DEPARTMENT OF HE			ID CERTIFICATI	CENTERS FO ON AND TRANSMITTAL	R MEDICARE & MEDICAID SERVICES ID: SX8J
				STATE SURVEY AGENCY	
1.         MEDICARE/MEDICAID PRO           (L1)         245562           2.STATE VENDOR OR MEDICA         (L2)           507042200         507042200		(L3) ELDERS HO	USLEY, PO BOX 188	3 (L6) <b>56567</b>	4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
	<b>03/16/2017</b> (L34)	<ol> <li>PROVIDER/SU</li> <li>01 Hospital</li> <li>02 SNF/NF/Dual</li> <li>03 SNF/NF/Distinct</li> <li>04 SNF</li> </ol>	PPLIER CATEGORY 05 HHA 09 E 06 PRTF 10 N 07 X-Ray 11 F 08 OPT/SP 12 E	F 14 CORF CF/IID 15 ASC	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
<ul> <li>11. LTC PERIOD OF CERTIFIC.</li> <li>From (a):</li> <li>To (b):</li> <li>12. Total Facility Beds</li> </ul>	<b>45</b> (L18)	A. In Complia Program 1 Complian 1.	Requirements ce Based On: Acceptable POC	And/Or Approved Waivers 2. Technical Perso 3. 24 Hour RN 4. 7-Day RN (Rur 5. Life Safety Cod	7. Medical Director     8. Patient Room Size
13.Total Certified Beds	<b>45</b> (L17)		mpliance with Program and/or Applied Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BRE	AKDOWN	-		15. FACILITY MEETS	
	9 SNF 19 SNF 45	ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L	38) (L39)	(L42)	(L43)		
17. SURVEYOR SIGNATURE	E NE II	Date :	04/10/2017 (L	18. STATE SURVEY AGE Shellae Dietrich, Co	NCY APPROVAL     Date:       ertification Specialist     07/21/2017 (L20)
	PART II - TO B	E COMPLETED	BY HCFA REGIO	NAL OFFICE OR SINGLI	E STATE AGENCY
<ol> <li>DETERMINATION OF ELIC</li> <li> 1. Facility is Elig</li> <li> 2. Facility is not</li> </ol>	ble to Participate		MPLIANCE WITH CIVIL GHTS ACT:		Financial Solvency (HCFA-2572) Control Interest Disclosure Stmt (HCFA-1513) Above :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 2	4. LTC AGREEMENT	26. TERMINATION ACT	ON: (L30)
OF PARTICIPATION <b>06/01/1991</b>	BEGINNINC	DATE	ENDING DATE	VOLUNTARY 01-Merger, Closure	00 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L2	27)	IVE SANCTIONS on of Admissions: uspension Date:	(L25) (L44)	02-Dissatisfaction W/ Reimbo 03-Risk of Involuntary Termi 04-Other Reason for Withdra	nation <u>OTHER</u>
			(L45)		
28. TERMINATION DATE:	2	9. INTERMEDIARY/		30. REMARKS	
		03001			
	(L28)			31)	
31. RO RECEIPT OF CMS-1539	3		OF APPROVAL DATE		
	(L32)	03/10/2017	(L	33) DETERMINATION A	PPROVAL



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24-5562

July 21, 2017

Ms. Lyn Sebenaler, Administrator Elders Home, Inc. South Tousley, P.O. Box 188 New York Mills, Minnesota 56567

Dear Ms. Sebenaler:

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 February 28, 2017 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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,

Shellae Dietrich

Shellae Dietrich, Certification Specialist Program Assurance Unit Health Regulation Division Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone #: (651) 201-4106 Fax #: (651) 215-9697 cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 10, 2017

Ms. Lyn Sebenaler, Administrator Elders Home Inc South Tousley, PO Box 188 New York Mills, Minnesota 56567

RE: Project Number S5562026

Dear Ms. Sebenaler:

On January 25, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 17, 2017. 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 March 16, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 1, 2017 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 January 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 28, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 17, 2017 and therefore remedies outlined in our letter to you dated January 25, 2017, 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.

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

Sincerely,

Mark meeth

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

cc: Licensing and Certification File

# **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	
	B. Wing	Y2	3/16/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS HOME INC		SOUTH TOUSLEY, PO BOX 188		
		NEW YORK MILLS, MN 56567		

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).

ITE	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	F0156	Correction	ID Prefix FC	0166	Correction	ID Prefix	F0225	Correction
Reg. #	483.10(d)(3)(g)(1 (13)(16)-(18)	)(4)(5) Completed	Reg. #	3.10(j)(2)-(4)	Completed	Reg. #	483.12(a)(3)(4)(c)(1)-(4	) Completed
LSC		02/03/2017	LSC		02/03/2017	LSC		02/17/2017
ID Prefix	F0226	Correction	ID Prefix FC	)253	Correction	ID Prefix	F0283	Correction
Reg. #	483.12(b)(1)-(3), 483.95(c)(1)-(3)	Completed	483 Reg. #	3.10(i)(2)	Completed	Reg. #	483.21(c)(2)(i)-(iii)	Completed
LSC		02/17/2017	LSC _		02/28/2017	LSC		02/24/2017
ID Prefix	F0441	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.80(a)(1)(2)(4	)(e)(f) Completed	Reg. #		Completed	Reg. #		Completed
LSC		02/24/2017	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS) GA/mm	DATE 04/10/201	7 SIGNATURE O		905	DA C	те 93/16/2017
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DA	TE
FOLLOW	JP TO SURVEY CO 7	OMPLETED ON			CTED DEFICIENCIES IES (CMS-2567) SENT			YES 🗌 NO

## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - 01 MAIN BUILDING			
245562 <sub>Y1</sub>	B. Wing	Y2	3/1/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS HOME INC		SOUTH TOUSLEY, PO BOX 188		
		NEW YORK MILLS, MN 56567		

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).

ITEI	м	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. # LSC	NFPA 101 K0223	Correction Completed 02/28/2017	Reg. #	PA 101 353	Correction Completed 02/03/2017	ID Prefix Reg. # LSC	NFPA 101 K0521		Correction Completed 01/26/2017
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction	ID Prefix Reg. #			Correction Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. # LSC		Completed	Reg. # 		Completed	Reg. # LSC			Completed
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/mm	<b>DATE</b> 04/10/201		OF SURVEYOR 36536			DATE 03/01	1/2017
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/11/2017				RECTED DEFICIENCIES NCIES (CMS-2567) SENT				в 🔲 но	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 9, 2017

Ms. Lyn Sebenaler, Administrator Elders Home Inc South Tousley, PO Box 188 New York Mills, Minnesota 56567

Re: Reinspection Results - Project Number S5562026

Dear Ms. Sebenaler:

On March 16, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 17, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

### Mark meath

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

cc: Licensing and Certification File

#### STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	SIT
	B. Wing		Y2	3/16/2017	Y3
NAME OF FACILITY	•	STREET ADDRESS, CITY, STATE, ZIP CODE			
ELDERS HOME INC		SOUTH TOUSLEY, PO BOX 188			
		NEW YORK MILLS, MN 56567			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	М	DATE	ITEN	1	DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20680	Correction	ID Prefix	21390	Correction	ID Prefix	21695	Correction
Reg. #	MN Rule 4658.0 Subp. 1	Completed	Reg. #	MN Rule 4658.0800 Subp. 4 A-I	Completed	Reg. #	MN Rule 4658.14 Subp. 4	15 Completed
LSC		02/10/2017	LSC		02/24/2017	LSC		02/28/2017
ID Prefix	21980	Correction	ID Prefix	22000	Correction	ID Prefix		Correction
Reg. #	MN St. Statute Subd. 3	Completed	Reg. #	MN St. Statute 626.557 Subd. 14 (a)-(c)	Completed	Reg. #		Completed
LSC		02/17/2017	LSC		02/17/2017	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
REVIEWI STATE A		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR			DATE
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		_		DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/17/2017				CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

	MEDICARE/MEDICAID CERTIFICA					ID: SX8J		
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	Facility ID: 00432		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245562		3. NAME AND ADD (L3) ELDERS HO		ΓY		4. TYPE OF ACTION: <u>2 (</u> L8) 1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID NO.		(L4) SOUTH TOU	SLEY, PO BOX	188		3. Termination     4. CHOW		
(L2) <b>507042200</b>		(L5) NEW YORK	MILLS, MN		(L6) <b>56567</b>	5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNE (L9)	RSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	Ý 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 01/17/20	017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:					
From (a):		A. In Compliance	e With		And/Or Approved Waivers Of The	Following Requirements:		
To (b) :		Program Rec Compliance			2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director		
12. Total Facility Beds	45 (L18)	Accep	table POC		4. 7-Day RN (Rural SNF)	8. Patient Room Size		
13. Total Certified Beds	45 (L13) 45 (L17)	B Not in Com	pliance with Program		5. Life Safety Code	9. Beds/Room		
13. Iotal Certified Beds	10 (EII)	-	ind/or Applied Waive		* Code: B	(L12)		
14. LTC CERTIFIED BED BREAKDOWN		I			15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
45								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:		
Tammy Williams,	HFE NE I	I (	02/08//2017	(L19)	Kate JohnsTon, Pr	ogram Specialist 03/09/2017 (L20)		
	PART II - TO	BE COMPLETEI	D BY HCFA RE	EGIONAL	OFFICE OR SINGLE STAT			
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH C	IVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
1. Facility is Eligible to Partici	pate	RIGH	ITS ACT:		<ol> <li>Ownership/Control I</li> <li>Both of the Above :</li> </ol>	Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	INT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE	Ξ	VOLUNTARY 00	INVOLUNTARY		
06/01/1991					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)			(L44)			00-Active		
(==')	B. Rescind Sus	pension Date:						
20. TEDMINIATION DATE	20	DITED (EDIA DV/C	(L45)		20. DEMARKO			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	ſE				
	(L32)			(L33)	DETERMINATION APPRO	VAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 25, 2017

Ms. Lyn Sebenaler, Administrator AdministratElders Home Inc South Tousley, PO Box 188 New York Mills, Minnesota 56567

RE: Project Number S5562026

Dear Ms. Sebenaler:

On January 17, 2017, 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.

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

#### **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 February 26, 2017, 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;

Elders Home Inc January 25, 2017 Page 3

- 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.

Elders Home Inc January 25, 2017 Page 4

#### 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 April 17, 2017 (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

Elders Home Inc January 25, 2017 Page 5 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 July 17, 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525 Elders Home Inc January 25, 2017 Page 6 Feel free to contact me if you have questions related to this eNotice.

Sincerely,

## Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

		AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION			E SURVEY IPLETED
		245562	B. WING _			01/	17/2017
NAME OF F	PROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE		
ELDERS	HOME INC			SOUTH TOUSLEY			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00 2/8/17 OI	Kail ander	Son	
	signature is not req						
F 156	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with 4)(5)(13)(16)-(18) NOTICE OF	F 15	56			2/3/17
SS=D	(d)(3) The facility m remains informed o of contacting the ph	SERVICES, CHARGES ust ensure that each resident f the name, specialty, and way hysician and other primary care onsible for his or her care.					
	(1) The resident has his or her rights and	tion and Communication. s the right to be informed of d of all rules and regulations conduct and responsibilities ay in the facility.					
	notices orally (mean	has the right to receive ning spoken) and in writing a format and a language he , including:					
	The facility must fur	as specified in this section. rnish to each resident a written rights which includes -					
		the manner of protecting der paragraph (f)(10) of this					
		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE
Electron	ically Signed						02/03/2017

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

PRINTED: 02/08/2017

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245562	B. WING		01/	17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 156	Continued From pa	ıge 1	F 15	56		
	procedures for esta including the right to	the requirements and ablishing eligibility for Medicaid, o request an assessment of ection 1924(c) of the Social				
	email), and telepho State regulatory and resident advocacy of Survey Agency, the State Long-Term Co protection and advo services where stat in long-term care fa agency for informat	addresses (mailing and one numbers of all pertinent d informational agencies, groups such as the State e State licensure office, the are Ombudsman program, the ocacy agency, adult protective te law provides for jurisdiction acilities, the local contact tion about returning to the Medicaid Fraud Control Unit;				
	complaint with the s concerning any sus federal nursing faci not limited to reside exploitation, misapp in the facility, non-c directives requirem	at the resident may file a State Survey Agency spected violation of state or ility regulations, including but ent abuse, neglect, propriation of resident property compliance with the advance tents and requests for ng returning to the community.				
	and local advocacy not limited to the St Long-Term Care Or (established under Americans Act of 19 U.S.C. 3001 et seq	contact information for State organizations including but tate Survey Agency, the State mbudsman program section 712 of the Older 965, as amended 2016 (42 and the protection and as designated by the state, and				

