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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QK7Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00051

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245437**

2.STATE VENDOR OR MEDICAID NO.
(L2) **816740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME - WATERTOWN**
(L4) **409 JEFFERSON AVENUE SOUTHWEST, BOX 638**
(L5) **WATERTOWN, MN** (L6) **55388**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/22/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Gayle Lantto, Supervisor — 09/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Kleppe, Enforcement Specialist — 09/26/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/16/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

.CMS Certification Number (CCN): 24-5437

Electronically Delivered: September 26, 2014

Ms. Corinne Allen, Administrator
Elim Home – Watertown
409 Jefferson Avenue SW, Box 638
Watertown, Minnesota 55388

Dear Ms. Allen:

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

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

Effective September 22, 2014, the above facility is certified for:

51 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 26, 2014

Ms. Corinne Allen, Administrator
Elim Home – Watertown
409 Jefferson Avenue SW, Box 638
Watertown, Minnesota 55388

RE: Project Number S5437022

Dear Ms. Allen:

On August 13, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 31, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 22, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 25, 2014 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 July 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 31, 2014, effective September 22, 2014 and therefore remedies outlined in our letter to you dated August 13, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245437	A. Building B. Wing	9/22/2014

Name of Facility	Street Address, City, State, Zip Code
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0332 Reg. # 483.25(m)(1) LSC	08/26/2014	ID Prefix F0356 Reg. # 483.30(e) LSC	08/26/2014	ID Prefix F0363 Reg. # 483.35(c) LSC	08/26/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/AK	09/26/2014	30923	09/22/2014

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

Followup to Survey Completed on: 7/31/2014

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245437	A. Building B. Wing **01 - MAIN BUILDING 01**	9/25/2014

Name of Facility	Street Address, City, State, Zip Code
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/01/2014**	ID Prefix	Correction Completed **08/15/2014**	ID Prefix	Correction Completed **09/22/2014**
Reg. # **NFPA 101** LSC K0017		Reg. # **NFPA 101** LSC K0021		Reg. # **NFPA 101** LSC K0038	
ID Prefix	Correction Completed **08/29/2014**	ID Prefix	Correction Completed **08/29/2014**	ID Prefix	Correction Completed **09/22/2014**
Reg. # **NFPA 101** LSC K0045		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0069	
ID Prefix	Correction Completed **08/01/2014**	ID Prefix	Correction Completed **08/18/2014**	ID Prefix	Correction Completed **08/15/2014**
Reg. # **NFPA 101** LSC K0072		Reg. # **NFPA 101** LSC K0143		Reg. # **NFPA 101** LSC K0144	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	09/26/2014	22373	09/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/31/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QK7Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00051

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

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME - WATERTOWN**
(L4) **409 JEFFERSON AVENUE SOUTHWEST, BOX 638**
(L5) **WATERTOWN, MN** (L6) **55388**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/31/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds 51 (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR Social Work Specialist 08/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/16/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5507

August 13, 2014

Ms. Corinne Allen, Administrator
Elim Home - Watertown
409 Jefferson Avenue Southwest, Box 638
Watertown, Minnesota 55388

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5437022

Dear Ms. Allen:

The above facility was surveyed on July 28, 2014 through July 31, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970
Telephone: (651) 201-3794
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This plan of correction constitutes our Written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of Correction is submitted To meet the requirement established By the state and federal law.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of fewer than 5% for 3 of 8 residents (R8, R30, R77) whose medication administration was observed. This resulted in a medication error rate of 11%. Findings include: R77's medication administration was observed after the resident had consumed breakfast on 7/28/14, at 8:36 a.m. A licensed practical (LPN)-B administered medications including enteric coated pantoprazole 40 milligrams (mg) for esophageal reflux.	F 332	POC accepted KStarkk 8/25/14	

