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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RX5F

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/03/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	106			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 10/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 10/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/31/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/30/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245494
October 25, 2016

Mr. Todd Lundeen, Administrator
Elim Home
701 First Street
Princeton, MN 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 September 26, 2016 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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 25, 2016

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

RE: Project Number S5494026

Dear Mr. Lundeen:

On September 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 18, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 3, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 5, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 18, 2016, effective September 26, 2016 and therefore remedies outlined in our letter to you dated September 1, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245494 Y1	A. Building B. Wing Y2	10/3/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(e), 483.75(l)(4)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	09/26/2016	LSC	09/26/2016	LSC	09/26/2016
ID Prefix F0279	Correction	ID Prefix F0282	Correction	ID Prefix F0314	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(c)	Completed
LSC	09/26/2016	LSC	09/26/2016	LSC	09/26/2016
ID Prefix F0323	Correction	ID Prefix F0412	Correction	ID Prefix F0465	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.55(b)	Completed	Reg. # 483.70(h)	Completed
LSC	09/26/2016	LSC	09/26/2016	LSC	09/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 10/25/2016	SIGNATURE OF SURVEYOR 10562	DATE 10/03/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/18/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245494	A. Building 01 - MAIN BUILDING 01 B. Wing	10/5/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 09/26/2016	ID Prefix Reg. # NFPA 101 LSC K0069	Correction Completed 09/26/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 10/25/2016	SIGNATURE OF SURVEYOR 10562	DATE 10/05/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245494	A. Building 02 - BUILDING 2 B. Wing	10/5/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 09/26/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** BF/KJ	**DATE** 10/25/2016	**SIGNATURE OF SURVEYOR** 10562	**DATE** 10/05/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RX5F

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

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/18/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	106			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sarah Kacena, HFE NEII — 09/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 1, 2016

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

RE: Project Number S5494026

Dear Mr. Lundeen:

On August 18, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 18, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5494018 that was found to be unsubstantiated.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
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 September 27, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 18, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 18, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	08/18/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On August 15, 2016 to August 18, 2016, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Elim Home was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5494018 was completed and found not to be substantiated.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		9/26/16

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

Electronically Signed | 09/11/2016

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F 164	Continued From page 1 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure personal privacy was maintained during cares for 2 of 2 residents (R74 and R116) who were reviewed for privacy. Findings include: R74's quarterly Minimum Data Set (MDS) dated 07/07/16, indicated she was severely cognitively impaired, needed assist of one with toileting. R74's care plan dated 7/7/16, indicated she had occasional bowel incontinence related to laxative use and had anger, frustration due to paranoid thoughts. During observation on 08/15/16, at 5:18 p.m. several residents and staff were in the dinning	F 164	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 -164 Personal Privacy/Confidentiality of Records	

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F 164	Continued From page 2 room eating supper. Overheard on the staff's personal communicator (PC) (a hand-held, portable, two-way radio transceiver where staff can communicate to each other) nursing assistant (NA)-C stated "resident in room 310 is having diarrhea all over can someone help me!" Registered Nurse (RN)-B replied over her PC that she would check to see if she can have a prn (as needed) medication. This was overheard by all of the residents and staff in the dinning room. During interview 08/15/16, at 5:33 p.m. RN-C stated all the nursing staff wear the PC's and everyone can hear what is said over them. RN-C stated she heard NA-C's comment about R310 and R74 was in that room. RN-C further stated the staff should be careful not to say personal things they need help with and she will re-educate the staff immediately about privacy and what not to say on the PC's. During interview 08/15/16, at 5:44 p.m. RN-B stated she was the nurse for R74 and that she wasn't feeling well. RN-B stated she heard what was said over the PC and that staff will be re-educated on privacy when using the PC's. During interview 08/16/16, at 1:55 p.m. family member (FM)-A stated R74 can have explosive diarrhea and she is embarrassed about that. He indicated if she knew that staff and other residents could hear what was said over the PC she would have been upset. FM-A stated they shouldn't have said that over the communicator and that she is extremely private and already has fantasies and delusions that the staff don't want her here and he asked me not to tell R74 what was heard.	F 164	Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: Staff mentioned in the 2567 received immediate education as to privacy/dignity and proper communication. Both residents, R74 & R116, have been evaluated with a 3 day bowel and bladder assessment to address noted issues. Medications changes are to be made PRN. Sure Response, our communicator vendor, was contacted about trial ear pieces for staff to wear in addition to the two-way radio transceiver. Actions taken to identify other potential residents having similar occurrences: Facility to audit Dignity/Privacy weekly and PRN. IDT to review findings and provide re-education if needed. Privacy Policy / Staff Equipment user agreement updated to include communication while performing cares and over two way devices utilized by Elim staff. Measures put in place to ensure deficient practice does not occur: Education completed immediately with NARs noted during the annual survey. Staff education to be provided to other nursing staff on appropriateness of sharing information via communication device and providing cares in a private area. Onboarding/orientation checklist reviewed and updated to include privacy	

