the importance of a safe, ad homelike environment. The could coordinate with ousekeeping and conduct esident care equipment, to n, functional and homelike ntained in the facility.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			10/26/1	
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a					
	by: Based on observative review, the facility for residents (R6, R10) daily living were four soiled/long fingernation assistance to enhance the facility had not provide the facility had not	ent is not met as evidenced ion, interview and document ailed to ensure for 2 of 3 7) reviewed for activities of and to be unshaven, had ails and was not provided nce their dignity. Furthermore, properly cleaned a commode ith dried visible feces to s dignity for 2 of 2 residents ad feces on their personal		corrected			
	LACK OF GROOM	ING:					
	LACK OF GROOM	ING:					

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00375	B. WING		09/17/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	T ADDRESS, CITY, STATE, ZIP CODE				
ELIM HO	ME		T STREET ON, MN 5537	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	ige 30	21805				
	6/16/15, identified F	um Data Set (MDS) dated R6 had intact cognition, and endence" on staff for his					
	was in his room in I on both hands, with dark colored substa nail. In addition, Re facial hair on his up likes his nails kept did not want facial I "used to shave eve salesman and "alw R6 stated not being before coming to th make me happy", a about it?" When s 9/15/15, at 1:31 p.m	on 9/14/15, at 3:29 p.m. R6 bed. R6 had long fingernails a several of his nails having a ance visible underneath the 6 had visible white and gray oper lip and chin. R6 stated he "shorter" than they were, and hair on his face. R6 stated he ryday" because he was a ays was very clean." Further, g kept as clean as he used to he nursing home this "don't and added, "What can I do ubsequently observed on n. R6 continued to have long, d visible facial hair on his face.					
	7:31 p.m. nursing a face and eyes, and shave today?" R6 offered" to shave h NA-E finished R6's did not offer to shave	evening cares on 9/15/15, at assistant (NA)-E cleaned R6's asked R6 if he "forget to responded that "nobody im, so it was not completed. evening cares, however she ve him, or trim and clean his even though R6 told NA-E he get shaved.					
	an, "Alteration in Albathing" Further,	ed 6/18/15, identified R6 had DLs of dressing, grooming and the care plan directed staff to e as needed with bath"					
		9/16/15, at 8:44 a.m. NA-B total assistance to complete					

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	
	00375	B. WING		09/17/2015	
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ME			'1		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Continued From pa	ge 31	21805			
of that for him." Sta personal hygiene for and evening." NA-I and long, dirty finge "needs to be shave be clipped down" and When interviewed of licensed practical n "totally dependent" were expected to h a preference "to be LPN-A was unawar long fingernails, and	aff were expected to complete or residents "every morning B observed R6's facial hair ernails. NA-B stated R6 d", and his fingernails "need to dding, "It doesn't look good." on 9/16/15, at 12:08 p.m. urse (LPN)-A stated R6 was on staff for his care, and staff elp him shave daily as R6 had clean shaven." Further, e of any preference to have d they should be clipped and				
was interviewed ab FM-G stated R6 us "every single day." and appearance wa Further, FM-G state being completed "a was concern for his feel better about the	out R6's care in the facility. ed to clip his nails and shave R6 used to be a salesman as very important to him. ed R6's grooming was not s often as I would like", and it s well-being, "A person does emselves when not laying				
R107's annual Mini 6/17/15, identified F memory problems a	mum Data Set (MDS) dated R107 had long and short term as she was "rarely/never				
	PROVIDER OR SUPPLIER <b>ME</b> SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa his personal hygiene of that for him." Sta personal hygiene for and evening." NA-I and long, dirty finge "needs to be shave be clipped down" ac When interviewed of licensed practical n "totally dependent" were expected to h a preference "to be LPN-A was unawar long fingernails, and cleaned, "They look underneath." On 9/17/15, at 8:31 was interviewed ab FM-G stated R6 us "every single day." and appearance was Further, FM-G stated being completed "a was concern for his feel better about the there scuzzie in beat LACK OF ASSISTA R107's annual Mini 6/17/15, identified F memory problems a understood", and re	PROVIDER OR SUPPLIER       STREET AT         ME       Z01 FIRS         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 31         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 also 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	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       00375     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ME     701 FIRST STREET PRINCETON, MN 55371       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PREFIX TAG     PROVIDER'S PLAN OF (EACH CORRECTIVE AC (EACH CORRECTIVE AC (CONSREFERENCED TO T) DEFICIENC       Continued From page 31     21805       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. FW-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 s	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:       00375       09/         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       TO FIRIST STREET       09/         ME       TO FIRIST STREET       PROVIDERS PLAN OF CORRECTION MUST BE