RECEIVED
AUG 25 2014

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

Arlene Allen | Administrator | 8-20-14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 1 A diagnostics report dated 7/29/14, for R77 included the diagnosis of esophageal reflux. A physician order report dated 7/20/14, directed staff to administer pantoprazole 40 mg twice daily. The Medication Administration Record (MAR) verified R77 had received the medication daily at 8:00 a.m. and 8:00 .p.m. while in the facility 7/20 through 7/30/14. On 7/28/14, at 8:55 a.m. LPN-B stated the pantoprazole was not administered 30 minutes prior to meals as recommended before meals, because it was a long-term medication and the resident had "always taken it" that way. R8 was given administered Synthroid (to regulate thyroid function) 112 micrograms (mcg) and Ativan (anti-anxiety medication) 0.5 mg to the resident after she had consumed lunch. The medications were administered by a trained medication aide (TMA)-A at 12:09 p.m. A diagnostic report for R8 dated 8/10/14, included the diagnosis of hypothyroidism. The physician order report dated 12/3/13 directed staff to administer Synthroid (levothyroxine) 112 mcg orally, and included "Special instructions: Pharmacy Consultant recommends to give in am r/t [the morning related to] insomnia on an empty stomach." Documentation in the MAR indicated R8 had received Synthroid in the morning between 7:00 a.m. and 10:00 a.m. from 5/1 through 7/31/14. R30 was administered medications in the dining room on 7/31/14, at 7:37 a.m. by LPN-A. The medications included pantoprazole 40 mg. LPN-A then assisted R30 to his room, and administered	F 332	**F 332 Medication Error** Medications not given 30 minutes Prior to meals as directed by pharmacy. **Corrective Action:** Medications that need to be given on empty stomach which will include Synthroid and pantoprazole will be scheduled at a specific time on empty stomach. These medications will be scheduled 30 minutes before the meal for full absorption. Staff will be educated at in service on Aug. 26th,2014 on medications scheduling of medications that need to be given 30 minutes prior to meals on empty Stomach. Monitoring will be done by clinical Coordinator on an ongoing basis. The Admitting nurse will identify on admission those residents who need specific time frames for their medication administration and schedule accordingly. DON will evaluate on a monthly basis with record change. **Date of Completion :August 26th , 2104.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 2 Restasis 0.05% opthalmic drops, 1 drop to each eye. LPN-A then assisted the resident back to the dining room at 7:48 a.m. where he resumed eating his breakfast. R30's physician order report dated 6/28/14, directed staff to administer pantoprazole 40 mg with special instructions to administer the medication prior to a meal, at 7:00 a.m. According to the MAR, the resident had been receiving the medication daily. On 7/31/14, at 8:00 a.m. LPN-A stated R30 was to have his pantoprazole administered before he went to bed. She stated she had noticed it was scheduled before a meal. LPN-A explained that technically it had been administered before a meal, but not 30 minutes prior to a meal as ordered. On 7/31/14, at :40 a.m. the director of nursing (DON) stated she expected pantoprazole and Synthroid to both be given 30 minutes prior to a meal. She explained the facility utilized a "liberalized medication pass," therefore it would have been difficult to ensure this practice. Product information at https://www.synthroid.com/prescription/tips.aspx revealed levothyroxine should be taken on an empty stomach, being best taken 30 to 60 minutes before eating breakfast. Product information at drugs.com noted pantoprazole was most effective when taken one hour before a meal without chewing or breaking, swallowing whole with water. "Always take Pantoprazole as directed by your physician." The Policy and Procedure Manual for Elim	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

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F 332	Continued From page 3 Rehab & Nursing Home revised 9/7/11 directed staff to know the effects of the medication given, medication-to-medication interactions, as well as food-to-medication interactions. In addition, the policy indicated time sensitive medications were to be administered according to the physician orders, which may have included specific time frames. On 7/31/14, at 9:35 a.m. the consultant pharmacist was interviewed via telephone. The pharmacist stated that pantoprazole and any similar medication other than Protonix was to be taken 30 minutes before a meal or on an empty stomach or the effectiveness of the drug may be reduced. He further explained that Synthroid needed to be taken 30 minutes before a meal or on an empty stomach for full absorption and consistency of the thyroid stimulating hormone levels. The pharmacist stated, "We write those orders for a purpose. Although it is not a significant problem, it is a problem."	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		