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F 164	Continued From page 3 During interview 08/17/16, at 12:58 p.m. the director of nursing (DON) stated NA-C is a newer employee and did not realize she had done anything wrong since she didn't use the residents name. The DON stated she should not have said she was having diarrhea. R116's quarterly MDS dated 6/13/16, indicated she had severe cognitive impairment, needed extensive assist with toileting and had dementia. R116's care plan dated 6/13/16, indicated she needed assist with toileting. During observation 08/16/16, at 8:45 a.m. in the hall outside of the dinning room. NA-D was in the tub room with the door open and the privacy curtain pulled while assisting R116 on the toilet. NA-D was overheard stating to R116, "try to keep pooping I will give you another three and a half minutes. Try to poop it out keep pushing it out, try push some more out just like that perfect." NA-D continued to clap her hands and verbalized encouragement to have a bowel movement to R116 with the door open. There were other unidentified residents and staff members, who walked by the bathroom during this time, while NA-D was telling R116 to "poop." During interview 08/16/16, at 2:21 p.m. homemaker (H)-A stated she had overheard what NA-D said to R116 and stated "I thought Oh, she shouldn't have said that." During interview 08/16/16, NA-D stated she knows she shouldn't have talked so loud and it had been the fourth time assisting R116 in the bathroom and she was just frustrated.	F 164	with communicators and providing privacy during cares. Sure Response, our communicator vendor, was contacted to send out options for ear pieces for staff to trial ear pieces to utilize with two way communicators. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 9/26/16 Those responsible to maintain compliance will be: DON or designee	

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F 164	Continued From page 4 During interview 8/17/16, at 1:00 p.m. the DON stated NA-D should not have said that to R116 so loud that others could hear her. She further stated staff have been re-educated on privacy with the residents. During interview 8/18/16, at 2:30 p.m. the DON stated they do not have a policy on privacy and staff are educated yearly thru health care academy about privacy and confidentiality.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225		9/26/16

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F 225	Continued From page 5 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of misappropriation of resident funds were immediately reported to the State agency for 1 of 4 residents (R90) whose allegations were reviewed. Findings include: R90's quarterly Minimum Data Set (MDS) dated 7/29/16, identified R90 had intact cognition. During interview on 8/15/16, at 3:06 p.m. R90 stated she had received, "Two hundred dollars and a Visa gift card" for Christmas, however it had been stolen while she was at the nursing home. R90 stated she reported it to the staff when she noticed it missing several months later. R90 stated the police were called, and they tracked the gift card to a Walmart where a nursing home staff member was video taped cashing it, "She was recognized," and, "She was dismissed [terminated]."	F 225	F -225 Investigate/Report Allegations/Individuals Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: R90's missing money/gift card(s) investigation was completed by the police, who did identify the alleged perpetrator as an Elim employee. This employee was suspended during the investigation and ultimately terminated. Restitution of the missing funds is being overseen by law enforcement officials at this time. Actions taken to identify other potential residents having similar occurrences: An audit of reported events was conducted to identify timeliness of reports. VA reporting audits will continue to be conducted weekly and prn.VA reporting	

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F 225	Continued From page 6 Review of the facility Verification of Investigation report dated 3/13/16, identified, "On Sunday 3/13/16 [R90] was with family at the casino and looked into her purse for her Christmas money and it was missing. She stated it was a $100, $50.$20 [sic], and several $5's and $1's. Plus a $100 Target gift card." The report identified R90 had received the money as Christmas presents and kept it in her purse. R90's stolen credit card had several hundred dollars worth of charges R90 stated, "I did not make." The administrator and police were notified and a case number was obtained. Further, the report identified several spaces to indicate who had been notified of the investigation and allegation. The row labeled, "State Agency Notified" had a black "X" marked next to, "NO." R90's Incident Report - Investigative Report Submission Completed record dated 3/14/16, identified the nursing home had reported the incident of R90's missing money and gift cards to the State agency on 3/14/16 (the day after it had been initially reported to staff by R90). When interviewed on 8/18/16, at 11:03 a.m. licensed practical nurse (LPN)-A stated R90 had reported the missing money on 3/13/16. LPN-A stated she called and reported the missing money and gift cards to registered nurse (RN)-D, "The next morning" and RN-D handled the investigation. LPN-A stated she did not notify the State agency about the missing money and gift cards. During interview on 8/18/16, at 12:43 p.m. RN-D stated LPN-A, "Called me up the morning after [3/14/16]" and reported R90's missing money and gift cards. RN-D stated the State agency had not	F 225	education updated for staff Orientation and yearly competency training education also updated for staff Measures put in place to ensure deficient practice does not occur: VA (OHFC) reporting procedure reviewed and updated with online reporting specific information. Vulnerable Adult Abuse Prohibition Plan policy reviewed and updated. Staff education provided on the updates to the policy & procedure. VA reporting audits to be conducted weekly and PRN. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 9/26/16 Those responsible to maintain compliance will be: DON or designee	

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F 225	Continued From page 7 been notified immediately as, "I didn't know about it until the day after." RN-D stated the missing money and gift card should have been reported to the State agency "Within two hours" after it had been originally reported missing by R90 on 3/13/16. Further, RN-D stated she was unaware if the floor staff had been trained on how to make reports to the State agency, nor had the facility had any training since R90's incident on how to ensure the State agency is notified timely of potential allegations of abuse, neglect, or misappropriation of resident funds, "Not that I can recall." When interviewed on 8/18/16, at 1:45 p.m. the director of nursing (DON) stated R90's missing money and gift cards should have been reported to the State agency on 3/13/16, "[We] want everything reported immediately." The DON stated all staff had been trained in reporting to the State agency, but added some had felt uncomfortable in doing so. Further, the DON stated the police were able to capture video footage of a staff member using R90's stolen gift card, and the employee had been terminated from the facility.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226		9/26/16