PRECEDED BY FULL       ID       PREVENCE OF OURS' DEFICIENCY MUST BE PRECEDED BY FULL       PREVENCE OF OTHER STREET         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREVENCE OF OTHER STREET       CROSS-REFERENCE OT OTHE APPROPRIATE         Continued From page 31       IS presonal hygiene and grooming, "[We] do all of that for him." Staff were expected to complete personal hygiene and sevening." NA-B observed R6's facial hair and long, dirty fingernalis. NA-B stated R6       CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY         When interviewed on 9/16/15, at 12:08 p.m. licensed practical nurse (LPN)-A stated R6 was "totaly 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 fingernalis, 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'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 Str (MDS) dated 6/17/15, identified R107 had long and short term memory problems as the was "arely/never understood", a

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00375	B. WING		09/	09/17/2015	
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
ELIM HC	DME	701 FIRST PRINCET	STREET ON, MN 5537	71			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	ge 32	21805				
	one other resident i R107 had a white of holding up from the contained diced can steak. There were to contained a red juid in it, and a glass of over the outside of up spilled rice and of eating it using her f in her hand. At 12: (NA)-C walked ove visited with her, how assistance to R107 from the table using 12:29 p.m. NA-C set food, and promptly to assist or re-direct spilled rice and card her fingers. At 12:3 with the spilled food when NA-C served a small dish. NA-C to eat the cake or m push food around of fingers. At 12:42 p entered the dining r tablemate assistance any assistance to F food using her finge approached R107 a are you doing?", R <sup>-</sup> non-sensical speed banana cake in the asked her, "Do you you?", as she brust the floor. RN-F the	was seated at a table with n the Skyview dining room. olored lipped plate she was table in her left hand which rrots, rice, and country fried wo glasses on the table, one e with pieces of diced carrot water with food smeared all the glass. R107 was picking carrots from the table and ingers while holding her plate 27 p.m. nursing assistant r to R107's tablemate and wever made no offer of who continued to pick up food g her fingers and eating it. At erved R107's tablemate her left the table making no offer t R107 who was still eating the rots from the table top using 31 p.m. R107 continued to play d on her table until 12:39 p.m. her a piece of banana cake in made no offer to assist R107 neal, as R107 continued to on the table and plate using her .m. registered nurse (RN)-F room and offered R107's ce with eating, but did not offer 8107 as she continued to eat ers. At 12:46 p.m. RN-F at the table and asked, "How 107 responded with th. RN-F cut up R107's small dish using a fork and mind if I get this rice off of ned it off her clothing and onto n picked up the glass of red it from the table telling R107					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00375	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ge 33	21805			
	table pushing food a fingers, spilling larg herself until 12:51 p she pushed the plat table using her soile When interviewed of NA-D stated R107 f [food]" when she is without any assistant her when they bring she would often ref	R107 remained seated at the around and eating using her e amounts on the floor and o.m. (26 minutes later) when te away from herself on the ed clothing protector. on 9/16/15, at 12:57 p.m. typically "wears a lot of it left alone to eat by herself nce. The staff often try to help g her a plate of food, however use assistance so staff just do what she does" with the er playing with it).				
	stated R107 will "so eating, adding she appropriate meal ch history of mixing up RN-F stated R107 s re-approached and encouragement to don't have anything playing with her foo assistance. Furthe	offered cues and eat her meal, and added, "We different in place" if R107 is d and not accepting r, RN-F stated other residents atching R107 play with her				
	SOILED COMMOD	E WITH FECES				
		8/13/2015, indicated he was nd independent with toileting.				
	was noted that in R shared by another r room, a commode	on 9/15/2015 at 7:20 p.m., it 165's bathroom, which was male resident in the adjoining stood was over the toilet. aad a raised toilet seat,				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
21805	Continued From pa	age 34	21805			
	existing bathroom t side hand rails. Th between the seat a layer of dried, dark extending around th of the commode. T lingering, malodoro During observation 9:24 a.m., R165's c positioned over the inside of the comm	t out bottom, placed over the collet, and was equipped with e inside of the plastic bowl, nd toilet, was covered with a brown-colored feces, he entire inside circumference he dried feces produced a bus scent in R165's bathroom. the next day, on 9/16/2015 at commode was again toilet in the bathroom. The ode bowl remained unclean, I present and a noticeable				
	stated that when th and dirty like that, I bathroom." R165 s should be cleansed disgusting." R165 s not the first time he bathroom, and add floor, and toilet "car cleanings." R165 s	9/16/2015 at 12:53 p.m., R165 e commode bowl was "soiled don't even want to use the said when it gets dirty, "It d right away, and not left. "It is also stated that "today" was e encountered an unclean ed he felt the bathroom, the n get very dirty between said the housekeeper only ugh cleaning "once a week."				