Facility ID: 00432

If continuation sheet Page 2 of 43

		AND HUMAN SERVICES			FORM	02/08/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		245562	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC			OUTH TOUSLEY, PO BOX 188 IEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 156	as established under Disabilities Assistar 2000 (42 U.S.C. 15 [§483.10(g)(4)(ii) w November 28, 2017 (iii) Information rega eligibility and covera [§483.10(g)(4)(iii) w November 28, 2017 (iv) Contact informat Disability Resource Section 202(a)(20)( Act); or other No W [§483.10(g)(4)(iv) w November 28, 2017 (v) Contact informat Control Unit; and [§483.10(g)(4)(v) w November 28, 2017 (vi) Information and grievances or comp suspected violation facility regulations, resident abuse, neg misappropriation of facility, non-complia directives requirem information regardin (g)(5) The facility m manner accessible residents, resident	er the Developmental nee and Bill of Rights Act of 001 et seq.) ill be implemented beginning 7 (Phase 2)] arding Medicare and Medicaid age; vill be implemented beginning 7 (Phase 2)] ation for the Aging and center (established under (B)(iii) of the Older Americans rong Door Program; vill be implemented beginning 7 (Phase 2)] tion for the Medicaid Fraud ill be implemented beginning 7 (Phase 2)] tion for the Medicaid Fraud ill be implemented beginning 7 (Phase 2)] d contact information for filing plaints concerning any of state or federal nursing including but not limited to glect, exploitation, resident property in the ance with the advance ents and requests for ng returning to the community. pust post, in a form and and understandable to	F 156			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING _			01/ <sup>.</sup>	17/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 156	agencies and advoc Survey Agency, the protective services jurisdiction in long-t of the State Long-To program, the protect home and commun and the Medicaid F (ii) A statement that complaint with the S concerning any sus federal nursing facil limited to resident a misappropriation of facility, and non-cor directives requirem I) and requests for it to the community. (g)(13) The facility r written information, applicants for admis information about h Medicare and Medi receive refunds for such benefits. (g)(16) The facility r and services to the admission and durin (i) The facility must and in writing in a la understands of his o regulations governing	ge 3 bers of all pertinent State cacy groups, such as the State State licensure office, adult where state law provides for erm care facilities, the Office erm Care Ombudsman ction and advocacy network, ity based service programs, raud Control Unit; and the resident may file a State Survey Agency pected violation of state or lity regulation, including but not abuse, neglect, exploitation, resident property in the mpliance with the advanced ents (42 CFR part 489 subpart information regarding returning must display in the facility and provide to residents and ssion, oral and written ow to apply for and use caid benefits, and how to previous payments covered by must provide a notice of rights resident prior to or upon ing the resident's stay.	F 1	56			

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	-	AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245562	B. WING	i		01/	17/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 156	Continued From pa	ge 4	F 1	156			
		also provide the resident with d notice of Medicaid rights and					
		information, and any nust be acknowledged in					
	(g)(17) The facility r	nust					
	writing, at the time of	licaid-eligible resident, in of admission to the nursing e resident becomes eligible for					
	nursing facility serv	services that are included in ices under the State plan and ent may not be charged;					
	facility offers and fo	ms and services that the r which the resident may be mount of charges for those					
	changes are made	dicaid-eligible resident when to the items and services aphs (g)(17)(i)(A) and (B) of					
	before, or at the tim periodically during t available in the faci services, including	must inform each resident ne of admission, and the resident's stay, of services lity and of charges for those any charges for services not licare/ Medicaid or by the ate.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY PLETED
		245562	B. WING			01/1	7/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 IEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 156	and services covered Medicaid State plan notice to residents of reasonably possible (ii) Where changes items and services facility must inform 60 days prior to imp (iii) If a resident dies transferred and doe facility must refund representative, or e deposit or charges per diem rate, for the resided or reserved facility, regardless of discharge notice ref (iv) The facility must resident representat the resident within 3 date of discharge fr v) The terms of an a behalf of an individue facility must not cor these regulations. This REQUIREMEN by: Based on interview facility failed to ensi- reviewed for liability Notice of Medicare	in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e. are made to charges for other that the facility offers, the the resident in writing at least oblementation of the change. s or is hospitalized or is es not return to the facility, the to the resident, resident state, as applicable, any already paid, less the facility's ne days the resident actually or retained a bed in the of any minimum stay or quirements. tt refund to the resident or tive any and all refunds due 30 days from the resident's	F	56	DEFICIENCY)  Correction:  The policy and procedure for Issu of required Notice of Medicare Non-Coverage Center		
	10123, which inforn	ned residents of their rights to edited review of their Medicare			Medicare and Medicaid Services (CI Form 10123 was reviewed, and is cu	MS) urrent.	Page 6 of 43

Facility ID: 00432

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		COM	PLETED
		245562	B. WING			01/	17/2017
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 IEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	Continued From pa	age 6	F 1	156			
	coverage, 48 hours	s prior to discontinuation of the ich were covered by the			<ol> <li>Form 10123 for R57 was discus verbally with resident's daughter via telephone and a copy of the origina mailed via USPS.</li> </ol>	a	
	The ADMISSION RECORD dated 1/17/17, indicated R57 was admitted to the facility for skilled rehabilitation services covered by Medicare Part A that began on 7/28/16, and was discharged from physical therapy (PT) services on 8/19/16, when PT goals were partially met. R57 discharged from the facility on 8/23/16. R57 had not received the required notice, CMS Form 10123, 48 hours prior to discontinuation of the skilled services which were covered by the Medicare Part A benefit.				<ul> <li>3. "ABN Notification" has been add the Weekly Medicare meeting minu outline to ensure that notification ar documentation is given to resident resident's representative within 48 prior to discontinuation of the skiller services which are covered by the Medicare Part A benefit.</li> <li>Education:</li> </ul>	ute's nd and/or hours d	
	manager (BOM) ve Medicare part A be services at the facil had not received th 48 hours prior to dis	Part A benefit. , at 2:58 p.m. the business office BOM) verified R57 had received part A benefits while receiving skilled the facility. The BOM confirmed R57 seived the required CMS Form 10123, rior to discontinuation of the skilled nich were covered by the Medicare			<ol> <li>CMS Regulation and Policy and Procedure was reviewed with staff responsible for issuance of Form 1 on 01/31/17. (MDS Coordinator/ Business Office/Therapy Represen Audits:</li> <li>Audit of potentially affected current residents in the last 3 months who</li> </ol>	0123 Itative). ent	
	(DON) stated she e required 48 hour no discharged from sk Medicare Part A, so they wanted to app confirmed R57 had notice 48 hours prio	a.m. the director of nursing expected staff to give the otice when a resident is cilled services covered by the resident could choose if eal the decision. The DON not received the required or to discontinuation of the ich were covered by the nefit.			<ul> <li>on skilled services through Medical would have required an ABN, with correction of any identified as being compliance.</li> <li>2. Weekly audits x8 of current residence during weekly Medic meeting to be completed by the Dirr of Nursing.</li> </ul>	re and g out of dents care	
	confirmed R57 had notice 48 hours prio skilled services whi Medicare Part A be	I not received the required or to discontinuation of the ich were covered by the nefit. are Advance Beneficiary			as determined during weekly Medic meeting to be completed by the Dir	care rector urrent	

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		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245562	B. WING			01/1	17/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156 F 166 SS=D	Notice (SNF-ABN) 1/17/17, indicated ti and appropriate AB Notice) to the Media him/her of changes on the facility adher 483.10(j)(2)-(4) RIG TO RESOLVE GRII (j)(2) The resident fr must make prompt grievances the reside with this paragraph (j)(3) The facility mu to file a grievance of resident. (j)(4) The facility mu to ensure the prompt grievance the prompt regarding the reside paragraph. Upon re a copy of the grieva grievance policy mu (i) Notifying residen postings in promine facility of the right to (meaning spoken) of grievances anonymo of the grievance off can be filed, that is, address (mailing ar number; a reasonal completing the revisit to obtain a written of grievance; and the	Denial Notices policy, dated he facility would issue a timely N (Advance Beneficiary care beneficiary informing in Medicare coverage based rence to Federal regulations. AHT TO PROMPT EFFORTS EVANCES has the right to and the facility efforts by the facility to resolve dent may have, in accordance Ust make information on how or complaint available to the ust establish a grievance policy pt resolution of all grievances ents' rights contained in this equest, the provider must give ance policy to the resident. The		156	Nursing/designee. 4. Audits results will be brought to the Committee for review and recommendations on a quarterly based of the second	ısis.	2/17/17

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING			01/-	17/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 IEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	be filed, that is, the Quality Improvement Agency and State L program or protection (ii) Identifying a Grie responsible for over receiving and tracking conclusions; leading by the facility; main information associate example, the identifing grievances submitted written grievance de coordinating with st necessary in light of (iii) As necessary, ta prevent further poter right while the allege investigated; (iv) Consistent with reporting all alleged abuse, including inj and/or misappropriate anyone furnishing st provider, to the adm as required by State (v) Ensuring that all include the date the summary of the per regarding the reside as to whether the g	pertinent State agency, nt Organization, State Survey ong-Term Care Ombudsman on and advocacy system; evance Official who is rseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all ted with grievances, for ty of the resident for those ed anonymously, issuing ecisions to the resident; and ate and federal agencies as f specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately I violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and	F 1	66			

Facility ID: 00432

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		AND HUMAN SERVICES			FORM	: 02/08/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (X3) DAT	E SURVEY IPLETED
		245562	B. WING		01	/17/2017
NAME OF I	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	and the date the wr (vi) Taking appropr accordance with St of the residents' rig or if an outside enti the State Survey Ag Organization, or loc confirms a violation rights within its area (vii) Maintaining evi result of all grievan 3 years from the iss decision. This REQUIREMEN by: Based on observat review, the facility f by the facility to tho missing dentures h residents (R14) in t for personal proper Findings include: R14's annual Minim 10/14/16, indicated cognition and indica no natural teeth). R14's care plan dat no natural teeth, and dentures. R14's dental exam	as a result of the grievance, iitten decision was issued; iate corrective action in ate law if the alleged violation hts is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement cal law enforcement agency of for any of these residents' a of responsibility; and dence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced tion, interview and document ailed to ensure prompt efforts roughly investigate a report of ad been completed for 1 of 1 he facility that was reviewed ty. num Data Set (MDS) dated R14 had moderately impaired ated R14 was edentulous (had ted 2/8/16, indicated R14 had id wore upper and lower	F 1	66	Correction: 1. The policy and procedure for grievances management was reviewed and updated for compliance with current regulatory guidance. 2. Affected incident involving R14 - grievance investigation was initiated, completed and resolved to resident and family satisfaction per policy and procedure. 3. "Grievance/complaints/missing items" section added to daily IDT outline and any identified grievance/complaint/missing item reports will be reviewed during IDT. 4. Grievance/complaint/missing items	
	R14's dental exam	dated 1/7/16, indicated R14's ntures fit reasonably well.				