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F 356	Continued From page 4 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide evidence nursing hours posted were current and correct. This had the potential to affect all 51 residents as well as the public. Findings include: On 7/28/14, at 7:12 a.m. during the initial observation tour the nursing hours were observed to be posted visibly in the entryway vestibule. Although the hours were posted in the correct format, there were spaces at the top of the form for nurse initial, date, and day. A recheck of the hours posting on 7/30/14, at 11:32 a.m. the nursing hours posting was corrected, including containing the correct date. At that time copies of postings for the prior seven	F 356	**F 356 Posted Nurse Staffing information** Per Elim Posted Nursing Staffing Hours Policy. Dated July , 2013, At beginning of the shift each morning the floor nurse will post in a visible area Scheduled nursing hours for the day. The Clinical Coordinator will monitor daily The accuracy of the posting to include date, Day, and nurse initials. At the end of the day shift the clinical coordinator will up date the actual hours worked. Night nurses will be educated to include the day, date and nurse initial on the scheduled hours posted at the Aug. 26th, 2014 meeting. **Date of completion: August 26th, 2014**	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356	Continued From page 5 days were requested. A review of these showed all, including one dated 7/28/14, to have dates filled in at the top, and the form dated 7/28/14 included handwritten entries including a staff person's initials and "7/28/14" and "Mon" (Monday). As above, the posting form observed Monday, 7/28/14 had had no markings at all at the top of the form. On 7/31/14, at 11:40 p.m. an interview was conducted with the DON, who stated, " [Regarding] the Nursing Hours Posting you saw on Monday, some time after you saw it someone added the date and day. I added the initials later, so we can identify who's doing them." The DON also indicated the nurse who filled in the form verified the hours and then filled in all the blanks before the copies were obtained. The DON stated she would obtain the original form observed by the surveyor. On 7/31/14 at 12:45 p.m. the DON returned to provide another copy of the Monday, 7/28/14 hours. This differed from the one included in the seven day copies obtained on two days later. The DON added, "When surveyors come we rush around correcting things. We got tagged on this last year. "	F 356		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance;	F 363		

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F 363	Continued From page 6 and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to serve pureed meals as planned. This affected 5 of 5 residents (R59, R28, R14, R36, R49) who were served pureed food. Findings include: On 7/30/14, at 11:30 a.m. R14 was observed eating his puree meal of a sloppy Joe over mashed potatoes, baked beans, and sherbet. The pureed cucumber salad listed on the menu was not served. There were other residents in the dining room served pureed meals and no pureed salads were observed. Cook (C)-A was interviewed at the time of the observation, and stated he did not serve the residents prescribed pureed diets cucumbers, "just the potatoes". The diet spread sheets were requested of cook-A, however, he was unsure what was being requested, and was unable to produce the diet spread sheets. Cook-A showed the surveyor where resident names and their respective diets were posted in a list near the steam table. The list did not include information such as alternate foods and serving sizes for residents prescribed modified diets. On 7/30/14, at 12:00 p.m. registered dietitians (RD)-A and RD-B were interviewed about serving modified diets. Although a menu was posted in the kitchen, a corresponding spread sheet was unavailable. RD-A and RD-B located a binder in	F 363	**F 363 S/S E Menus meet Resident needs/ Prep In advance/followed** **Corrective Action:** On 7/30/14 & 7/31/14, all cooks were educated on the use of spreadsheets & following the menus to ensure all diets were served the appropriate items. Pureed diets were discussed and that all items on the menu need to be offered. Education by the corporate RD was given the following week on 8/4/14 to the dietary manager to ensure the spreadsheets are readily available to all cooks to follow. An in service will be done on 8/26/14 with the dietary staff on how to properly puree a variety of items with our thickened liquid sales representative. Audits will be done by the dietary manager or designee for at least 5 meals per week varying the day & meal to ensure pureed food is prepared appropriately and menu spreadsheets are followed. Audits will be reviewed quarterly at QA meetings until resolved. **Date Completion: August 26th , 2014**	