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F 226	Continued From page 8 Based on interview and document review, the facility failed to implement policies and procedures to ensure allegations of misappropriation of resident funds were immediately reported to the state agency for 1 of 4 residents (R90) whose allegations were reviewed. Findings include: A facility Vulnerable Adult Abuse Prohibition Plan policy dated 11/2015, identified a, "Basic Responsibility" of, "All staff must report suspected/alleged abuse, neglect, mistreatment of residents, and/or misappropriation of resident property." The policy directed staff to, "Report all suspected/alleged violations immediately [bolded font] to the state agency and to all other agencies as required..." and added, "Person(s) initially identifying potential abuse, neglect, mistreatment, and/or misappropriation of property may, by state law, be accountable to make initial call." R90's quarterly Minimum Data Set (MDS) dated 7/29/16, identified R90 had intact cognition. During interview on 8/15/16, at 3:06 p.m. R90 stated she had received, "Two hundred dollars and a Visa gift card" for Christmas, however it had been stolen while she was at the nursing home. R90 stated she reported it to the staff when she noticed it missing several months later. R90 stated the police were called, and they tracked the gift card to a Walmart where a nursing home staff member was video taped cashing it, "She was recognized," and, "She was dismissed [terminated]."	F 226	F -226 Develop/Implement Abuse Neglect, Etc Policies Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: R90's missing money/gift card(s) investigation was completed by the police, who did identify the alleged perpetrator as an Elim employee. This employee was suspended during the investigation and ultimately terminated. Restitution of the missing funds is being overseen by law enforcement officials at this time. Actions taken to identify other potential residents having similar occurrences: An audit of reported events was conducted to identify timeliness of reports. VA reporting audits will continue to be conducted weekly and prn.VA reporting education updated for staff Orientation and yearly competency training education also updated for staff Measures put in place to ensure deficient practice does not occur: VA (OHFC) reporting procedure reviewed and updated with online reporting specific information. Vulnerable Adult Abuse Prohibition Plan policy reviewed and updated. Staff education provided on the updates to the policy & procedure. VA reporting audits to be conducted weekly and PRN. The DON/designee will report	

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F 226	Continued From page 9 A facility Verification of Investigation report dated 3/13/16, identified, "On Sunday 3-13-16 [R90] was with family at the casino and looked into her purse for her Christmas money and it was missing. She stated it was a $100, $50.$20 [sic], and several $5's and $1's. Plus a $100 Target gift card." The report identified R90 had received the money as Christmas presents and kept it in her purse. R90's stolen credit card had several hundred dollars worth of charges R90 stated, "I did not make." The administrator and police were notified and a case number was obtained. Further, the report identified several spaces to indicate who had been notified of the investigation and allegation. The row labeled, "State Agency Notified" had a black "X" marked next to, "NO." R90's Incident Report - Investigative Report Submission Completed record dated 3/14/16, identified the nursing home had reported the incident of R90's missing money and gift cards to the State agency on 3/14/16 (the day after it had been initially reported to staff by R90). When interviewed on 8/18/16, at 11:03 a.m. licensed practical nurse (LPN)-A stated R90 had reported the missing money on 3/13/16. LPN-A stated she called and reported the missing money and gift cards to registered nurse (RN)-D, "The next morning" and RN-D handled the investigation. LPN-A stated she did not notify the State agency about the missing money and gift cards. During interview on 8/18/16, at 12:43 p.m. RN-D stated LPN-A, "Called me up the morning after [3/14/16]" and reported R90's missing money and gift cards. RN-D stated the State agency had not been notified immediately as, "I didn't know about	F 226	findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 9/26/16 Those responsible to maintain compliance will be: DON or designee	

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F 226	Continued From page 10 it until the day after." RN-D stated the missing money and gift card should have been reported to the State agency "Within two hours" after it had been originally reported missing by R90 on 3/13/16. Further, RN-D stated she was unaware if the floor staff had been trained on how to make reports to the State agency, nor had the facility had any training since R90's incident on how to ensure the State agency is notified timely of potential allegations of abuse, neglect, or misappropriation of resident funds, "Not that I can recall." When interviewed on 8/18/16, at 1:45 p.m. the director of nursing (DON) stated R90's missing money and gift cards should have been reported to the State agency on 3/13/16, "[We] want everything reported immediately." The DON stated all staff had been trained in reporting to the state agency, as the policy identifies.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		9/26/16

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F 279	Continued From page 11 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan to address unwanted sexual advances for 1 of 2 residents (R21) reviewed for behavior and emotional well-being. Findings include: R21's annual Minimum Data Set (MDS) dated 5/18/16, identified R21 had severe cognitive impairment and required extensive assistance with locomotion. R21's progress notes identified the following: 6/18/16: female resident (R37) shaking R21 tying to keep him awake and also attempting to kiss R21. 6/26/16: R21 requesting his own personal space away from R37 7/13/16: Staff observed R37,"groping [R21] below the waist, which was stopped by staff 7/18/16: R21 requesting a break from R37 7/19/16: R21 moved to a different room in the facility to, "Separate him from a female resident [R37] that is spending more time with him than what [R21] desires," and the female [R37] had become, "Possessive of [R21]". Further, the note identified, "[R21] family requested that if female resident [medical record inserted] attempts to visit [R21] in his room or household, that staff	F 279	F -279 Develop Comprehensive Care 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: R21's care plan was reviewed and updated. Resident has adjusted well to his new environment, which is on target with his established goal. Actions taken to identify other potential residents having similar occurrences: Identification of resident R37 was provided to the nursing staff on the household of R21, to assist with re-direction if needed. Staff interviews show that R37 has never made an attempt to go visit R21 in his new household. Both residents have been observed together in group activities in common areas, which is compliant with their care plans. There have not been any incidences of unwanted affection or sexual advances by either resident. Measures put in place to ensure deficient	