Facility ID: 00432

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245562 **B** WING 01/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOUTH TOUSLEY, PO BOX 188 **ELDERS HOME INC** NEW YORK MILLS, MN 56567 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 166 Continued From page 10 F 166 During observation on 1/11/17, at 6:40 p.m. R14 in prominent locations throughout the was provided a nutritional supplement by licensed facility for resident/family/visitor and staff practical nurse (LPN)-C, and it was noted R14's access. upper and lower dentures were not in place. On 1/12/17, at 9:14 a.m. R14 was observed eating Education: oatmeal and toast while seated in a wheelchair. and R14's upper and lower dentures were not in 1. Direct Care staff were provided and place. On 1/12/17, at 9:38 a.m. licensed practical educated on updated Policy and nurse (LPN)-A entered R14's room to administer Procedures for R14 a nutritional supplement. LPN-A did not grievance/complaint/missing items question why R14's upper and lower dentures management through Nursing Staff were not in place. On 1/13/17, at 9:51 a.m. meetings being held 02/01/2017 and activity assistant (AA)-A assisted R14 into the 02/08/2017. All other departments will be activity room, R14's upper and lower dentures educated on the updated policy and were not in place. On 1/17/17, at 9:53 a.m. R14 procedures on 02/15/17. was observed seated in a wheelchair in the hallway and did not have upper or lower dentures Audits: in place. 1. Weekly x8 weeks, random resident On 1/11/17, at 2:24 p.m. a telephone interview and family interviews will be conducted by was conducted with family member (FM)-A who Social Services designee. reported R14's upper and lower dentures had been missing for the past two months, and 2. Ongoing random audits will be confirmed she had informed a facility staff conducted monthly, x3 of member of the missing dentures at that time. resident/family/staff interviews completed FM-A could not recall which staff member she and reviewed by Social Service designee had reported the missing dentures to, and stated and quarterly QA meetings. the staff member did not seem to know what had happened to the dentures. FM-A confirmed the facility had not followed up regarding the missing dentures. On 1/12/17, at 9:30 a.m. family member (FM)-B was interviewed. FM-B reported R14's dentures went missing a month or more ago, and stated the facility was aware of it. FM-B stated the family reported the missing dentures right away to AA-A, and reported AA-A seemed helpful, and could understand why we were concerned. FM-B

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES			FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE	E SURVEY PLETED
		245562	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 166	also stated they told the missing denture member did not giv identify the name o missing dentures w reported R14 did w when she had them interviewed at the s and FM-C confirme and/or social service regarding R14's mission On 1/17/17, at 9:55 was the charge nur R14's care. LPN-A R14's upper and loo place, and confirme residents for dentur she was not aware and stated she had November of 2016. realize dentures are resident what could nursing assistants to before to interview On 1/17/17, at 9:58 confirmed she help 1/17/17. NA-B reported R14 was ab reported R14 was ab reported R14 was re dentures because to not sure how long to missing. NA-B statt R14's missing dent was aware they we	d another staff member about es, and stated, " that staff re a rip." FM-B was unable to f the second staff that the vere reported to. FM-B rear her dentures everyday n. Family member (FM)-C was same time as FM-B, both FM-B ed the facility administration ces had not approached them ssing dentures. 6 a.m. LPN-A confirmed she rese and also responsible for a stated she had not noticed wer dentures were not in ed she does not check re placement. LPN-A reported of R14's missing dentures, I been working with R14 since . LPN-A stated when staff e missing, staff initially ask the d have happened, then call the that were working the night them. 8 a.m. nursing assistant (NA)-B not deat independently. NA-B not wearing upper or lower they were missing, and was the dentures had been ted staff had searched for tures, and confirmed the facility	F 166			

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		AND HUMAN SERVICES			FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245562	B. WING		01/	17/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 166	(NA)-C confirmed F missing for over two was not the staff med dentures were miss R14's missing dent NA-C stated all mis to the nurse, then c missing item is initia service department On 1/17/17, at 10:0 (DON) was not awa and stated the nurs missing items, alert necessary, and upo department. On 1/17/17, at 10:0 was aware of R14's she thought they has she had reported the head nurse at that the On 1/17/17, at 10:1 designee (SSD) sta R14's missing dent when R14's family is conference. SSD r R14's dentures had months. The SSD employed by the far months, but was no protocols regarding SSD confirmed she of missing items fro employment began On 1/17/17, at 10:1	A14's dentures had been o months. NA-C stated she ember who initially realized the sing, and stated she thought ures had been reported. sing items are to be reported complete a search for the ated, and report to the social is made if needed. 66 a.m. the director of nursing are of R14's missing dentures be should look for any reported to ther departments as date the social service 99 a.m. AA-A confirmed she is missing dentures, and stated ad been found. AA-A stated he missing dentures to the time. 5 a.m. the social service ated she was not aware of ures until five minutes ago, informed her during care eported the family stated d been missing for the past two established she had been cility for greater than two of aware of any facility missing personal items. The a had not dealt with any reports om any residents since her	F 16			

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		AND HUMAN SERVICES			FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING		<b>01</b> / <sup>.</sup>	17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 166 F 225 SS=D	missing dentures. staff to report missi and the charge nurse missing items to the The DON stated the changes over the p confirmed there wa communication reg- dentures. A facility policy regative was requested, but 483.12(a)(3)(4)(c)(1 ALLEGATIONS/INE (a) The facility must (3) Not employ or of who- (i) Have been found exploitation, misappe mistreatment by a c (ii) Have had a findine nurse aide registry exploitation, mistreative misappropriation of (iii) Have a discipline or her professional body as a result of a exploitation, mistreative misappropriation of (4) Report to the Stalicensing authorities	The DON stated she expected ng items to the charge nurse, se was expected to report e social service department. e facility has had many staff ast few months, and s a break in the arding R14's missing arding missing personal items not provided. 1)-(4) INVESTIGATE/REPORT DIVIDUALS t- therwise engage individuals d guilty of abuse, neglect, propriation of property, or court of law; ing entered into the State concerning abuse, neglect, atment of residents or their property; or hary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or	F 166			2/17/17

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		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245562	B. WING	i		<b>01</b> / <sup>.</sup>	17/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	HOME INC			S	SOUTH TOUSLEY, PO BOX 188		
LEDENS				Ν	NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 14	F:	225			
	which would indicat nurse aide or other	e unfitness for service as a facility staff.					
		Illegations of abuse, neglect, treatment, the facility must:					
	abuse, neglect, exp including injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injury the events that caus abuse and do not re the administrator of officials (including to adult protective ser- for jurisdiction in lor accordance with Sta procedures.	alleged violations involving ploitation or mistreatment, unknown source and resident property, are ely, but not later than 2 hours is made, if the events that n involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established					
	thoroughly investiga						
	(3) Prevent further prevent further prevent further prevent further prevent for the second se						
	administrator or his representative and with State law, inclu Agency, within 5 wo if the alleged violatio corrective action mo	to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245562 B. WING 01/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOUTH TOUSLEY, PO BOX 188 **ELDERS HOME INC** NEW YORK MILLS, MN 56567 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 225 Continued From page 15 F 225 Based on interview and document review, the The facility will ensure that all allegations facility failed to ensure allegations of abuse and of abuse and injuries of unknown origin injuries of unknown origin were immediately are immediately reported to the State reported to the State agency (SA) and were agency and thoroughly investigated. thoroughly investigated for 3 of 4 residents (R7, R8, and R58) whose allegations of abuse Correction: incidents were reviewed. 1. The policy and procedure for Abuse Prevention, which includes the procedure Findings include: for reporting and investigation, was reviewed to ensure it is in compliance with current regulatory guidance. R7's admission Minimum Data Set (MDS) dated 12/21/16, indicated R7 was cognitively intact, 2. Affected incidents involving R7, R8, required extensive assist of one staff with and R58, were reviewed, investigated, activities of daily living (ADL's) and had diagnoses completed and documented to resident of anxiety and depression. and family satisfaction. 3. Abuse Prevention Policy and Procedure training is included in the New R7's current care plan dated 12/14/16, indicated R7 was a vulnerable adult related to Hire orientation process. communication, physical & cognitive impairment, and directed staff to engage resident in 4. Abuse Prevention Policy and conversation while providing cares, allow resident Procedure training included in yearly all to voice concerns or worries, establish a staff training schedule. relationship which encouraged resident to share difficulties and experiences. The care plan also 5. A daily IDT (Interdisciplinary indicated R7 had ADL self care performance Team)Review form has been created and deficit related to being used daily at morning standup. This developmentally/intellectually disabled, and includes grievances/complaints/concerns; required staff assistance with all ADL's incidents; falls; pressure sores; pain/comfort: resident change in condition; infections; behaviors; and Review of the CONCERN AND/OR COMPLAINT staffing concerns. REFERRAL FORM, dated 1/11/17, indicated licensed practical nurse (LPN)-A reported to social worker (SW) that nursing assistant (NA)-A Education: had slapped her last night. Further review of the CONCERN AND/OR COMPLAINT REFERRAL 1. All staff were provided and educated

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

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#### PRINTED: 02/08/2017 FORM APPROVED

	<u>TS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	ripi f (			0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245562	B. WING _			01/1	7/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				UTH TOUSLEY, PO BOX 188 W YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	FORM indicated on SW interviewed R7 her arm too hard ar indicated "NA-A is r with her, she is awf indicated to the SW tongue out at her, a provide any further cares or services. T COMPLAINT REFE indicated steps take complaints of NA-A	A 1/11/17, at 10:30 a.m. the Who indicated NA-A "grabbed and also slapped her." R7 mean to her and gets rough ful mean to me." R7 also What NA-A also stuck her and R7 did not want NA-A to assistance with personal The CONCERN AND/OR ERRAL FORM further en to investigate R7's alleged I's abuse, however, had not ad been immediately notified of	F 2:		on the current Policy and Procedu Abuse Prevention with focus on gr for reporting, procedure for reporti investigation process, on 02/01/17 Nurses, 02/08/17 for CNA's, and o 02/15/17 for all other disciplines. 2. Continuation of individual direc staff education at time of incident reporting guidelines and investigat process by DON/SW/designee if deficiencies are found. Audits:	uidelines ng and ' for on t care on	
	reviewed, and a VA not been made on allegations of abuse was found submitte 1/12/17. On 1/11/17 at 7:47 (DON) indicated sh allegations of abuse	p.m. the director of nursing was aware of R7's by NA-A, and confirmed the herein the state agency dated			<ol> <li>Nursing notes and risk manage notes in PCC are reviewed daily b DON and/or charge nurse. These then reviewed by the IDT team for additional information and follow u Administrator to keep daily notes of meetings in a binder and reviewed to ensure compliance of any repor concerns.</li> <li>Weekly x8 weeks of random and facility staff to ensure understanding the Abuse Prevention Policy and</li> </ol>	y the are p. of IDT I weekly table VA udits of	
	allegations of abuse On 1/12/17 at 11:22 confirmed she was allegations of abuse facility had not imm allegations of abuse	e to the state agency. 2 a.m. the administrator immediately notified of R7's e by NA-A, and confirmed the lediately reported R7's e to the state agency. unknown origin which was not			Procedure manual. Also weekly a IDT meeting notes to identify trend timely reporting, and investigating appropriately per policy and proce completed by the Director of Nurs 3. Monthly ongoing audits, x3 mo facility staff to ensure understandi Abuse Prevention Policy and Proce along with review of IDT meeting r weekly to identify trends, complete	dure dure ng. nths of ng of edure, notes	

Facility ID: 00432

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED
		245562	B. WING _		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 225	Continued From pa	age 17	F 22	25		
		ed to the SA or thoroughly		Director and Nursing, and report to QA Committee for review and recommendations.		
	was cognitively impassist of one or two	S dated 12/7/16, indicated R8 paired, required extensive o staff with ADL's, and had ure, manic depression, and				
	R8 was a vulnerab communication, ar impairment. The ca engage R8 in conv allow R8 to voice ca a relationship that difficulties and exp indicated R8 was ca tasks due to impain diagnoses of Alzhe dementia, arthritis, incontinence. The	care plan further indicated R8 related to severe cognitive &				
	12:00 a.m. indicate wheelchair by the r restless. R8's pers a.m. and R8 was fo floor in front of the indicated R8's pan blankets were four There were no witr identified. The repo	nent Report, dated 3/14/16, at ed R8 was seated in a hurses station due to being onal alarm sounded at 12:00 bund laying on back on the wheelchair. The report ts, incontinent brief, and hd down around the ankles. hesses of this incident brt indicated R8 had injuries eration near the right eye that				

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		AND HUMAN SERVICES				FORM	: 02/08/2017 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1)           PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:				LE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
245562		B. WING	i		01/17/2017		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ELDERS	B HOME INC				SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	measured 0.5 centi the forehead that m near the right eye/c cm x 3 cm, and R8' and painful with no indicated the medic attorney (POA) wer 3/14/16. Review of the nurse 10:38 a.m. indicate x-ray of the left ank X-ray the Perham h reported R8 had a c of the left ankle whi Further review of R the SA was not imm of unknown origin, a the aforementioned completed. On 1/13/17 at 10:07 had a unwitnessed the left ankle area. incident was not rep not here at the time the SA should of be out R8 had a fractu investigation should On 1/13/17 at 10:02 confirmed the SA h unwitnessed fall wit	age 18 imeters (cm), an abrasion of heasured 2 cm, an abrasion sheek area that measured 4 's left ankle was very tender bruising noted. The report cal doctor and the power of re notified of the incident on es notes dated 3/14/16, at d R8's POA agreed to have the due to pain. Following the hospital called at 3:15 p.m. and distal tibia and fibula fracture ich had been splinted. 's's medical record revealed nediately notified of R8's injury and a thorough investigation of d incident had not been 1 a.m. the DON Confirmed R8 fall and sustained fractures to The DON also verified the ported to the SA and she was a R8 fell. The DON confirmed een notified when they found the of her ankle and a d of been conducted. 3 a.m. the administrator ad not been notified of R8's th fractures and stated " yes reported." The administrator	F	225			