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F 363	Continued From page 7 the kitchen with spread sheets, however, they were from the previous winter's menu. They explained that the menu changed in April or May and new spreadsheets had been posted in the kitchen. RD-A and RD-B stated that the cook most likely "remembered" the appropriate amounts to serve residents. At 1:00 p.m. RD-A and RD-B produced the new folder with spread sheets for the spring menu. The folder appeared in pristine condition and was in a folder that could have been propped up at the food service area for quick reference. RD-A and RD-B verified that it appeared to not have been used by staff to direct serving of modified diets. Cook-A was interviewed at the same time and stated that he did not use the spread sheets to direct serving. When asked about the serving of pureed vegetables and fruits, he stated that he did not puree the cucumbers as they became too watery and did not look good when thickened. He went on to explain that there were other fruits and vegetables that were not pureed as they also became too watery. The RDs verified that all items were to be served to the purees as listed on the menus and that they would look into working with food thickeners for production of puree items. An undated facility policy for therapeutic diets indicated that routine menus were planned by the food service manager and approved by the RD for nutritional adequacy. The regular menu was to be modified by the RD for therapeutic diets, with input from the dietary manager for feasibility of kitchen production.	F 363		

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BLDG. 01 -MAIN BUILDING 01 B. WING	07/31/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 31, 2014. At the time of this survey, Elim Home Watertown was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok TB 8-29-14 RECEIVED AUG 29 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Verna Allen	Administrator	8/29/14

Any d- ieteridy 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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	245437	A. BUILDING: 01 - MAIN BUILDING 01 B. WING	07/31/2014

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Elim Home Watertown is a one-story building with partial basement. The facility was constructed at three different times. The original building was constructed in 1964 and was determined to be of Type 1(222) construction. In 1988, an addition was constructed to the north and was determined to be of Type 11(111) construction. In 1998, an addition was constructed to the west and was determined to be of Type V (111) construction. The nursing home is separated from an apartment building by a complying two-hour fire wall assembly. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 51 beds and had a census of 50 at time of the survey. Because the original building and the two additions met the minimum construction types	K 000		

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K 000	Continued From page 2 allowed for existing buildings, the facility was surveyed as one building, and one (1) Form CMS 2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the minimum one-half hour fire resistance rating of a corridor wall, in accordance with the requirements at NFPA 101 (2000), Chapter 19, Section 19.3.6. This deficient practice could adversely affect 23 out of 51 residents.	K 017		

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K 017	Continued From page 3 FINDINGS INCLUDE: On 07/31/2014 between 9:30 AM and 4:30 PM, observation revealed a penetration through the corridor wall, between the north-side Mechanical Room and the concealed space above the drop-ceiling in the corridor. The wall was penetrated by an electrical conduit, and the interstitial space between the wall and the conduit was not sealed with an approved fire caulking material, to maintain the fire resistance rating of the wall and to prevent the migration of smoke. This deficient practice was confirmed with the housekeeping manager at the time of discovery.	K 017	**K 017 S/S E NFPA Life Safety Code Standard** Wall penetration: Mechanical room: **Corrective Action:** Penetration around wires of Mechanical room sealed. Maintenance Supervisor Will follow up with Contractors To be sure wires are sealed with an Approved intumescent fire caulking. **Date Completed: August 1, 2014**	
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021		

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	245437	A. BLDG. 01 - MAIN BUILDING 01 B. WING C O M P L E T E D	07/31/2014

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K 021	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had improperly held-open a corridor door protecting a hazardous area enclosure, by use of an unapproved door hold-open device. This deficient practice was not In conformance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.2.2.2.6 and Chapter 7, Section 7.2.1.8.1. This deficient practice could adversely affect 23 of 51 residents. FINDINGS INCLUDE: On 07/31/2014 between 9:30 AM and 4:30 PM, observation revealed the Nursing Storage Room was a space greater than 50 square feet, and was used to store combustible materials in a quantity deemed hazardous. Further observation revealed the corridor door to the Nursing Storage Room was improperly held-open with a two-piece magnetic door hold open device, which was not electrically interconnected with the building fire alarm system to release upon activation of the fire alarm system. This finding was confirmed with the housekeeping manager at the time of discovery.	K 021	**K 021 S/S=E NFPA Life Safety Cade Standard** Un approved door hold open device For Nursing Storage. **Corrective Action:** Hold open device removed Door handle changed. **Date Completed: August 15, 2014** Maintenance Supervisor to monitor	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038		