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F 279	Continued From page 12 intervene and ask her to leave the area." The note also identified R37 might see R21 at "whole house activities," even though their rooms were in different areas of the building. Review of R21's care plan dated 5/21/16, identified R21 to be, "Sexually inappropriate with staff at times," and directed staff to have a male caregiver providing his baths as needed and redirect any inappropriate behavior. The care plan did not identify the problem of the unwanted sexual advances between R21 and R37, as identified in the 7/19/16 progress note. There was no plan developed or interventions identified to assist R21 to maintain his personal space from R37, should R37 seek R21 out in the facility. A facility SSC Group I listing (sheet used by floor staff to guide care) dated 8/16/16, identified R21's name and his care needs. The sheet lacked any information about keeping R37 or any female residents from visiting R21 in the household or his room. During interview on 8/16/16, at 2:38 p.m. nursing assistant (NA)-E stated staff had been told R21 moved to the unit because a female resident had become, "More aggressive" with him. NA-E stated she was unaware the family did not want R21 to see the female resident adding she did not even know who the female resident was, "We [staff] have not even been told who this resident was." When interviewed on 8/16/16, at 2:46 p.m. NA-F stated R21 had moved to her household unit recently because, "A female [resident] was entering his room." NA-F stated she was unaware of any specifics regarding the situation	F 279	practice does not occur: Identification of resident R37 was provided to the nursing staff on the household of R21, to assist with re-direction if needed. Nursing has received education related to the updates to care plans, family's wishes and timeliness of updates to staff. Activity staff to audit interactions of residents during activities prn. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 9/26/16 Those responsible to maintain compliance will be: DON or designee	

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F 279	Continued From page 13 including who the female resident was or if she was able to visit R21 in the household, "[I'm] not sure who the person is." During interview on 8/17/16, at 12:35 p.m. licensed practical nurse (LPN)-B stated R21 moved to the household unit about three weeks prior because a female resident had been having, "Possibly too much contact" with him. LPN-B stated the information about R21 moving rooms was passed in an e-mail a couple weeks prior, however LPN-B stated she was unaware who the female resident was staff were to be mindful of watching for. When interviewed on 8/17/16, at 12:45 p.m. registered nurse (RN)-B stated R21 moved to the household because a female resident had been spending more time with him than he desired, however RN-B was unsure which female resident this was, "I don't know." RN-B stated there was, "Nothing in his care plan that I could find" directing staff to stop the female resident from visiting R21 as his family had requested, and it should be added, "I think so."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toileting	F 282	F -282 Service By Qualified Persons/Per Care	9/26/16

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F 282	Continued From page 14 assistance as directed by the care plan for 1 of 3 residents (R22) reviewed for urinary incontinence. Findings include: R22's annual Minimum Data Set (MDS) dated 5/9/16, identified R22 had intact cognition, was totally dependent on staff for toileting care, and was frequently incontinent of urine. R22's elimination care plan dated 8/17/16, identified R22 had an, "Alteration in bowel and bladder" and directed staff to, "Toilet: Upon Rising, Before Meals & [and] HS [hour of sleep]." A Prairie Bloom Group I sheet (used to relay the care plan to the nursing staff) dated 8/16/16, directed staff to, "Toilet: Upon Rising, Before Meals & HS. Use toileting sling and commode." During observation on 8/17/16, at 7:39 a.m. R22 was in bed when nursing assistant (NA)-A and NA-B entered to help assist her with morning cares. R22's bedding was removed which exposed a soiled green incontinent product. NA-A and NA-B changed R22's incontinence product while she remained in bed, then assisted her to dress and transfer into her wheelchair using a mechanical lift and cut sling. NA-A and NA-B then left the room to help other residents, later returning and helping R22 to the breakfast table. R22 had not been assisted with or offered toileting as directed by her care plan. When interviewed on 8/17/16, at 8:28 a.m. NA-B stated R22 was totally dependent on staff for her toileting cares, "We do everything for her." NA-B stated R22 had been incontinent of urine that morning so, "We just changed her." Further,	F 282	plan Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited residents: R22's was reviewed and reassessed for her elimination patterns. CARE PLAN and NAR assignment sheets updated with residents needs/preferences. Actions taken to identify other potential residents having similar occurrences: Resident's with toileting plans will randomly be observed for compliance and audited on compliance. Changes to individual CARE PLAN and NAR assignment sheet made as needed. Measures put in place to ensure deficient practice does not occur: Education provided to nursing staff on timely toileting, following the care plan and reporting any elimination pattern changes to nursing leadership. Toileting program audits being done weekly and prn. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 9/26/16 Those responsible to maintain compliance will be: DON or designee	