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CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI			FORM MB NO.	02/08/2017 APPROVED 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			i			PLETED
		245562	B. WING	i			01/	17/2017
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP C	DDE		
ELDERS	HOME INC				SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 225	also indicated that a unwitnessed fall wit reported immediate R58 reported an all during cares, and th investigate or repor the SA. R58's quarterly MD R58 was cognitively included: seizure di the cervical spine (r sensation to one sis staff to provide guid to assist with dress R58's care plan dat alert and oriented to assistance with dre abuse. The care pla to voice concerns o On 1/12/17, the fac Complaint," forms w report dated 11/24/ R58 reported an all therapy staff the mo identified therapy st abuse to the social then interviewed R5 R58 reported, "roug when staff assisted sweatshirt. R58 sta (11/25/16,) his neck report further indica	Any time there was an th a injury it needed to be ely and investigated. egation of rough treatment ne facility failed to thoroughly t R58's allegation of abuse to S dated 11/29/16, identified y intact, had diagnoses that sorder, sprain of ligaments of neck) with resulting decreased de of the body, and required ded maneuvering of the limbs ing. ted 12/6/16, identified R58 was o person, required extensive ssing, and was vulnerable to an directed staff to allow R58		225				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FC	TED: 02/08/2017 DRM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	245562		B. WING			01/17/2017		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	E		
ELDERS	HOME INC				SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	E (X5) COMPLETION DATE	
F 225	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 care of, and didn't want to get anybody in trouble. On 1/12/17, at 1:59 p.m. administrator stated she was aware R58 had complained of rough treatment and confirmed a facility, "Concern and/or Complaint Form," dated 11/25/16 had been completed. The administrator stated R58 was interviewed following the allegation and felt R58 rescinded the allegation, therefore determined R58's allegation of rough treatment would not be reported to the SA. The DON confirmed there was no documentation or follow up after R58 was interviewed. On 1/17/17, at 9:45 a.m. R58 was interviewed, and confirmed the allegation of rough treatment and stated he felt the nursing assistant (NA) lost her temper when she assisted with removing the sweatshirt because it was too tight. R58 stated, "I am telling the truth, I was treated roughly that night." R58 indicated he had most likely suffered a scratch on the back of the neck and stated, "I just didn't like it, I was trying to get ready for bed." R58 explained that the night of the incident he had fallen asleep when the NA finally came into his room to assist with evening cares, and felt the NA was in a big hurry to get done so she could go on her way. R58 stated the NA acted		F	225				
	overwhelmed and p assist after helping stated he didn't like night, and stated he upset with the treat thankful the NA left	viewed on 1/17/17, at 10:39						

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		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245562	B. WING	i		01/-	17/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 IEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	of rough treatment the DON and admin instructed the SSD complaint form. The to investigate R58's treatment, however assist R58 on 11/24 NA-D reported she investigation. The S NA-D's interview to thought she was do investigation, and the rest of the investigation, and the rest of the investigation, and the rest of the investigation of rough form was completed the SSD regarding policy and procedure allegations of abused should be immediat confirmed R58's all had not been report R58's allegation of criteria for reporting confirmed a vulnerat documentation and allegation of rough completed. The DON was inter a.m. and stated she she becoming await treatment on 11/25/ staff were rushed the apologetic and states stated NA-F, NA-E,	ge 21 er R58 reported the allegation on 11/24/16, the SSD spoke to histrator on 11/25/16, who to complete a concern and/or e SSD stated she called NA-D s allegations of rough 7, NA-D told her she did not 4/16, at 7:30 p.m. and stated had nothing else to add to the SSD stated she then reported the DON, and stated she one with her part of the ne DON would complete the ation. The SSD stated she had ything else related to R58's treatment after the concern d. During further interview with the facility's vulnerable adult re, the SSD stated any e including rough treatment ted to the SA, even though mistreatment met their policy g to the SA. The SSD able adult report or any further follow up related R58's treatment had not been	F	225			

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU			FORM MB NO.	02/08/2017 APPROVED 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			G		PLETED
		245562	B. WING	i		01/1	17/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	denied being rushe manner. The DON had not identified w evening cares. Add produce a thorough allegation of rough with the DON confin practice for address included the followi allegation of abuse, reported to the nurs information gatherin to the DON, who we allegation was report confirmed all report be reported right aw R58's allegation sh right away and conf further follow up wa allegation of mistre. The facility's Abuse 12/22/16, was revie individual has the ri sexual, physical, ar injuries of unknown the resident proper mistreatments, neg and financial or ma home employee or aware of abuse, mi misappropriations s nursing home admi administrator or des incidents of abuse a of unknown origin to	telephone and all of the NA's d or treating R58 in a rough had not interviewed NA-D, and which NA assisted R58 with litionally, the DON could not n investigation of R58's treatment. Further interview rmed the facilities customary sing allegations of abuse ng: after the resident made an , the allegation would be se, who would then do initial ng and report the information ould then determine if the ortable to the SA. The DON ts of rough treatment should way to the SA. The DON stated nould have reported to the SA firmed documentation and as not documented for R58's		225	5		

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		AND HUMAN SERVICES			FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING _	i	01/	17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
F 225 F 226 SS=D	directs the facility to investigation and ar abuse, neglect, inju financial exploitation 483.12(b)(1)-(3), 48 DEVELOP/IMPLME	o conduct a root cause nalysis of all allegations of iries of unknown origin, and n.	F 22 F 22			2/17/17
	written policies and	t develop and implement procedures that: went abuse, neglect, and				
	exploitation of resid resident property,	lents and misappropriation of				
	(2) Establish policie investigate any suc	es and procedures to h allegations, and				
	(3) Include training §483.95,	as required at paragraph				
	the freedom from a requirements in § 4	and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum				
		constitute abuse, neglect, isappropriation of resident h at § 483.12.				
		or reporting incidents of abuse, n, or the misappropriation of				
	(c)(3) Dementia ma	anagement and resident abuse				

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CENTE		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMEN	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING	ì		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 IEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 226	prevention. This REQUIREMEN by: Based on interview facility failed to ensu- were implemented injuries of unknown R8, and R58) whos incidents were revie Findings include: R7's admission Min 12/21/16, indicated required extensive activities of daily livi of anxiety and depr R7's current care p R7 was a vulnerabl communication, phy and directed staff to conversation while to voice concerns of	NT is not met as evidenced v and document review, the ure vulnerable adult policies for allegations of abuse and/or origin for 3 of 4 residents (R7, e allegations of abuse ewed.	F2	226	The facility will ensure that their we policies and procedures that prohit abuse, neglect, mistreatment and misappropriation of property are implemented and that all allegation abuse and injuries of unknown orig immediately reported to the State a and thoroughly investigated. The facility will ensure that all alleg of abuse and injuries of unknown or are immediately reported to the State agency and thoroughly investigated Correction: 1. The policy and procedure for At Prevention, which includes the pro- for reporting and investigation, was reviewed to ensure it is in compliar current regulatory guidance. 2. Affected incidents involving R7, and R58, were reviewed, investigat completed and documented to resi	bit os of jin are agency ations origin ate d. Duse cedure soce with R8, ted,	
	indicated R7 had Al deficit related to be developmentally/int	eriences. The care plan also DL self care performance ing ellectually disabled, and tance with all ADL's.			<ul> <li>and family satisfaction.</li> <li>3. Abuse Prevention Policy and Procedure training is included in th Hire orientation process.</li> </ul>	e New	
	REFERRAL FORM licensed practical n	CERN AND/OR COMPLAINT , dated 1/11/17, indicated urse (LPN)-A reported to that nursing assistant (NA)-A			<ol> <li>Abuse Prevention Policy and Procedure training included in year staff training schedule.</li> <li>A daily IDT (Interdisciplinary</li> </ol>	'ly all	

Facility ID: 00432

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245562 **B** WING 01/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOUTH TOUSLEY, PO BOX 188 **ELDERS HOME INC** NEW YORK MILLS, MN 56567 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 226 Continued From page 25 F 226 had slapped her last night. Further review of the Team)Review form has been created and CONCERN AND/OR COMPLAINT REFERRAL used daily at morning standup. This FORM indicated on 1/11/17, at 10:30 a.m. the includes grievances/complaints/concerns; SW interviewed R7 who indicated NA-A "grabbed incidents; falls; pressure sores; her arm too hard and also slapped her." R7 pain/comfort: resident change in indicated "NA-A is mean to her and gets rough condition: infections: behaviors: and with her, she is awful mean to me." R7 also staffing concerns. indicated to the SW that NA-A also stuck her tongue out at her, and R7 did not want NA-A to provide any further assistance with personal Education: cares or services. The CONCERN AND/OR COMPLAINT REFERRAL FORM further 1. All staff were provided and educated indicated steps taken to investigate R7's alleged on the current Policy and Procedure for complaints of NA-A's abuse, however, had not Abuse Prevention with focus on guidelines identified the State agency (SA) had been for reporting, procedure for reporting and immediately notified of R7's alleged allegations of investigation process, on 02/01/17 for Nurses, 02/08/17 for CNA's, and on abuse. 02/15/17 for all other disciplines. The vulnerable adult (VA) reports for R7 were 2. Continuation of individual direct care reviewed, and a VA report to the state agency had staff education at time of incident on not been made on 1/11/17, when R7 reported reporting guidelines and investigation allegations of abuse to LPN-A, rather a VA report process by DON/SW/designee if was found submitted to the state agency dated deficiencies are found. 1/12/17. Audits: On 1/11/17 at 7:47 p.m. the director of nursing 1. Nursing notes and risk management (DON) indicated she was aware of R7's notes in PCC are reviewed daily by the allegations of abuse by NA-A, and confirmed the DON and/or charge nurse. These are facility had not immediately reported R7's then reviewed by the IDT team for allegations of abuse to the state agency. additional information and follow up. Administrator to keep daily notes of IDT meetings in a binder and reviewed weekly On 1/12/17 at 11:22 a.m. the administrator to ensure compliance of any reportable VA confirmed she was immediately notified of R7's concerns. allegations of abuse by NA-A, and confirmed the facility had not immediately reported R7's 2. Weekly x8 weeks of random audits of allegations of abuse to the state agency. facility staff to ensure understanding of

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

Facility ID: 00432

PRINTED: 02/08/2017

		AND HUMAN SERVICES			FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING		01/ <sup>-</sup>	17/2017
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 226	Continued From participated accord immediately reported investigated accord R8's quarterly MDS was cognitively impleasist of one or two diagnoses of fracture Alzheimer. R8's current care p R8 was a vulnerable communication, and impairment. The care of a relationship that e difficulties and experindicated R8 was d tasks due to impair diagnoses of Alzhei dementia, arthritis, incontinence. The communication for the Risk Managem The Risk Managem Statement a stat	ge 26 unknown origin which was not ed to the SA or thoroughly ling to the facility policy. dated 12/7/16, indicated R8 aired, required extensive o staff with ADL's, and had re, manic depression, and lan dated 12/13/16, indicated e adult related to impaired d physical & cognitive ure plan directed staff to ersation while providing cares, oncerns/worries, and establish encouraged R8 to share eriences. The care plan ependent upon staff for ADL ed mobility secondary to imer 's disease, severe and functional care plan further indicated R8 related to severe cognitive &	F 226	DEFICIENCY)	udits of s of lure ng. ths of g of edure, otes d by the	
	restless. R8's perso a.m. and R8 was fo the floor in front of t	urses station due to being onal alarm sounded at 12:00 ound on the laying on back on the wheelchair. The report s, incontinent brief, and				