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	245437	A. BUILDING 01 -MAIN BUILDING 01 B. WING	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038	Continued From page 5 Based on observation and interview, the facility failed to maintain the means of egress in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.2. This deficient practice could adversely affect 8 of 51 residents. FINDINGS INCLUDE: On 07/31/2014 between 9:30 AM and 4:30 PM, the following deficiencies were observed: A). Observation revealed the exit discharge path leading from the exit discharge door on the west egress corridor, was not of a continuous hard surface material from the building exterior to a public way. This deficient practice was not in accordance with the requirements at NFPA 101 (00) Sections 7.1, 7.5.4.3 and 7.7.1; B). The cross-corridor doors leading to the horizontal exit on the South Corridor were painted with a "bookcase motif" mural, which created confusion in readily identifying the exit doors and gave an appearance of a dead-end corridor. This arrangement was not in conformance with NFPA 101 (00) Chapter 7, Sections 7.1.10.2.1, 7.10.1.7 and Minnesota State Fire Code (2007 edition) Chapter 10, Section 1028.4. This finding was confirmed with the facility administrator.	K 038	**K 038 S/S =E NFPA Life Safety Code Standard.** Exit access readily accessible at all times. A). Exit path from exit door on West Wing not of continuous hard surface Material from the building exterior to a public way. **Corrective Action:** Getting bids for hard surface path From building exit to public way. Will establish path as soon as contractor able to complete. **Completion date: September 22,th ,2014** B). South Corridor door way painted with book case motif" **Corrective Action:** "Bookcase motif" removed. Door painted. **Completed: August 5th, 2104** Maintenance Supervisor to monitor	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045		