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F 282	Continued From page 15 NA-B stated staff only help R22 to use the toilet or commode when she asks for it, "Its always been just if she asks." During interview on 8/17/16, at 11:51 a.m. registered nurse (RN)-A stated R22 should have been offered and assisted with using the toilet or commode as directed by her care plan. A facility Care Plans and Care Conferences policy dated 6/2000, identified a purpose, "To meet the physical, social, psychological, and spiritual needs and problems of each resident," and directed staff to, "Formulate and update an integrated plan of care for each resident."	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facilty failed to comprehensively reassess, adequately monitor the condition of, and implement new interventions to assist in healing a pressure ulcer for 1 of 3 residents (R152) reviewed for pressure ulcers.	F 314	F - 314 Treatment/SVCS To Prevent/Heal Pressure Sores Elim Care and Rehab Center has the expectation that staff will show competence with the continued	9/26/16

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F 314	Continued From page 16 Findings include: R152's Resident face sheet dated 3/3/16, identified diagnosis of nutritional deficiency, actinic keratosis (lesions which appear on the body) and edema. R152 was discharged from the facility to the hospital on 5/23/16 per R152's resident face Sheet. R152's 14 day Minimum Data Set (MDS), dated 4/4/16, indicated R152 was cognitively intact, required assistance of one as needed with activities of daily living (ADL), risk for pressure ulcer development, and was admitted with moisture associated skin damage (MASD). R152's Skin Care Area Assessment (CAA) worksheet dated 4/26/16, indicated R152 required assistance with bed mobility and was at risk for skin breakdown due to a history of medications, falls and a total knee arthroplasty (knee replacement surgery). Further, it indicated R152 was admitted with an open area to his (R152) buttocks. Interventions included; pressure relieving device to bed and wheelchair. R152's Comprehensive Narrative Summary dated 4/26/16, indicated R152 has an open area on his left buttock which turned pink and blanchable if he (R152) sat on his coccyx for a long period of time. Interventions included encouraged repositioning every two hours, licensed nursing to complete skin checks weekly and to report changes to the physician as needed. R152's Care Plan dated 3/3/16, indicated R152 was at risk for altered skin integrity due to moisture/friction to left buttocks with a goal of R152's skin will heal without complications.	F 314	compliance of the following plan: Regarding cited residents: R152 is no longer a resident here at Elim and could not be reassessed related to skin concerns. His closed record was reviewed. Actions taken to identify other potential residents having similar occurrences: All residents who have a noted pressure ulcer were reviewed by designated nursing staff. Each floor of the facility has a designated nurse to observe and document on wounds. Upon resident's admit/re-admit, nursing staff will view noted skin impairments and, if identified as a pressure area, the designated nurse will include them on their wound rounds. Measures put in place to ensure deficient practice does not occur: Facility will do skin assessments on admit and re-admit of all residents. All new skin impairments are discussed at the daily IDT stand up meeting. Weekly skin checks are done by nursing staff. Upon request, Consultant wound specialist/surgeon views skin impairments and oversees the ongoing care in collaboration with PMD/GNP. All wounds are monitored weekly by a designated wound nurse or designee. Weekly F314 audits showing measurements are completed and turned in to DON. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued	

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F 314	Continued From page 17 Interventions included; monitoring skin integrity with care, pressure relieving device to bed/chair and to update physician as needed. Review of R152's nursing notes indicated the following: 3/22/16- R152 returned from the hospital with a new open area on his left buttock which measured 2 centimeters (cm) by 1.5 cm. 3/23/16- R152 had second open area to coccyx measured 2.5 cm by .2. Area cleaned and Cavilon preparation used. There was no mention of the open area on R152's left buttock. 3/28/16- R152 was seen by physician today who thought the open area on his left buttock was caused by moisture/friction and encouraged the facility to utilize proper pressure relieving devices. Per (R152), "I get these areas once and a while and they go away." 3/29/16- R152's left buttock's open wound is shiny pink with brownish slough (stingy tissue which is attached to a stage 2 or 3 pressure ulcer) around the outside perimeter. Small amount of drainage noted. There was no mention of the open area of R152's coccyx was noted in this progress note. 3/29/16 the Physician Progress note, indicated R152 had an open area on his left buttock approximately the size of a nickel. The area appeared abraded (scrape or wear away by friction or erosion) with minor depth and had no drainage. The nursing notes identified the following: 3/30/16- R152's first open area on his coccyx is healed at this time and the second area to right buttock [sic] is scabbed over appears superficial. Event was closed at this time. 4/1/16 - Buttock open area in crease appears to	F 314	compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 9/26/16 Those responsible to maintain compliance will be: DON or designee	

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be healing.
4/4/16 -The first area on R152's buttock cheek area is not bleeding and is still indented in. The second area on R152's coccyx spot is pink.
4/11/16 -Open area on left buttock is open and appears healing is stalled. Progress notes did not mention the "pink area" on R152's coccyx on this date, or if the area had healed.
4/12/16- Buttock wound on left gluteal cheek is circular and superficial. Measurements are 1.1 cm by 1.7 cm by .1 cm deep. Reports moderate pain at site. There was no mention of area on R152's coccyx.
4/19/16- Coccyx area is red and blanchable with a 1.0 by 1.0 open area. No mention of R152's open area on left buttock.
4/20/16- R152 reported the open area to his left buttock is a "little sore", area was healing per wife who was in the room. There was no mention of R152's area on coccyx.
5/2/16- coccyx is pink, no open areas noted
5/7/16- wound to coccyx is healing.
5/8/16- wound to coccyx is healing with dry patch of skin to outer area.
5/16/16- coccyx is chaffed, skin pealing with small open area.

There were no further notes, monitoring or assessment identified in R152's chart about the coccyx being chaffed, skin peeling with small open areas even though R152 was still in the facility and was discharged to the hospital on 5/23/16.