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		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMEN	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245562	B. WING	à		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 226	blankets were foun There were no with identified. The report that included a lace measured 0.5 cention the forehead that measured of the medic attorney (POA) wer 3/14/16. Review of the nurse 10:38 a.m. indicate x-ray of the left ank X-ray the Perham here reported R8 had a control of the left ankle which Further review of R the SA was immedited origin, and a thorout aforementioned income On 1/13/17 at 10:00 had an unwitnessed to the left ankle are incident was not report to the left ankle are incident was not report the SA should of be out R8 had a fracture investigation should	nge 27 d down around the ankles. lesses of this incident ort indicated R8 had injuries eration near the right eye that imeters (cm), an abrasion of heasured 2 cm, an abrasion sheek area that measured 4 's left ankle was very tender bruising noted. The report cal doctor and the power of re notified of the incident on es notes dated 3/14/16, at d R8's POA agreed to have le due to pain. Following the hospital called at 3:15 p.m. and distal tibia and fibula fracture ich had been splinted. 8's medical record revealed iately notified of R8's of known ogh investigation of the ident had not been completed. 1 a.m. the DON confirmed R8 d fall and sustained fractures a. The DON also verified the ported to the SA and she was a R8 fell. The DON confirmed een notified when they found are of her ankle and a d of been conducted. 3 a.m. the administrator	F	226			

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	H AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
	245562	B. WING	i		01/	17/2017
NAME OF PROVIDER OR SUPPLIE	7			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS HOME INC				SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
<ul> <li>unwitnessed fall v this should of bee also indicated tha unwitnessed fall v reported immedia</li> <li>R58 reported an a during cares and Vulnerable Adult F reporting to the S. thorough investigat</li> <li>R58 reported an a during cares, and investigate or reported the SA.</li> <li>R58's quarterly M R58 was cognitive included: seizure the cervical spine sensation to one a staff to provide gu to assist with dress</li> <li>R58's care plan d alert and oriented assistance with di abuse. The care p to voice concerns</li> <li>On 1/12/17, the fa Complaint," forms</li> </ul>	had not been notified of R8's with fractures and stated "yes in reported." The administrator t any time there is a with a injury it needs to be tely and investigated. Allegation of rough treatment the facility failed to follow their Policy related to the immediate A, and had not conducted a ation of alleged abuse. Allegation of rough treatment the facility failed to thoroughly ort R58's allegation of abuse to DS dated 11/29/16, identified ely intact, had diagnoses that disorder, sprain of ligaments of (neck) with resulting decreased side of the body, and required tided maneuvering of the limbs to person, required extensive ressing, and was vulnerable to blan directed staff to allow R58		226			

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		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245562	B. WING	à		01/ <sup>-</sup>	17/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	R58 reported an all therapy staff the mo- identified therapy sta abuse to the social then interviewed R5 R58 reported, "roug when staff assisted sweatshirt. R58 sta (11/25/16,) his neck report further indica were overwhelmed care of, and didn't w On 1/12/17, at 1:59 was aware R58 had treatment and confi and/or Complaint F been completed. TI was interviewed fol R58 rescinded the determined R58's a would not be report The interim director was no documentar interviewed. On 1/17/17, at 9:45 and confirmed the a and stated he felt th her temper when sI sweatshirt because am telling the truth, night." R58 indicate a scratch on the ba just didn't like it, I w R58 explained that	age 29 egation of "rough treatment" to brning of 11/25/16. The report taff reported the allegation of services designee (SSD), who 58. The report further indicated gh treatment," on 11/24/16, R58 with removing a ted the next morning was still sore/tender. The ated R58 realized facility staff and had lots of people to take want to get anybody in trouble. p.m. administrator stated she d complained of rough irmed a facility, "Concern form," dated 11/25/16 had he administrator stated R58 lowing the allegation and felt allegation, therefore allegation of rough treatment red to the state agency (SA). r of nurses confirmed there tion or follow up after R58 was 5 a.m. R58 was interviewed, allegation of rough treatment he nursing assistant (NA) lost he assisted with removing the it was too tight. R58 stated, "I I was treated roughly that ed he had most likely suffered ck of the neck and stated, "I vas trying to get ready for bed." the night of the incident he then the NA finally came into	F	220	6		

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		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245562	B. WING	_		<b>01</b> / <sup>.</sup>	17/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 IEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 226	his room to assist w NA was in a big hur on her way. R58 sta overwhelmed and p assist after helping stated he didn't like night, and stated he upset with the treatu thankful the NA left The SSD was interva a.m. and stated afte of rough treatment of the DON and admir instructed the SSD complaint form. The to investigate R58's treatment, however assist R58 on 11/24 NA-D reported she investigation. The S NA-D's interview to thought she was do investigation, and the rest of the investigation allegation of rough form was completed the SSD regarding for policy and procedur allegations of abuse should be immediati confirmed R58's all- had not been report allegation of mistreat for reporting to the source vulnerable adult report	with evening cares, and felt the ry to get done so she could go ated the NA acted probably had 10 residents to him get ready for bed. R58 the treatment received that a hadn't told the NA he was ment received, and was t the room and was gone. wiewed on 1/17/17, at 10:39 er R58 reported the allegation on 11/24/16, the SSD spoke to histrator on 11/25/16, who to complete a concern and/or e SSD stated she called NA-D s allegations of rough r, NA-D told her she did not 4/16, at 7:30 p.m. and stated had nothing else to add to the SSD stated she then reported the DON, and stated she one with her part of the he DON would complete the ation. The SSD stated she had bything else related to R58's treatment after the concern d. During further interview with the facility's vulnerable adult re, the SSD stated any e including rough treatment tely reported to the SA, and egation of rough treatment ted to the SA, although R58's atment met their policy criteria SA. The SSD confirmed a	F 2	26			

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		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245562	B. WING			01/ <sup>.</sup>	17/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa allegation of rough completed. The DON was inter a.m. and stated she she becoming awar treatment on 11/25/ staff were rushed th apologetic and state stated NA-F, NA-E, evening of 11/24/16 interviewed via the denied being rushe manner. The DON had not identified w evening cares. Add produce a thorough allegation of rough with the DON confir practice for address included the followin allegation of abuse, reported to the nurs information gatherir to the DON, who we allegation was repo confirmed all report be reported right aw R58's allegation sh right away. and cor further follow up wa allegation of mistres The facility's Abuse 12/22/16, was revie individual has the ri	ige 31 treatment had not been viewed on 1/17/17, at 11:01 e had interviewed R58 after re of the allegation of rough (16, and R58 reported facility hat night, and R58 was very ed he misspoke. The DON and NA-G worked the 5, and all 3 of NA's were telephone and all of the NA's d or treating R58 in a rough had not interviewed NA-D, and thich NA assisted R58 with litionally, the DON could not ninvestigation of R58's treatment. Further interview rmed the facilities customary sing allegations of abuse ng: after the resident made an , the allegation would be se, who would then do initial ng and report the information ould then determine if the ortable to the SA. The DON ts of rough treatment should way to the SA. The DON stated nould have reported to the SA nfirmed documentation and as not documented for R58's atment.	F 2	226			
		ght to be free from verbal , nd mental abuse, (including					

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM	): 02/08/2017 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245562	B. WING	01	/17/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
ELDERS	HOME INC			OUTH TOUSLEY, PO BOX 188 IEW YORK MILLS, MN 56567	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 F 253 SS=E	the resident propert mistreatments, neg and financial or ma home employee or aware of abuse, mi misappropriations s nursing home admi administrator or des incidents of abuse a of unknown origin to and federal required directs the facility to investigation and ar abuse, neglect, inju financial exploitation 483.10(i)(2) HOUSI SERVICES (i)(2) Housekeeping necessary to mainta comfortable interior This REQUIREMEN by: Based on observat review, the facility fa housekeeping and provided for 17 of 2 Rm201, Rm228, Rr Rm316, Rm314, Rr Rm315, Rm202, Rr Rm304) observed v Findings include:	source, misappropriation of ty, corporal punishment, lect, involuntary seclusion, terial exploitation.) Any nursing volunteer who becomes streatment, neglect, or shall immediately report to nistrator. The nursing home signee will immediately report and neglect including injuries o the state agency per state ments. Additionally, the policy o conduct a root cause nalysis of all allegations of ries of unknown origin, and n. EKEEPING & MAINTENANCE g and maintenance services ain a sanitary, orderly, and ", NT is not met as evidenced tion, interview and record ailed to ensure adequate maintenance services were 8 resident rooms (Rm306, m222, Rm203, Rm212, m214, Rm217, Rm308, m211, Rm301, Rm208, with environmental concerns.	F 226	The facility has housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The following repairs will be made: Corrections: Room 306 - bathroom faucet will be replaced. Room 201 - black marks above the bed will be removed, and nail holes above the	
	On 1/13/17, at 1:57	p.m. an environmental tour of			

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						MB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
		245562	B. WING			01/17/2017
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO
F 253	Continued From pa	ae 33	F 2	53		
	the facility was con assistant (MA)-A ar	ducted with maintenance nd the housekeeping Both MA-A and HS-A			bathroom walls will be repaired and painted, and the facet will be replaced and the facet wil	
	confirmed the follow	wing findings:			Room 228 - the bathroom door will repaired and stained, bathroom fau be replaced.	
	build up	om faucet had thick lime scale			Room 222 - bathroom faucet will b replaced and the wall to the right o	
	of 1-2 feet in diame	Il next to the bed had an area eter with several black marks			sink repaired and painted.	will be
	and nail holes above the bed. The bathroom wal had several nails and nail holes present and the faucet had thick lime scale build up with black spots present.	nd nail holes present and the			Room 203 - wall marks by the bed removed, bathroom wall area with glue like substance will be removed bathroom faucet will be replaced.	yellow
		throom door had several large nissing. Thick lime scale build e bathroom faucet.			Room 212 - bathroom faucet will b replaced.	
	and the paint on the	throom faucet had corrosion e wall to the right side of the			Room 316 - wall around the outlet the bed will be painted.	
	sink was cracking a				Room 314 - grout around the toilet replaced.	will be
	black scrape marks area approximately	Il near the bed had several 5. The bathroom wall had an 8 X 10 inches with yellow glue sent. Thick lime scale build up			Room 214 - bathroom faucet will b replaced.	e
	was noted on the fa	aucet. The faucet was dripping.			Room 217 - bathroom faucet will b replaced and the bathroom floor sa and varnished.	
	and had thick lime was dripping.	scale build present. The faucet			Room 308 - bathroom faucet will b replaced.	e
	around the outlet no				Room 303 - bathroom faucet will b replaced.	e
		out around the toilet was brown/black substance was			Room 315 - grout around the floor	will be

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	OF DEFICIENCIES					<u>10. 0938-0</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
		245562	B. WING _			01/17/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
ELDERS	HOME INC				DUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
F 253	Continued From pa	ige 34	F 25	3		
	observed in severa	-			replaced and remove dark brown/black	
					substance observed in several areas.	
	-Room 214, the bat and thick lime scale	throom faucet had corrosion			Room 202 - bathroom faucet will be	
		e build up.			replaced, grey spotted area on floor in	
		throom faucet had corrosion			front of toilet sanded and varnished.	
		e build up. R18's bathroom			Design Odd, the like second for each little s	
	floor had dark stain	is near the tollet.			Room 211 - bathroom faucet will be replaced.	
	-Room 308, the bat scale present.	Room 308, the bathroom faucet had thick lime cale present.			Room 301 - bathroom faucet will be	
	-Boom 303 the bai	throom faucet had thick lime			replaced.	
	scale present.				Room 208 - bathroom faucet will be replaced, grout around the toilet.	
	-Room 315, The g	rout around the floor was				
	peeling and a dark observed in severa	brown/black substance was I areas.			Room 304 - bathroom faucet will be replaced, and bathroom doorknob replaced.	
	-Room 202, the bat	throom faucet had thick lime				
		Grey spotted area			Education:	
	approximately 1 foo in front of the toilet.	ot in diameter was on the floor			Housekeeping and Maintenance Direct	
	-Room 211, the bat scale was present.	hroom faucet had thick lime			conducted a mandatory in-service for a Housekeeping, Laundry and Maintenan staff on 02/02/17 to review the survey	
	-Room 301, the bat	throom faucet had thick lime			results. Housekeeping staff were in-serviced on the requirement that they	/
	scale was present.				report any maintenance and/or safety concern to the Maintenance Departmer	
		throom faucet had thick lime			by completing the newly created	
		A dark brown/black			Housekeeping Audit tool on a daily basi	S.
	grout around the to	d in several places on the ilet.			The housekeeping audit tool will be reviewed by the Housekeeping Director who will then write all repairs in the	,
	-Room 304. the bat	throom faucet had thick lime			who will then write all repairs in the Maintenance log book located at the	
		The bathroom doorknob was			nurses' station. Maintenance will check daily for repairs, and reviewed by the Administrator monthly.	