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	245437	A. BUILDING 01 - MAIN BUILDING 01 B. WING C O M P L E T E D	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME -WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had exit discharge locations which were not illuminated in accordance with the requirements at NFPA 101 (2000), Chapter 19, Section 19.2.8. and Chapter 7, Section 7.8. This deficient practice could adversely affect 51 of 51 residents. FINDINGS INCLUDE: On 07/31/2014 between 9:30 AM and 4:30 PM, observation revealed illumination of the means of egress at exit discharge locations in the following areas were not properly equipped with either; 1). A two-bulb type fixture, or, 2). Two light fixtures of the single-bulb type: A). Basement exit discharge; B). Exit discharge from the horizontal exit on the South Corridor; C). Exit discharge doors, southwest egress corridor. These findings were verified with the housekeeping manager.	K 045	**K 045 S/S=E NFPA Life Safety Code Standard.** Illumination of means of egress A). basement exit B).Horizontal exit on the SouthCorridor C).South West egress Corridor **Corrective Action:** New fixtures have been purchased And installed. **Completion Date: August,29th, 2014** Maintenance Supervisor to monitor	
K 052 SS.F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. This deficient practice could adversely affect 51 of 51 residents. FINDINGS INCLUDE: On 07/31/2014 between 9:30 AM and 4:30 PM, while revlewing the facility's annual fire alarm inspection and testing reports, the following deficiencies were confirmed: A). During a review of the facility's annual fire alarm inspection & test report by a contract vendor and dated 01/08/2014, fifty-nine (59) alarm initiating devices were noted on the system, however, no documentation was provided identifying the locations and functional testing outcomes for each of these alarm initiating devices. As such, it could not be verified that inspection and testing of the complete fire alarm system had been properly conducted within the previous year; B). No documentation could be provided verifying the facility's digital alarm communicator transmitter (DACT) was tested during December 2013, January 2014 and May 2014. This finding was confirmed with the chief building engineer.	K 052	**052 S/S =F NFPA Life Safety Code** A).No documentation identifying Location and functional testing outcomes for each alarm initiating device. B).no documentation verifying facility's Digital Alarm communicator Transmitter was tested during Dec.2013, January 2014 & May 2014 **Corrective Action:** New forms have been initiated To Facilitate the accurate information is documented timely. Monitoring to be done by Maintenance supervisor. **Completion Date: August 29th . 2014**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLIM HOME -WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069	Continued From page 8	K 069	**KO69S/S=F NFPA Life Safety Code**	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it could not be confirmed the automatic hood extinguishment system was electrically interconnected to the building fire alarm system to provide proper annunciation to building occupants, in accordance with NFPA 96 (1998) Chapter 7, Section 7-6. This deficient practice could adversely affect 51 of 51 residents. FINDINGS INCLUDE: On 07/31/2014 between 9:30 AM and 4:30 PM, during an inspection of the facility's commercial cooking area within the Dietary Department, it was observed the commercial range and exhaust hood were protected by an automatic fire extinguishing system, however, electrical interconnection of the automatic fire extinguishing system to the building fire alarm system could not be confirmed. Further, a review of the most recent semi-annual inspection and testing report from a contract vendor dated 07/17/2014, indicated the system was not electrically interconnected with the building fire alarm system. This deficient arrangement was not in conformance with the requirements at NFPA 96 (98) Chapter 7, Section 7-6.2. This finding was confirmed with the chief building engineer.	K 069	Commercial range and exhaust hood Automatic fire extinguishing system could not be found to be electrically connected to automatic fire system. **Corrective Action:** Automatic fire extinguishing system To be wired to the automatic Fire alarm system. **Completion Date Sept. 22th 2014** Maintenance Supervisor to monitor	
K 072	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF X TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETION DATE
K 072 SS=E	Continued From page 9 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain an egress corridor free from impediments to full instant use in the case of fire or other emergency, in accordance with the requirements at NFPA 101 (2000), Chapter 7, Sections 7.1.10. In an emergency evacuation situation, these impediments could interfere with the prompt and orderly evacuation of residents, staff and visitors in the Administrative corridor. FINDINGS INCLUDE: On 07/31/2014 between 9:30 AM and 4:30 PM, observation revealed a greeting card carousel and a paper shredder stored in the Administrative corridor. This storage arrangement was not in conformance with NFPA 101 (00) Chapter 7, Section 7.1.10. This finding was confirmed with the facility administrator.	K 072	K 072 S/S = .E NFPA Life Safety code Standard: Impediment Free Corridor **Corrective Action:** Carousel and Paper shredder Removed from egress corridor. **Completion date: August 1, 2014** Maintenance Supervisor to Monitor	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
	245437	A. BUILDING _____ B. WING C O M P L E T E D	01 - MAIN BU 07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 143	Continued From page 10 wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide proper signage at the Oxygen Transfill room, in accordance with the requirements at NFPA 99 (1999) Chapter 8, Section 8-6.2.5.2 (c). This deficient practice could adversely affect 20 out of 51 residents. FINDINGS INCLUDE: On 07/31/2014 between 9:30 AM and 4:30 PM, observation revealed an absence of signage posted in the area of the Oxygen Transfill Room, indicating that oxygen transferring is occurring, and that smoking in the immediate area is not permitted. This finding was confirmed with the housekeeping manager.	K 143	**K 143 S/S=E NFPA Life Safety Code Standard:** Absence of signage posted in the area of Oxygen Transfill Room indicating transferring is occurring and smoking in the immediate area is permitted. **Corrective Action:** Signs are posted on the Transfil Room indicating Transfills are occurring And no smoking is permitted. **Completion Date:** August 18, 2014 Maintenance supervisor to monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144 K 144 SS=F	Continued From page 11 NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the emergency generator in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9,1.3 and NFPA 110 (1999) Chapter 6, Section 6-4. This deficient practice could adversely affect 51 of 51 residents. FINDINGS INCLUDE: On 07/31/2014 between 9:30 AM and 4:30 PM, during a review of the emergency generator monthly inspection and testing logs for the previous year, the following deficient practices were confirmed: A). The emergency generator had not been exercised under load for a minimum of 30 minutes monthly, during February, March, April, May and June of 2014; B). During monthly load tests of the emergency generator during February, March, April, May and June of 2014, the percent of load (Kw) was not documented. This finding was confirmed with the chief building	K 144 K 144	**K 144 S/S= F NFPA Life Safety Code Standard:** Generators are exercised under load for 30 minutes per month. **Corrective Action:** Generator was run for 30 minutes on August 15, 2014 and will be run for at least 30 minutes on a monthly basis under load Will be inspected weekly and documented. Monitoring will be done by Maintenance Supervisor. **Completion Date:August 15, 2014**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BLDG: 01 - MAIN BUILDING 01 B. WING	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