Review of R152's Skin Integrity Progress form dated 3/21/16, identified R152 had a partial thickness wound on his left buttock which was 2 cm by 1.5 cm and had 100 percent epithelial tissue (new tissue which is growing over wound

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tissue). On 3/29/16, R152's skin assessment for his left buttock measured 2 cm by 1.7 cm and had 90% epithelial tissue and 10% slough. R152's skin assessment dated 4/4/16, identified area on left buttock measured 2 cm by 1 cm and had 60% epithelial and 40% granulation tissue.. On 4/12/16 152's skin assessment on his left buttock was 1.7 cm by 1 cm. There were no wound assessment or event notes for skin integrity completed for the open area on R152's coccyx, even though these areas were identified in the nursing notes as being open.

During interview on 8/18/16, at 10:18 a.m. with registered nurse (RN)-F stated there were very few documented wound measurements for R152 for his weekly skin assessments. Further, RN-F stated if slough was noted during R152's skin assessments his primary physician should have been notified, "this isn't our normal process."

When interviewed on 8/18/16, at 11:05 a.m. with RN-D stated skin assessments should be completed at least once a week for wound monitoring. Further, RN-D stated an area which has slough would be considered a stage three pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) and stated, "I do not see consistent skin assessments were being completed for R152."

Although the facility identified R152's had pressure ulcers on his left buttock/coccyx, there was no indication they consistently monitored these areas to determine if these were two separate or one pressure ulcer for R152. The

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F 314	Continued From page 20 weekly monitoring was not consistent and did not include type of ulcer, location, shape, measurements including depth, ulcer characteristics, or if there was any drainage or pain associated with the ulcer. There was no indication a comprehensive assessment was completed to determine if the current interventions were effective, or new interventions needed to be implemented to aide in healing and or prevent further skin breakdown for R152. A facility policy titled "Pressure Ulcer Documentation" dated 06/2014 indicated, "It is the policy of Elim Care to document on a regular basis the observation, interventions, treatment and evaluation of response to treatment plan for a resident with a pressure ulcer.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety with smoking for 1 of 4 residents (R180) identified who smoked while residing in the facility. Findings include:	F 323	F -323 Free Of Accident Hazards/Supervision/Devices Elim Care and Rehab Center has the expectation that staff will show competence with the continued	9/26/16

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F 323	Continued From page 21 R180's Resident Face Sheet, undated, identified she was admitted August 2016; there was no admission Minimum Data Sheet (MDS) completed to date. R180's Diagnoses Report, undated, identified R180 had a diagnosis on admission to the facility of, "Tobacco use." R180's History and Physical, dated 8/11/16, indicated R180 reported she had been smoking cigarettes, had a 15-pack-year smoking history, and had never used smokeless tobacco. R180's Care Plan, dated 8/12/16, indicated, "Resident is at risks for falls due to: Groin wound, weakness, medications." However, R180's care plan lacked any indication R180 was currently smoking, or any indication of how much assistance she needed to smoke safely while in the facility. During interview on 8/18/16, at 9:05 a.m. nursing assistant (NA)-J stated R180 was a smoker and was safe to smoke. She had never seen any burn holes or unsafe smoking by this resident, and residents typically smoked on a park bench just outside the exit door of the facilty. When interviewed on 8/18/16, at 9:08 a.m. R180 stated she has been a smoker since she was 14 years old, and goes outside two or three times a day to smoke. No one had ever told her she could not go outside to smoke. During observation on 8/18/16, at 9:08 a.m. R180 used a four-wheeled seated walker and proceeded to go outside of the building. She	F 323	compliance of the following plan: Regarding cited residents: Smoking assessment was completed on R180 during when she was identified as being a smoker at the facility. Her assessment showed that she was safe with her smoking habits and understood the rules of the facility. Care plan was updated with this information. She had no smoke related injuries while residing at the facility. Resident discharged from facility on 9/3/16. Actions taken to identify other potential residents having similar occurrences: Residents identified as being smokers were audited to see if a smoking assessment had been completed. Care plan and Nursing assistant assignment sheets updated prn. Admission process reviewed and updated to aid in the identification of smokers. Measures put in place to ensure deficient practice does not occur: Admission process reviewed and updated to include more information on the identification of smokers. Education provided to staff on identification of residents that smoke and notification of nursing supervor. Admission process/smoking assessment audits to be completed weekly and prn. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches.	

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F 323	Continued From page 22 walked down the sidewalk and stopped near a park bench. R180 sat on her walker and reached for her lighter and lit a cigarette. She smoked her cigarette while seated on her walker. When R180 was done smoking her cigarette she extinguished her cigarette butt on the cement, carried and disposed the cigarette butt into the garbage can prior to entering the building. There were no burn holes or unsafe smoking noted by the surveyor during this observation. During interview on 8/18/16, at 9:17 a.m. NA-K stated she was aware that R180 was a smoker and goes outside to smoke several times a day. NA-K also stated she had never seen her smoke, but knows R180 smokes because she can smell cigarette smoke on her when she comes in from outside. When interviewed on 8/18/16, at 9:52 a.m. registered nurse (RN)-E stated he would expect every resident that was a smoker in the nursing home to have a smoking assessment completed within the first day of admission to make sure they are safe to smoke. RN-E stated he should have written a note yesterday about R180's smoking and whether R180 was safe to smoke or not. RN-E stated R180's smoking assessment was just completed this morning, 8/18/16 at 9:33 a.m., but the smoking assessment should have been completed when she was admitted (six days ago), to make sure R180 was a safe smoker. During interview on 8/18/16, at 1:39 p.m. the director of nursing (DON) stated she was not aware R180 was a smoker until this morning. DON further stated once she became aware R180 was a smoker she completed R180's smoking assessment. DON also stated,	F 323	Effective implementation of actions will be monitored by: 9/26/16 Those responsible to maintain compliance will be: DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	08/18/2016