Facility ID: 00432

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		AND HUMAN SERVICES			Pr		APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245562	B. WING			<b>01</b> /1	7/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION DATE
F 253	Continued From pa	ge 35	F 2	253			
	During the tour, at 1	1:57 p.m. MA-A verified the			Audits:		
		stated he was unaware of					
		A-A indicated the maintenance			1. Weekly audits, x8 by housekeep		
		tified of concerns by the ept at the nurses desk. He			staff using the Housekeeping Audit Audits will be turned in daily.	1001.	
	stated they checked	d this daily, often 2-3 times per			Housekeeping Director will review of		
		d staff also notified them of MA-A indicated he did not			and track in the Maintenance log w repairs or safety concerns are note		
		le for painting walls, however,			Maintenance will review daily and		
		rector, who was not present at			complete repairs in a timely manne		
		ave one written down also confirmed the findings			Administrator will review and condu random audits to visually inspectior		
	and stated the facili	ity utilized a light acid cleaner			rooms, and the facility on a weekly	basis,	
		throom cleaner and tried to do to keep the lime scale from			along with the audit documentation accuracy and completion.	tool for	
	building up.				accuracy and completion.		
					2. Monthly audits, x3 by housekeep		
	During interview on	1/13/17, at 2:30 p.m. the			staff using the Housekeeping Audit with above protocol, conducting mo		
	administrator verifie	ed the housekeeping staff tried			audits by the Administrator. Finding	gs will	
		could to keep lime scale			be reported to the QA committee qu	Jarterly	
		ninistrator indicated some of replaced as needed, but			for review and recommendations.		
	they were unable to	replace them all at once.					
		ndicated at this time, there n was in place to replace the					
	faucets.	i was in place to replace the					
	On 1/17/17. at 2:13	p.m. the maintenance log					
	was reviewed from	August 2016, to current date.					
	The aforementioned on the maintenance	d findings were not identified					
	on the maintenality						
	Review of facility po	blicy titled, Maintenance Repair					
		directed staff to notify the transmission tensor tenso					

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PRINTED: 02/08/2017

		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING			01/	17/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 IEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253 F 283 SS=D	services by docume the "Maintenance L be written unless er equipment or hazar standards, in those notify the maintenan Review of facility po Policies and Procect housekeeping staff rooms daily. It also staff to examine the repairs needed to b note on clipboard o maintenance depar 483.21(c)(2)(i)-(iii) A RECAP STAY/FINA (c)(2) Discharge Su When the facility ar must have a discha but is not limited to, (i) A recapitulation of includes, but is not of illness/treatment radiology, and cons (ii) A final summary include items in par the time of the discl release to authorize	enting on request slips, kept in log Book". All requests must mergency repairs to vital dous violations to safety cases staff are directed to nce director immediately. Dicy titled, Housekeeping dures, undated, directed the to clean sinks in resident of directed the housekeeping e resident rooms for any be done while cleaning and n cart to be reported to tment. ANTICIPATE DISCHARGE: AL STATUS ummary thicipates discharge, a resident arge summary that includes, the following: of the resident's stay that limited to, diagnoses, course or therapy, and pertinent lab, sultation results. To the resident's status to ragraph (b)(1) of §483.20, at harge that is available for ed persons and agencies, with resident or resident's	F 2				2/10/17

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	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) MI II				0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		245562	B. WING	i		01/1	7/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC				SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 283	<ul> <li>medications with the resident's post-discharge medications (both prescribed and over-the-counter).</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on interview and document review, the facility failed to complete a discharge summary and recapitulation of the resident's stay for 3 of 3 residents (R1, R9, R35) reviewed for death in the facility.</li> <li>Findings include:</li> <li>R1 had expired while in the facility in January 2017. R1's medical record lacked a discharge summary which included a recapitulation of the residents stay that included but was not limited to: diagnoses, course of illness/treatment or therapy and pertinent lad, radiology and consultation results.</li> </ul>		F 2	283	When the facility anticipates discharge resident will have a discharge summa that includes a recapitulation of reside stay, final summary of the resident's status at the time of discharge, and reconciliation of all pre-discharge and post-discharge medications. Correction:	ary ent's	
					<ol> <li>The policy and procedure for Discharge Summary and Recapitulation reviewed and updated to ensure compliance with current regulatory guidance.</li> <li>Affected discharge files involving F R9, and R25 were reviewed and discharge summary/recapitulation for completed and forwarded to their Print</li> </ol>	R1, ms	
	R9's medical record which included a re stay that included b diagnoses, course and pertinent lad, ra results.	bired in the facility in August 2016. cal record lacked a discharge summary ided a recapitulation of the residents cluded but was not limited to: , course of illness/treatment or therapy ent lad, radiology and consultation			<ul> <li>MD for review and signature.</li> <li>3. Audit of all discharge charts in the six (6) months for missing discharge summary/recapitulation forms. Any for to be deficient will be reviewed and discharge summary/recapitulation form completed and forwarded to MD for review and signature.</li> </ul>	last ound	
	summary which inc residents stay that i diagnoses, course	rd lacked a discharge luded a recapitulation of the included but was not limited to: of illness/treatment or therapy adiology and consultation			4. Discharge summary/recapitulation forms reviewed and updated to includ required information per current regul guidance.	le	

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		& MEDICAID SERVICES				<u>). 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY
		245562	B. WING _		0 <sup>.</sup>	1/17/2017
NAME OF I	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	
ELDERS	HOME INC				DUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 283	Continued From pa results.	ge 38	F 2	83		
(             					5. Discharge summary/recapitulation forms added to discharge checklist.	
	On 1/17/17, at 10:49 a.m. licensed practical nurse (LPN-B) confirmed she signed R1, R9 and R35's discharge summary forms, and confirmed all				Education:	
	lacked a recapitula She stated she nor admission informat	entioned medical records tion of their stay in the facility. mally included resident's ion, admission diagnoses, and a synopsis of their facility ge summary form.			1. Policy, Procedure and Regulatory Guidance education completed with staff responsible completion of discharge summary and recapitulation forms (responsible party MDS Coordinator).	
	(DON) confirmed L R35's discharge su they lacked admittin whether they receiv in status. She state needed to be more told a story of the ti facility. She stated	1 a.m. the director of nurses PN-B signed R1, R9 and mmary forms, and confirmed ng diagnoses, a summary of red therapy or not, and decline d the discharge summary complete and should have me period they were in the she would expect staff to h and timely discharge discharge.			<ol> <li>Audits:</li> <li>Weekly audits x8 for all new discharged resident charts by the MDS Coordinator.</li> <li>Monthly random audits x3 of discharged charted by MDS coordinator t ensure compliance. Monitored and reviewed by QA committee quarterly.</li> </ol>	o
F 441 SS=E	Summary Form Ins would complete a s at the facility upon of 483.80(a)(1)(2)(4)(0 PREVENT SPREA	Discharge and Recapitulation tructions," identified the facility ummary of the resident's stay discharge from the facility. e)(f) INFECTION CONTROL, D, LINENS	F 4	41		2/24/17
		tablish an infection prevention n (IPCP) that must include, at				

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		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		STRUCTION		(X3) DATE	E SURVEY PLETED
		245562	B. WING _	 		01/ <sup>.</sup>	17/2017
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COI	DE	-	
ELDERS	HOME INC			TOUSLEY, PO BOX 188 ORK MILLS, MN 56567			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 441	<ul> <li>investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin accepted national s implementation is F</li> <li>(2) Written standard for the program, wh limited to:</li> <li>(i) A system of surv possible communic before they can spr facility;</li> <li>(ii) When and to wh communicable dise reported;</li> <li>(iii) Standard and tr to be followed to pro- (iv) When and how resident; including to (A) The type and du depending upon the involved, and (B) A requirement to</li> </ul>	owing elements: eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual d upon the facility assessment og to §483.70(e) and following standards (facility assessment Phase 2); ds, policies, and procedures nich must include, but are not reillance designed to identify eable diseases or infections read to other persons in the nom possible incidents of ease or infections should be ransmission-based precautions event spread of infections; isolation should be used for a	F 44	 DEFICIENCY)			

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		AND HUMAN SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING			01/*	17/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	• .,	
ELDERS	HOME INC				OUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	must prohibit emplo disease or infected contact with resider contact will transmi (vi) The hand hygie by staff involved in (4) A system for rec under the facility's I actions taken by the (e) Linens. Person process, and transp spread of infection. (f) Annual review. annual review of its program, as necess This REQUIREMEN by: Based on observat review, the facility fi communally used b to prevent the poss blood-borne pathog one resident (R32) affect 5 residents w Findings include: On 1/12/17, at 11:2 (LPN)-A was observed	ces under which the facility byees with a communicable skin lesions from direct the disease; and ne procedures to be followed direct resident contact. cording incidents identified PCP and the corrective e facility. nel must handle, store, port linens so as to prevent the The facility will conduct an IPCP and update their	F 4	141	The facility will properly disinfect bl glucose monitors in order to preven possible transmission of blood-born pathogens before and after use who glucometer's are shared. Correction: 1. R32 blood glucose monitor was cleansed per policy on 01/12/17 and was educated on proper procedure 2. Facility has created a new Gluco Policy which instructs each resident have their own individual glucometer	t the en d LPN ometer t will	
	monitor labeled Ass the medication cart					er	

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	OF DEFICIENCIES	KANDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	( )	PLE CONSTRUCTION G		E SURVEY PLETED
		245562	B. WING		01/-	17/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 441	the glucometer and blood from R32's fi glucose test using After she complete LPN-A returned to obtained an alcoho down the blood glu on the cart for 1-2 into the medication During interview or confirmed the facili glucose monitor for required blood gluc LPN-A stated her p glucose monitor be down with an alcoh back to the drawer During interview or director of nursing glucose monitor wa	d proceeded to draw a drop of nger and performed the blood the blood glucose monitor. d the blood glucose test, the medication cart and I swab and began to wipe cose monitor then laid it down minutes then placed it back	F 44	<ol> <li>use per manufacturer guidelines.</li> <li>Education:         <ol> <li>All RN's, LPN's, and TMA's will educated on the new Glucometer with competency by 02/24/17 by it in-service training.</li> </ol> </li> <li>Audit:         <ol> <li>Infection Control Nurse is resp for assigning the blood glucose m to new and current residents. An tracking system has been implem This system tracks the machines assigned to each resident by seria number. In addition, a process for tracking Quality Assurance has be implemented. This will also be m by the Infection Control Nurse. If is determined to not be within con limits, it will be removed from use new machine issued to that reside new machine serial number will b</li> </ol></li></ol>	Policy ndividual onsible achines neter ented. al r sen onitored a meter trol and a ent. The	
	she expected staff proper disinfection between residents. procedure, she sta should be disinfect cover the machine should be set out, I give specific details working on policies per manufactures r and auditing compl	to follow facilty policy on of blood glucose monitors When asked of specific ted the blood glucose monitor ed with a specific type of wipe, with the wipe and then it out she stated she could not s. She stated they were a for blood glucose monitors recommendations for cleaning liance, but the goal date for the a was set for 1/20/17, therefore		<ul> <li>documented on the meter tracking Monthly the machine serial number resident names will be verified by Control Nurse.</li> <li>2. Audit weekly x8, those individu completing blood glucose testing competency by direct supervision completed by the Director of Nurse</li> <li>3. Monthly x3, random blood gluco testing of staff competency by direct observation completed by the Director of Nurse</li> </ul>	g form. er's and Infection lals for ing. cose ect ector of	

Facility ID: 00432

		AND HUMAN SERVICES			FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245562	B. WING		01/ <sup>.</sup>	17/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Assure Prism Multi instruction sheet, A identified the meter procedure complete of blood-borne path disinfectant produc number of 67619-1 The procedure inclu of the meter 3 times vertically to remove the towelette. Allow minute, then wipe the On 1/13/17, a policy blood glucose mon	ge 42 nsing and Disinfecting your Blood Glucose Meter System rkray USA, dated 01/15, must have a disinfection ed to prevent the transmission nogens. It stated any t with the EPA registration 2 may be used on the devise. uded wiping the entire surface s horizontally and 3 times blood-born pathogens with v exterior to remain wet for 1 he meter using a dry cloth. y on cleansing and disinfecting itors shared by residents was facility did not provide a	F 441			

		& MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 7	E CONSTRUCTION 01 - 01 main building	(X3) DAT COM	E SURVEY
		245562	B. WING		01/	/11/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP C	ODE	
ELDERS	HOME INC			OUTH TOUSLEY, PO BOX 188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	rs	K 000			
	ALLEGATION OF C DEPARTMENTS A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT CONDUCTED TO					
	REGULATIONS HA ACCORDANCE W A Life Safety Code	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. Survey was conducted by the nent of Public Safety. At the				
	compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National (NFPA) Standard 1 Chapter 19 Existing	Elders Home was found not in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care and the 2012 h Care Facilities Code (NFPA				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY		EDO	C	
	HEALTH CARE FIR STATE FIRE MARS 444 CEDAR STRE ST. PAUL, MN 551	SHAL DIVISION ET, SUITE 145		EFU		
	By e-mail to:					

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 provide. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES				FORM	02/06/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - 01 MAIN BUILDING	(X3) DATE COM	E SURVEY PLETED
		245562	B. WING			01/1	11/2017
NAME OF	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·		EET ADDRESS, CITY, STATE, ZIP CODE		*:
ELDERS	HOME INC				UTH TOUSLEY, PO BOX 188 W YORK MILLS, MN 56567		
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/or responsible for comprevent a reoccurre Elders Home is a 1 basement. The origin 1959 and was de construction. In 199 the south that was (111). In 1999 an a Dinning Room to the The building is divided by 30 minut The facility was sur the lack of a 2 hour types of construction Safety Code section structure meets the The building is fully accordance with N Installation of Autor	tate.mn.us m@state.mn.us RRECTION FOR EACH TT INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency.	KO	00			

If continuation sheet Page 2 of 7

		E & MEDICAID SERVICES			ſ	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 01 - 01 MAIN BUILDING		E SURVEY PLETED
		245562	B. WING		01/1	11/2017
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LDERS	HOME INC			SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	accordance with N Alarm Code". Othe automatic fire dete have single smoke operated. The facility has a c census of 33 at the	artment notification, installed in IFPA 72 "The National Fire er hazardous areas have ectors. The sleeping rooms e detectors that are battery capacity 48 beds and had a e time of the survey. at 42 CFR, Subpart 483.70(a) is	K 000	D	1.8	
K 223 SS=E	Doors with Self-Cl Doors in an exit pa or horizontal exit, a area enclosure are closed position, ur device complying closes all such do compartment or et * Required manua * Local smoke det smoke passing the smoke detection s * Automatic sprink * Loss of power. 18.2.2.2.7, 18.2.2. This STANDARD Based on observe facility failed to pro on hazardous roor Safety Code (NFP deficient practice of corridor making it This could affect 7	assageway, stairway enclosure, smoke barrier, or hazardous e self-closing and kept in the aless held open by a release with 7.2.1.8.2 that automatically ors throughout the smoke ntire facility upon activation of: I fire alarm system; and ectors designed to detect rough the opening or a required	K 22	<ul> <li>The facility will provide the require closer's on hazardous rooms as st the 2012 Life Safety Code.</li> <li>Correction:</li> <li>Self-closing hinges for the door two storage rooms have been order</li> </ul>	ated in s on	2/28/17

Facility ID: 00432

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1 · · ·	NG 01 - 01 MAIN BUILDING		PLETED
		245562	B. WING		01/*	11/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
ELDERS	HOME INC		121	SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
K 223	Continued From pa	age 3	K 22	23		
	Findings include:			02/01/17, and will be installed rooms #47 and #29.	in storage	
	On the facility tour between 9:00 am to 1:00 pm on 01/11/2017 observations and staff interview revealed two storage rooms over 50 square feet,			2. Completion date for the ins be complete by 02/28/2017.	tallation will	
		t have self closer's.		Education:		
	This deficient cond Director of Mainter	lition was confirmed by the nance.		1. Maintenance director has a 2012 Life Safety Code manual required education concerning self-closer's on hazardous roo skilled nursing facilities.	l for the	
			đ	2. Maintenance director is re- ordering, installing, and maint self-closing hinges.		
				Audits:		
				1. Audits will be completed m closures are in good working added to the Maintenance Pre monthly check list.	order and	
	NFPA 101 Sprinkle Testing	er System - Maintenance and	K 3	53		2/3/17
	Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, insp	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily				

Facility ID: 00432

If continuation sheet Page 4 of 7

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE	0938-039 SURVEY PLETED
		245562	B. WING		1/2017
IAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE SOUTH TOUSLEY, PO BOX 188	
LDERS	HOME INC			NEW YORK MILLS, MN 56567	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 353	Continued From pa b) Who provided s	_	K 353	3	
	c) Water system s	upply source			
	any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This STANDARD is Based on observat facility failed to mai accordance with the (NFPA 101) and NF standard for testing systems. This defice sprinkler system no allow for the spread	KS information on coverage for r partial automatic sprinkler and NFPA 25 s not met as evidenced by: tion and staff interview, the ntain the sprinkler system in e 2012 Life Safety Code PA 25 section 5.2.1.1.2. The and maintenance of sprinkler itent condition could cause the ot to function properly and d of fire. This could affect an unt of residents, staff and		The facility will maintain the sprinkler system in accordance with the 2012 Life Safety Code so they remain free from lint. Correction: 1. The sprinkler heads in the kitchen dish washing area and laundry room have been cleaned as of 01/12/17. Education:	
	on 01/11/2017 obse revealed a two spri	between 9:00 am to 1:00 pm ervations and staff interview nkler heads covered in lint. dish washing area and one in		<ol> <li>Maintenance Director reviewed the 2012 Life Safety Code manual for the standard for testing and maintenance of the sprinkler systems.</li> <li>Audits:</li> </ol>	
	This deficient cond Director of Mainten	ition was confirmed by the ance.		<ol> <li>Maintenance Director is responsible for keeping the sprinkler heads clean.</li> <li>Inspection of the sprinkler heads has been added to the Daily Preventive Maintenance checklist and reported to the Administrator of any concerns or issues</li> </ol>	
K 521 SS=C	NFPA 101 HVAC		K 52	on a monthly basis. 1	1/26/17

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE	CONSTRUCTION (X3) D	O. 0938-0391 ATE SURVEY OMPLETED
ND PLAN (	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILC	0 NG 0	1 - 01 MAIN BUILDING	JWIFLETED
		245562	B. WING			1/11/2017
	PROVIDER OR SUPPLIER			sc	REET ADDRESS, CITY, STATE, ZIP CODE DUTH TOUSLEY, PO BOX 188 EW YORK MILLS, MN 56567	
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 5 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2		K	521		
	Based on observa facility failed to main throughout all reside 2012 Life Safety Co and NFPA 91 Stand Air Conveying of Va Noncombustible Pa This deficient pract of the 33 residents of staff and visitors Findings include: On the facility tour on 01/11/2017 observe revealed the bathroor rooms were not op	ice could negatively affect all and an undetermined amount between 9:00 am to 1:00 pm ervations and staff interview bom exhaust in the resident erable. ition was confirmed by the			<ul> <li>The facility will maintain proper exhaust throughout all residents wings as required by the 2012 Life Safety Code.</li> <li>Correction: <ol> <li>The exhaust system motor was rebut and new belts were installed at the same time and is in working order as of 01/26/17.</li> <li>All resident bathroom exhaust system are presently working.</li> </ol> </li> <li>Education: <ol> <li>Maintenance Director reviewed the 2012 Life Safety Code for proper exhaut maintenance throughout all residents wings, (reviewed at time of installation).</li> </ol> </li> <li>Audits: <ol> <li>Maintenance Director is responsible maintenance of the exhaust system.</li> </ol> </li> </ul>	ed ilt e ns st

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT COM	0938-039 E SURVEY
	245562	174		01/	11/2017
			STREET ADDRESS, CITY, STATE, ZIP CODE		11/2017
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETIO DATE
Continued From p	bage 6	K 52′			
			exhaust performance.		
ri -					
	HOME INC SUMMARY S (EACH DEFICIENT REGULATORY OR	PROVIDER OR SUPPLIER	DF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245562       B. WING         PROVIDER OR SUPPLIER       B. WING         HOME INC       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING 01 - 01 MAIN BUILDING         245562       B. WING	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING 01 - 01 MAIN BUILDING       COM         245562       B. WING       01/         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       01/         HOME INC       STREET ADDRESS, CITY, STATE, ZIP CODE       SOUTH TOUSLEY, PO BOX 188         NEW YORK MILLS, MN 56567       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID       PREFIX       CACOSS-REFERENCED TO THE APPROPRIATE         DEFICIENCY OR LSC IDENTIFYING INFORMATION)       K 521       exhaust performance.       2. Random audits will be conducted weekly x8 for proper exhaust in resident



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 25, 2017

Ms. Lyn Sebenaler, Administrator Elders Home Inc South Tousley, PO Box 188 New York Mills, Minnesota 56567

Re: State Nursing Home Licensing Orders - Project Number S5562026

Dear Ms. Sebenaler:

The above facility was surveyed on January 10, 2017 through January 17, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Elders Home Inc January 25, 2017 Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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

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

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

Sincerely,

mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesc	ta Department of He	alth	-			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		00432	B. WING		01/1	7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELDERS	HOME INC		OUSLEY, PO K MILLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Dep Determination of with corrected requires requirements of the number and MN Ru When a rule contait comply with any of lack of compliance. re-inspection with a result in the assess that was violated during the survey of the the survey of the survey of the survey of the survey of the the survey of the surv	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 02/03/17
	ioany orgineu					52/00/17

If continuation sheet 1 of 32

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	ATE, ZIP CODE		
ELDERS	HOME INC		OUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proo completion date, the corrected prior to el Minnesota Departm On January 10th, 1 surveyors of this De above provider and orders are issued. electronic plan of co	11th, 12th, 13th and 17th 2017 epartment's staff, visited the the following correction Please indicate in your orrection that you have ers, and identify the date wher				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement, evidence by." Follow are the Suggested Time period for Cor	RD THE HEADING OF THE				

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	NT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		e survey IPleted
		00432	B. WING		01/	17/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ELDERS	HOME INC		FOUSLEY, P RK MILLS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 680	MN Rule 4658.0465 and Death: Dis. Su	5 Subp. 1 Transfer, Discharge Immay	, 2 680			2/10/17
	a resident dies, the	ge summary at death. When nursing home must compile a / that includes the date, time,				
	by: Based on interview facility failed to com and recapitulation of	ent is not met as evidenced and document review, the pplete a discharge summary of the resident's stay for 3 of 3 R35) reviewed for death in the		Corrected		
	Findings include:					
	2017. R1's medica summary which inc residents stay that diagnoses, course	le in the facility in January I record lacked a discharge luded a recapitulation of the included but was not limited to of illness/treatment or therapy adiology and consultation	:			
	R9's medical record	he facility in August 2016. I lacked a discharge summary capitulation of the residents	,			

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ELDERS	HOME INC		FOUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 680	Continued From pa	age 3	2 680			
	diagnoses, course	out was not limited to: of illness/treatment or therapy adiology and consultation				
	R35's medical reco summary which inc residents stay that diagnoses, course	the facilty in September 2016. ord lacked a discharge cluded a recapitulation of the included but was not limited to of illness/treatment or therapy adiology and consultation	:			
	(LPN-B) confirmed discharge summary three of the aforem lacked a recapitula She stated she nor admission informat	9 a.m. licensed practical nurse she signed R1, R9 and R35's y forms, and confirmed all entioned medical records tion of their stay in the facility. mally included resident's ion, admission diagnoses, and a synopsis of their facility ge summary form.	9			
	(DON) confirmed L R35's discharge su they lacked admittin whether they receiv in status. She state needed to be more told a story of the ti facility. She stated	1 a.m. the director of nurses PN-B signed R1, R9 and immary forms, and confirmed ng diagnoses, a summary of ved therapy or not, and decline ed the discharge summary complete and should have me period they were in the she would expect staff to gh and timely discharge discharge.				
	Review of facility, "	Discharge and Recapitulation				