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K 144	Continued From page 12 engineer.	K 144		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5507

August 13, 2014

Ms. Corinne Allen, Administrator
Elim Home - Watertown
409 Jefferson Avenue Southwest, Box 638
Watertown, Minnesota 55388

RE: Project Number S5437022

Dear Ms. Allen:

On July 31, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 9, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 9, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 31, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 31, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00051	A. BUILDING: _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On July 28, 29, 30, and 31, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00051	A. BUILDING: _____ B. WING _____	07/31/2014

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2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21050	MN Rule 4658.0625 Subp. 1 Menus; Meal Planning Subpart 1. Menu planning. All menus must be planned in advance, dated, and followed. Any changes in the meals actually served must be of equal nutritional value. The general menu for a seven-day period must be posted prior to the start of that seven-day period at a location readily accessible to residents, and any changes to the general menu must be noted on that posted	21050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00051	A. BUILDING: _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

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21050	Continued From page 2 menu. All menus and any changes for the current and following seven-day periods must be posted in the dietary area. Records of menus and of foods purchased must be filed for six months. A variety of foods must be provided. A file of tested recipes adjusted to a yield appropriate for the size of the home must be maintained. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to serve pureed meals as planned. This affected 5 of 5 residents (R59, R28, R14, R36, R49) who were served pureed food. Findings include: On 7/30/14, at 11:30 a.m. R14 was observed eating his puree meal of a sloppy Joe over mashed potatoes, baked beans, and sherbet. The pureed cucumber salad listed on the menu was not served. There were other residents in the dining room served pureed meals and no pureed salads were observed. Cook (C)-A was interviewed at the time of the observation, and stated he did not serve the residents prescribed pureed diets cucumbers, "just the potatoes". The diet spread sheets were requested of cook-A, however, he was unsure what was being requested, and was unable to produce the diet spread sheets. Cook-A showed the surveyor where resident names and their respective diets were posted in a list near the steam table. The list did not include information such as alternate foods and serving sizes for residents prescribed modified diets.	21050		

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	00051	A. BUILDING: _____ B. WING _____	07/31/2014

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21050	Continued From page 3 On 7/30/14, at 12:00 p.m. registered dietitians (RD)-A and RD-B were interviewed about serving modified diets. Although a menu was posted in the kitchen, a corresponding spread sheet was unavailable. RD-A and RD-B located a binder in the kitchen with spread sheets, however, they were from the previous winter's menu. They explained that the menu changed in April or May and new spreadsheets had been posted in the kitchen. RD-A and RD-B stated that the cook most likely "remembered" the appropriate amounts to serve residents. At 1:00 p.m. RD-A and RD-B produced the new folder with spread sheets for the spring menu. The folder appeared in pristine condition and was in a folder that could have been propped up at the food service area for quick reference. RD-A and RD-B verified that it appeared to not have been used by staff to direct serving of modified diets. Cook-A was interviewed at the same time and stated that he did not use the spread sheets to direct serving. When asked about the serving of pureed vegetables and fruits, he stated that he did not puree the cucumbers as they became too watery and did not look good when thickened. He went on to explain that there were other fruits and vegetables that were not pureed as they also became too watery. The RDs verified that all items were to be served to the purees as listed on the menus and that they would look into working with food thickeners for production of puree items. An undated facility policy for therapeutic diets indicated that routine menus were planned by the food service manager and approved by the RD for nutritional adequacy. The regular menu was to be modified by the RD for therapeutic diets, with input from the dietary manager for feasibility of	21050		

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21050	Continued From page 4 kitchen production. SUGGESTED METHOD OF CORRECTION: The registered dietitians could ensure spread sheets are provided and utilized by staff. Training in the preparation of mechanically altered food could be provided. Audits could be conducted to ensure staff are following menus for all residents with specialized diets, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21050		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and	21545		