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

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F 323	Continued From page 23 "Smoking assessments should be completed right away when residents get here." An Admission Policies/Resident Handout, revised May 2016, indicated Elim was a Smoke Free and Tobacco Free Facility. On campus/outdoor only smoking was allowed only by residents who have been assessed by Elim to be safe and only when complying with MN rules and Elim's rule of being 50' (feet) or further from the entrance and only if the resident can smoke safely, unassisted and unsupervised by staff. E-Cigarettes (electronic) are not permitted.	F 323		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely follow up for dental examinations for 1 of 3 residents (R90) reviewed for dental status and whom had missing teeth. Findings include:	F 412	F -412 Routine/Emergency Dental Services in NFS Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan:	9/26/16

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F 412	Continued From page 24 R90's quarterly Minimum Data Set (MDS) dated 7/29/16, identified R90 had intact cognition. On 8/15/16, at 3:12 p.m. R90 was seated in her recliner chair in her room and was interviewed about her oral health. R90 opened her mouth and showed she had two missing teeth on her upper palate. R90 stated she wore dentures on her upper palate typically, however had been choosing not to wear them for the past several weeks because they, "Don't fit right anymore." R90 stated it was, "Hard to eat with them" and she would like to visit with the dentist about getting them fixed. R90 stated nobody from the facility had ever discussed it with her though, so she had never had a dental appointment since admitting to the facility. R90's progress note dated 11/5/15, identified R90 had recently admitted to the facility and had, "Two false teeth that were not in at this time." Further, the note identified, "She [R90] stated she is due for a cleaning but wants to continue with her current provider." R90's Patient Consent to Services record dated 11/5/15, provided an option to have, "Dentistry" provided and directed the resident to circle their choice of, "YES," or, "NO" on the record. R90 circled, "YES" and identified she wore a partial denture and would prefer dental care, "Every 6 months." When interviewed on 8/18/16, at 9:21 a.m. nursing assistant (NA)-B stated R90 had a partial dentures but doesn't like wearing it. NA-B stated they were not sure why R90 never wore the denture. Further, NA-B stated she had never seen or heard of R90 having a dental	F 412	Regarding cited residents: Dental assessment completed on R90. Dental service consent reviewed and confirmed. Resident is scheduled to be seen by DDS at the next visit to the facility. Actions taken to identify other potential residents having similar occurrences: Facility audited dental services and consents. Admission process reviewed and updated on the offering of dental services. Measures put in place to ensure deficient practice does not occur: Facility to audit dental care on admit/readmits and prn. Facility also looking into alternate on site dental options for residents. The DON/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 9/26/16 Those responsible to maintain compliance will be: DON or designee	

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F 412	Continued From page 25	F 412		

appointment since living at the facility.

During interview on 8/18/16, at 10:47 a.m. registered nurse (RN)-A stated R90 had never been to the dentist since admitting to the facility in November 2015, "She has not." RN-A stated R90 selected to have dental care every six months according to her signed consent so the facility health unit coordinator should of arranged the appointments for her as selected on the consent.

When interviewed on 8/18/16, at 1:23 p.m. R90's family member (FM)-A stated R90 had not had any dental appointments since her admission to the nursing home, but added she should be seen, "She should be going to the dentist." Further, FM-A stated R90 should be seen routinely for dental care, not just when residents or family specifically ask for it, "I feel like I have to ask for stuff."

During interview on 8/18/16, at 1:39 p.m. the medical records director (MRD) stated R90 was covered under Medicaid while in the nursing home. MRD stated she had flow sheets which identify each resident seen by the dentist, however R90 was never added to the listing for the dentist to round on, "[It] doesn't look like she got on here." MRD stated the facility had trouble always ensuring the dentist would show up for treatments because of the lower case load, but added R90 should have been seen every six months as she requested on her consent form, "I should have followed through."

The facility Inhouse Senior Services Dental flowsheets dated 12/22/15, through 6/6/16, identified columns with resident names and the date of their last dental appointment. However,

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F 412	Continued From page 26 R90 was not identified on the flowsheets as ever having been seen by the dentist. A facility Dental Services policy dated 6/2000, identified staff would, "Compile a list of residents to be seen" by the dentist and, "Maintain an orderly system to assure that residents will be seen in a timely manner both on admission and on an ongoing basis."	F 412		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain sanitary conditions for 5 of 5 resident rooms (102-2, 103-1, 103-2, 109-1 and 111-1) and one common living space reviewed (Rum river) in the facility. Findings include: On 8/18/16, at 9:33 a.m. an environmental tour of the facility was conducted with maintenance supervisor (MS) and the MS confirmed the following findings: In 102-2, a large 2.5 centimeter (cm) scrape exposing sheetrock was located on the wall behind the residents recliner.	F 465	F -465 Safe/Functional/Sanitary/Comfortable Environ Elim Care and Rehab Center has the expectation that staff will show competence with the continued compliance of the following plan: Regarding cited areas: All rooms and common areas identified during the annual survey have been repaired. Actions taken to identify other potential residents having similar occurrences: Environmental tour(s) conducted and observe for any further problem areas throughout the facility. Action plans in	9/26/16