	registered nurse (R had been cleaned. were responsible for the resident rooms commode. RN-E s	9/16/2015 at 1:50 p.m., RN)-E stated R165's commode RN-E said the nursing staff or the "day-to-day cleaning" in , including things like the said she would "expect" R165's a, and that it "should have been				
	the assistant direct	on 9/17/2015 at 1:53 p.m., or of nursing (ADON) in control, stated that if feces is				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00375	B. WING		09/	09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
ELIM HO	OME		T STREET ON, MN 5537	71			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	ige 35	21805				
	right away," and tha concern." The ADC clean up bodily fluid is all our responsible	face, "It should be cleaned at this was "an infection control DN stated the responsibility to ds falls on "whoever sees it, it ility." The ADON also said she ent commodes "to be always					
	SOILED BLANKET	WITH FECES					
	mobility, continent of	7/14/15, was independent with of bladder, and frequently els (unable to control bowel					
	required assistance	ted 7/14/15, identified R73 to complete personal to clean up after incontinent					
	R73 was seated in a white blanket. R7 bathroom exposing discoloration, dried measuring approxin inch in size. During 9/16/15 at 8:14 a.m her recliner with se	feces, on the blanket, mately three inches by one g a subsequent observation on h., R73's white blanket was in veral stuffed animals. The d increased to approximately					
	nursing assistant (N her recliner chair w [bowel movement]. the soiled blanket v approximately 1:50	on 9/16/15, at 1:43 p.m. NA)-D stated R73's blanket in as soiled, and "looks like BM " NA-D proceeded to change vith a new blanket. At p.m. on 9/16/15, NA-G stated nket in the chair with feces					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ОМЕ		T STREET ON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	was "kind of a regu R73's blanket was of the blanket was "ch During a subsequed 9:15 a.m., R73's ha with visible, dark, ta feces, measuring a two inches in size. During interview on member (FM)-K sta to perform her own FM-K said R73 had blankets with feces for up to "several da which identifies R73 stated this was ups me, but it also make stated (R73) had ex before as well, and someone else" was on her chair. FM-K time she sees it, an has done that." A facility policy rega but none was provid SUGGESTED MET The director of nurs review/revise policies the provision of dig services. Employee these policies. A sy monitoring consiste policies could be de	lar thing." NA-G also said often stained "with bowel" and hanged as needed." Int observation on 9/17/15, at ad another white blanket again an-colored stain, possible pproximately three inches by 9/17/15, at 11:04 a.m. family ated R73 was not always able cares due to her dementia. I "previous instances" of a left in her chair, sometimes ays without being changed, " 3 was incontinent. FM-K etting to (R73), and "It annoys es me sad." Further, FM-K kpressed concerns with it also said R73 "thinks s putting the blanket with feces a said "It bothers [R73] every ad [R73] thinks someone else	21805			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
ELIM HO	ME		T STREET	371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ge 37	21805			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21942	MN St. Statute 144 Resident and Fami	A.10 Subd. 8b Establish ly Councils	21942			10/26/1
	boarding care home advisory council an fewer than three per participating. If one function, the nursin home shall docume council or councils year. This subdivisi	council. Each nursing home or e shall establish a resident d a family council, unless ersons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar on does not alter the rights of ies provided by section n 27.				
	by: Based on observati review, the facility f care units (Turnaro unit), were provided in resident council a	ent is not met as evidenced on, interview and document ailed to ensure 1 of 6 facility und Point,a short term care d an opportunity to be involved activities. This had the II 15 residents (R172) who around Point unit.		corrected		
	at 1:27 p.m., reside were posted on sev three floors of the f only pertained to se	ur of the facility on 9/14/2015, nt council meeting minutes veral bulletin boards on all acility. However, the minutes eparate meetings of resident k place on the second and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ME		T STREET FON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21942	Continued From pa	ige 38	21942			
	separate resident c	d and 3rd floor each had councils, and meeting minutes, put from, or mention of, the esident unit.				
	registered nurse (R Turnaround Point u the facility" for an e could also reside in several weeks or m	on 9/16/15, at 9:59 a.m. N)-C stated residents on the init they were "typically not in xtended period of time, but the Turnaround Point unit for nonths, depending on how the with their therapies.				
	stated she had bee Point Unit for a cou of any Resident Co or posting of the mi	9/17/15, at 1:36 p.m. R172 in residing on the Turnaround ple weeks, and was "unaware uncil" for the short term unit, inutes from the other floors, or ittend resident council				
	worker (SW)-A stat minutes "are posted residents," and that council" meeting of residents. SW-A s would not be interest	on 9/17/15, at 2:00 p.m., social ed the resident council d for the Turnaround Point t " there was no resident fered to the Turnaround Point stated, he felt the residents sted, and that "They don't themselves as part of a unit."				
	A facility policy on r requested, but none	esident council meetings was e was provided.				
	The Administrator, designee, could rev procedures related Administrator, DON	THOD OF CORRECTION: Director of Nursing (DON) or <i>r</i> iew/revise policies and resident rights. The I or designee could work with /or activities to promote,				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		00375	B. WING	B. WING		17/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
ELIM HO	ME		ST STREET FON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21942	Continued From pa	age 39	21942			
	residents to meet a evaluating and mor implementation of t developed, with the brought to the facili Committee for revis	these policies could be results of these audits being ty's Quality Assurance				
	epartment of Health					