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21545	Continued From page 5 precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of fewer than 5% for 3 of 8 residents (R8, R30, R77) whose medication administration was observed. This resulted in a medication error rate of 11.1%. Findings include: R77's medication administration was observed after the resident had consumed breakfast on 7/28/14, at 8:36 a.m. A licensed practical (LPN)-B administered medications including enteric coated pantoprazole 40 milligrams (mg) for esophageal reflux.	21545		

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21545	Continued From page 6 A diagnostics report dated 7/29/14, for R77 included the diagnosis of esophageal reflux. A physician order report dated 7/20/14, directed staff to administer pantoprazole 40 mg twice daily. The Medication Administration Record (MAR) verified R77 had received the medication daily at 8:00 a.m. and 8:00 .p.m. while in the facility 7/20 through 7/30/14. On 7/28/14, at 8:55 a.m. LPN-B stated the pantoprazole was not administered 30 minutes prior to meals as recommended before meals, because it was a long-term medication and the resident had "always taken it" that way. R8 was given administered Synthroid (to regulate thyroid function) 112 micrograms (mcg) and Ativan (anti-anxiety medication) 0.5 mg to the resident after she had consumed lunch. The medications were administered by a trained medication aide (TMA)-A at 12:09 p.m. A diagnostic report for R8 dated 8/10/14, included the diagnosis of hypothyroidism. The physician order report dated 12/3/13 directed staff to administer Synthroid (levothyroxine) 112 mcg orally, and included "Special instructions: Pharmacy Consultant recommends to give in am r/t [the morning related to] insomnia on an empty stomach." Documentation in the MAR indicated R8 had received Synthroid in the morning between 7:00 a.m. and 10:00 a.m. from 5/1 through 7/31/14. R30 was administered medications in the dining room on 7/31/14, at 7:37 a.m. by LPN-A. The medications included pantoprazole 40 mg. LPN-A then assisted R30 to his room, and administered Restasis 0.05% opthalmic drops, 1 drop to each	21545		

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21545	Continued From page 7	21545		

eye. LPN-A then assisted the resident back to the dining room at 7:48 a.m. where he resumed eating his breakfast.

R30's physician order report dated 6/28/14, directed staff to administer pantoprazole 40 mg with special instructions to administer the medication prior to a meal, at 7:00 a.m. According to the MAR, the resident had been receiving the medication daily.

On 7/31/14, at 8:00 a.m. LPN-A stated R30 was to have his pantoprazole administered before he went to bed. She stated she had noticed it was scheduled before a meal. LPN-A explained that technically it had been administered before a meal, but not 30 minutes prior to a meal as ordered.

On 7/31/14, at :40 a.m. the director of nursing (DON) stated she expected pantoprazole and Synthroid to both be given 30 minutes prior to a meal. She explained the facility utilized a "liberalized medication pass," therefore it would have been difficult to ensure this practice.

Product information at https://www.synthroid.com/prescription/tips.aspx revealed levothyroxine should be taken on an empty stomach, being best taken 30 to 60 minutes before eating breakfast. Product information at drugs.com noted pantoprazole was most effective when taken one hour before a meal without chewing or breaking, swallowing whole with water. "Always take Pantoprazole as directed by your physician."

The Policy and Procedure Manual for Elim Rehab & Nursing Home revised 9/7/11 directed staff to know the effects of the medication given,

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21545	Continued From page 8 medication-to-medication interactions, as well as food-to-medication interactions. In addition, the policy indicated time sensitive medications were to be administered according to the physician orders, which may have included specific time frames. On 7/31/14, at 9:35 a.m. the consultant pharmacist was interviewed via telephone. The pharmacist stated that pantoprazole and any similar medication other than Protonix was to be taken 30 minutes before a meal or on an empty stomach or the effectiveness of the drug may be reduced. He further explained that Synthroid needed to be taken 30 minutes before a meal or on an empty stomach for full absorption and consistency of the thyroid stimulating hormone levels. The pharmacist stated, "We write those orders for a purpose. Although it is not a significant problem, it is a problem." SUGGESTED METHOD OF CORRECTION: The pharmacist could provide instruction to the director of nursing (DON) and or designee and then licensed staff could be trained in the importance of medication administration timing. Audits could be conducted and the results reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21545		