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F 465	Continued From page 27 In 103-1, a 3 inch dent in the sheetrock was located behind the residents bed. After MS inspected the area, he stated the area would, "need to be repaired". In 103-2, a 2 inch scrape mark exposing sheetrock located behind residents bed. There were also two smaller gouges approximately the size of a quarter behind the head of the residents bed. In 109-1 there was a large scrape in the wall exposing sheetrock which measured 3.5 by 5.5 cm in length. In 111-1, a 1.4 inch gouge exposing sheetrock was located behind the resident's recliner. There were also several small black scrapes located behind the residents recliner. In the Rum River hallway, a 9.75 inch scrape exposing sheetrock was located on the hallway wall next to the door entrance with sheetrock dust located on the carpet next to the scrape. MS stated he had never seen the scrape before and was unsure of its origins. On 8/18/16, at 9:46 a.m. MS confirmed all of the findings listed above. MS stated the usual facility practice was for facility staff to notify maintenance with paper slips which were picked up daily by eminence staff. Furthermore, MS stated room repairs on the 1st floor wing often waited until the resident moved out of the room because it was "hard to move them [residents] around" when trying to complete room maintenance. Review of policy titled, "Preventative Maintenance	F 465	place for any problem areas noted during these observations. Measures put in place to ensure deficient practice does not occur: Our preventative maintenance plan has been updated to reflect our current practice. In addition, our own plant ops staff will continue to round/audit and note needed repairs and get them into the work queue. The Administrator/designee will report findings of audits to the Quality Assurance Committee who reviews for continued compliance and further recommendations and approaches. Effective implementation of actions will be monitored by: 9/26/16 Those responsible to maintain compliance will be: DON or designee	

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F 465	Continued From page 28 Plan" dated 10/15, identified the facilities goal was to "keep our residents homes looking nice" and potential fixes are triaged by housekeeping and given to maintenance for further repair.	F 465		

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	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/19/2016**

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

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/11/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/19/2016**

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K 000	Continued From page 1 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Elim Home Princeton is a 3 story building with no basement. The original building was constructed in 1971 and was determined to be of Type II(111) construction. An additions was built on in 1989 of the same construction type,. Therefore the building was inspected as one building. The building also has an apartment complex attached that is properly separated. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 106 beds and had a	K 000		

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K 000	Continued From page 2 census of 99 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 99 of 99 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 8:00 AM and 12:00 PM on 08/19/2016, observations and a review of all available reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 4 of 12 monthly tests of the digital alarm communicator transmitter (DACT).	K 052	The Fire Drill Checklist has been modified to remind the drill instructor to pull the alarm on the day shift immediately after a night shift drill. The drill instructor will then call the monitoring company to verify alarm was received and document the same on the Checklist. Paul Whitcomb, plant operations director, is responsible for correction and monitoring to prevent a recurrence.	9/26/16

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K 052	Continued From page 3 This deficient condition was verified by a Maintenance Supervisor.	K 052		
K 069 SS=E	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 observations and staff interview, the facility is cooking food items that produces grease-laden vapors in 1 of multiple dining rooms without the proper exhaust hood equipment and extinguishing system in accordance with NFPA 101(00), Section 19.3.2.6 and NFPA 96(98) 1-3.1. This deficient practice could affect 20 of 99 residents, as well as an undetermined number of staff, and visitors Findings Include: On facility tour between 8:00 AM and 12:00 PM on 08/19/2016, during the facility tour it was observed that there was a dietary staff member cooking eggs in a frying pan located in on a conventional oven located in the dining room that was not equipped with a hood ventilation and suppression system. After questioning the staff member, they stated that she had been using butter to fry the eggs for the residents. This deficient condition was verified by a Maintenance Supervisor.	K 069	Dietary staff have been reeducated regarding our long-standing policy of not allowing staff to use butter to fry food in our household kitchens. Proofs of that training are in each employee's personnel file. Paula Welch, our Director of Nutritional Services, is responsible for correction and monitoring to prevent a recurrence.	9/26/16

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	245494	A. BUILDING **02 - BUILDING 2** B. WING _____	**08/19/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Elim Home Princeton Bldg 02 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/11/2016

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K 000	Continued From page 1	K 000		

By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Elim Home Princeton is a 3 story building with no basement. The building construction type has been determined to be Type II(442). This inspection only reflects the building that opened 11/04/2003. It is properly separated from the original building constructed in 1971.

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

The facility has a capacity of 106 beds and had a census of 99 at the time of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	**701 FIRST STREET PRINCETON, MN 55371**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4., 18.3.6.3.2, 18.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 99 of 99 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 8:00 AM and 12:00 PM on 08/19/2016, observations and a review of all available reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 4 of 12 monthly tests of the digital alarm communicator transmitter (DACT).	K 052	The Fire Drill Checklist has been modified to remind the drill instructor to pull the alarm on the day shift immediately after a night shift drill. The drill instructor will then call the monitoring company to verify alarm was received and document the same on the Checklist. Paul Whitcomb, plant operations director, is responsible for correction and monitoring to prevent a recurrence.	9/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **02 - BUILDING 2** B. WING _____	**08/19/2016**

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K 052	Continued From page 3 This deficient condition was verified by a Maintenance Supervisor.	K 052		