SX8J11

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
		00432	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
ELDERS	HOME INC		OUSLEY, PO K MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 680	Summary Form Ins would complete a s at the facility upon c	ge 4 tructions," identified the facility ummary of the resident's stay discharge from the facility. 'HOD OF CORRECTION:	2 680			
	review and revise d and provide educat completeness of the DON or designee c discharge summari	ing (DON) or designee could ischarge summary procedures ion to staff in order to ensure e summary, as require. The ould conduct auditing of the es to ensure compliance. The ought to the quality committee				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and com E. a resident he immunization progr defined in part 465 procedures of resid the prevention and	<ul> <li>Subp. 4 A-I Infection Control and procedures. The infection ist include policies and rovide for the following: based on systematic data rosocomial infections in</li> <li>detection, investigation, and s of infectious diseases; d precautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; nent and implementation of</li> </ul>	21390			2/24/17

SX8J11

If continuation sheet 5 of 32

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE		
			OUSLEY, P			
ELDERS	HOME INC		RK MILLS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 5	21390			
	practices, including defined in part 465 G. a system fo Products which affe disinfectants, antise incontinence produ I. methods for current standards of This MN Requirem by: Based on observat review, the facility f communally used b to prevent the poss blood-borne pathog one resident (R32)	r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and		Corrected		
	Findings include:					
	(LPN)-A was obser monitor labeled Ass the medication cart alcohol swab. LPN the glucometer and blood from R32's fi glucose test using the After she complete LPN-A returned to the obtained an alcoho down the blood glu	25 a.m. licensed practical nurse ved to retrieve a blood glucose sure Prism from the drawer of s, and wiped it down with an I-A entered R32's room with I proceeded to draw a drop of nger and performed the blood the blood glucose monitor. d the blood glucose test, the medication cart and I swab and began to wipe cose monitor then laid it down minutes then placed it back				

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	·	
ELDERS	HOME INC		TOUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21390	Continued From pa	ge 6	21390			
	confirmed the facili glucose monitor for required blood gluc LPN-A stated her p glucose monitor be down with an alcoh	1/12/17, at 8:30 a.m. LPN-A ty used the same blood all of the residents who ose monitoring in the facility. ractice was to clean the blood tween residents by wiping it ol swab before returning it of the medication cart.				
	director of nursing of glucose monitor wa required blood gluc she expected staff proper disinfection between residents. procedure, she stat should be disinfector cover the machine should be set out, b give specific details working on policies per manufactures r and auditing compl	1/13/17, at 1:10 p.m. the (DON) confirmed the blood as shared by residents who ose monitoring. She stated to follow facilty policy on of blood glucose monitors When asked of specific ted the blood glucose monitor ed with a specific type of wipe, with the wipe and then it but she stated she could not s. She stated they were for blood glucose monitors ecommendations for cleaning iance, but the goal date for the was set for 1/20/17, therefore pompleted yet.				
	Assure Prism Multi instruction sheet, A identified the meter procedure complete of blood-borne path disinfectant produc number of 67619-1	nsing and Disinfecting your Blood Glucose Meter System rkray USA, dated 01/15, must have a disinfection ed to prevent the transmission nogens. It stated any t with the EPA registration 2 may be used on the devise. uded wiping the entire surface				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	-	
ELDERS	HOME INC		TOUSLEY, PO			
	SI IMMA DY STA		ORK MILLS, MI	PROVIDER'S PLAN OF		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	ge 7	21390			
	vertically to remove the towelette. Allow	s horizontally and 3 times blood-born pathogens with v exterior to remain wet for 1 he meter using a dry cloth.				
	blood glucose mon	y on cleansing and disinfecting itors shared by residents was facility did not provide a	3			
	The director of nurs on disinfection of bl manufactures recor conducted to ensur	THOD OF CORRECTION: sing could implement a policy ood glucose meters per mmendations. Audits could be e staff are disinfecting per could be brought to the quality w.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
21695	MN Rule 4658.141 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			2/28/17
	provide housekeep necessary to maint comfortable interior	eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, ixtures, equipment, lighting,				
	by:	ent is not met as evidenced		Corrected		
	Based on observati	on, interview and record		Corrected		

STATE FORM

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If continuation sheet  $\,8$  of 32  $\,$ 

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00432	B. WING	B. WING		17/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ELDERS	HOME INC		TOUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21695	review, the facility f housekeeping and provided for 17 of 2 Rm201, Rm228, R Rm316, Rm314, R Rm315, Rm202, R Rm304) observed v Findings include: On 1/13/17, at 1:57 the facility was con assistant (MA)-A at supervisor (HS)-A. confirmed the follow -Room 306, bathro build up -Room 201, the wa of 1-2 feet in diame	Failed to ensure adequate maintenance services were 28 resident rooms (Rm306, m222, Rm203, Rm212, m214, Rm217, Rm308, m211, Rm301, Rm208, with environmental concerns.	•			
	had several nails a faucet had thick lim spots present. -Room 228, the ba scrapes with stain	nd nail holes present and the ne scale build up with black athroom door had several large missing. Thick lime scale build	•			
	-Room 222, the ba and the paint on th sink was cracking a					
innesota D	black scrape marks	Il near the bed had several s. The bathroom wall had an v 8 X 10 inches with yellow glue	e			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00432	B. WING		01/	01/17/2017	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		01/	17/2017	
	HOME INC		OUSLEY, PO				
LDENS		NEW YO	RK MILLS, MN	I 56567		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21695	Continued From pa	ige 9	21695				
		ent. Thick lime scale build up aucet. The faucet was dripping					
		throom faucet was corroded scale build present. The faucet					
	-Room 316, the paint was chipped on the wall around the outlet near the bed.						
	-Room 314, the grout around the toilet was peeling and a dark brown/black substance was observed in several areas.						
	-Room 214, the bat and thick lime scale	throom faucet had corrosion e build up.					
		throom faucet had corrosion e build up. R18's bathroom is near the toilet.					
	-Room 308, the bat scale present.	throom faucet had thick lime					
	-Room 303, the bat scale present.	throom faucet had thick lime					
		rout around the floor was brown/black substance was I areas.					
	scale was present.	ot in diameter was on the floor					
	-Room 211, the bat scale was present.	hroom faucet had thick lime					
	-Room 301, the bat	throom faucet had thick lime					

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ELDERS	HOME INC		FOUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21695	Continued From pa	ge 10	21695			
	scale was present.					
	scale was present.	hroom faucet had thick lime A dark brown/black d in several places on the ilet.				
		hroom faucet had thick lime The bathroom doorknob was				
	above findings and above findings. MA department was no maintenance log ke stated they checked day. MA-A indicate concerns verbally. know of the schedu the maintenance di time of tour, may ha somewhere. HS-A and stated the facil and disinfectant ba	1:57 p.m. MA-A verified the stated he was unaware of A-A indicated the maintenance tified of concerns by the ept at the nurses desk. He d this daily, often 2-3 times per d staff also notified them of MA-A indicated he did not ile for painting walls, however, rector, who was not present at ave one written down also confirmed the findings ity utilized a light acid cleaner throom cleaner and tried to do to keep the lime scale from				
	administrator verifie to do the best they removed. The adm the faucets would b they were unable to The administrator in	1/13/17, at 2:30 p.m. the ed the housekeeping staff tried could to keep lime scale ninistrator indicated some of be replaced as needed, but o replace them all at once. Indicated at this time, there is was in place to replace the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00432	B. WING		01/	17/2017
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	01/	17/2017
	HOME INC	SOUTH	TOUSLEY, PO RK MILLS, MN	BOX 188		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From pa	age 11	21695			
	was reviewed from	B p.m. the maintenance log August 2016, to current date. Indings were not identified e repair log.				
	Request, undated, maintenance depa services by docum the "Maintenance L be written unless e equipment or haza standards, in those	olicy titled, Maintenance Repai directed staff to notify rtment of needed repairs and enting on request slips, kept in Log Book". All requests must mergency repairs to vital rdous violations to safety e cases staff are directed to ance director immediately.				
	Policies and Proce housekeeping staff rooms daily. It also staff to examine the repairs needed to be	olicy titled, Housekeeping dures, undated, directed the f to clean sinks in resident o directed the housekeeping he resident rooms for any be done while cleaning and on cart to be reported to rtment.				
	The director of main was in place to clear prioritized schedule ensure staff are clear	THOD OF CORRECTION: intenance could ensure a plan an and replace faucets on a e. Audits could be conducted to eaning and reporting timely s could be brought to the for review.				
	TIME PERIOD FO (21) days	R CORRECTION: Twenty-one				

STATEMEN	Ita Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
		00432	B. WING		01/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	HOME INC	SOUTH T	OUSLEY, PO	BOX 188		
ELDENS		NEW YOI	RK MILLS, MI	N 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLET DATE
21980	MN St. Statute 626. Maltreatment of Vul	.557 Subd. 3 Reporting - Inerable Adults	21980			2/17/17
	reporter who has revulnerable adult is to or who has knowled has sustained a phy reasonably explained information to the c individual is a vulne the individual is adur reporter is not requi maltreatment of the to admission, unles (1) the individual wa another facility and believe the vulnerab previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in this known or suspected knows or has reason been made to the c (d) Nothing in this reporter from also r agency. (e) A mandated r reason to believe the	as admitted to the facility from the reporter has reason to ole adult was maltreated in the nows or has reason to believe a vulnerable adult as defined s, subdivision 21, clause (4). required to report under the ection may voluntarily report a. s section requires a report of d maltreatment, if the reporter on to know that a report has				
	subdivision. If the r time believes that a	make a report under this reporter or a facility, at any n investigation by a lead ne or should determine that				

If continuation sheet 13 of 32

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :		E SURVEY PLETED
			20.20.10			
		00432	B. WING		01/17/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ELDERS	HOME INC		FOUSLEY, PO RK MILLS, N			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
21980	Continued From pa	age 13	21980			
	the criteria under set 17, paragraph (c), of facility may provide directly to the lead how the event mee 626.5572, subdivisit (5). The lead ager information when n the report under su This MN Requirem by: Based on interview facility failed to ens	vas not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ts the criteria under section ion 17, paragraph (c), clause ncy shall consider this naking an initial disposition of bdivision 9c. ent is not met as evidenced and document review, the ure allegations of abuse and norigin were immediately		Corrected		
	reported to the Stat thoroughly investig	te agency (SA) and were ated for 3 of 4 residents (R7, se allegations of abuse				
	12/21/16, indicated required extensive	nimum Data Set (MDS) dated R7 was cognitively intact, assist of one staff with ing (ADL's) and had diagnoses ression.	8			
nnesota D	R7 was a vulnerabl communication, ph and directed staff to conversation while to voice concerns of	lan dated 12/14/16, indicated le adult related to ysical & cognitive impairment, o engage resident in providing cares, allow resident or worries, establish a encouraged resident to share				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00432			01/	17/2017
			DRESS, CITY, S <sup>-</sup> OUSLEY, PO			
ELDERS	HOME INC		RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ige 14	21980			
	indicated R7 had A deficit related to be developmentally/int required staff assis Review of the CON REFERRAL FORM licensed practical m social worker (SW) had slapped her las CONCERN AND/O FORM indicated or SW interviewed R7 her arm too hard an indicated "NA-A is m with her, she is awf indicated to the SW tongue out at her, a provide any further cares or services. COMPLAINT REFE indicated steps take complaints of NA-A identified the SA ha R7's alleged allega The vulnerable adur reviewed, and a VA not been made on allegations of abust	tance with all ADL's ICERN AND/OR COMPLAINT I, dated 1/11/17, indicated urse (LPN)-A reported to that nursing assistant (NA)-A st night. Further review of the R COMPLAINT REFERRAL 1/11/17, at 10:30 a.m. the Who indicated NA-A "grabbed nd also slapped her." R7 mean to her and gets rough ful mean to me." R7 also / that NA-A also stuck her and R7 did not want NA-A to assistance with personal The CONCERN AND/OR ERRAL FORM further en to investigate R7's alleged I's abuse, however, had not ad been immediately notified of				
	(DON) indicated sh	p.m. the director of nursing e was aware of R7's e by NA-A, and confirmed the				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			- (X3) DATE SURVEY COMPLETED - 01/17/2017	
		00432	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ELDERS	HOME INC		FOUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	ge 15	21980			
		ediately reported R7's e to the state agency.				
	confirmed she was allegations of abuse facility had not imm	2 a.m. the administrator immediately notified of R7's e by NA-A, and confirmed the ediately reported R7's e to the state agency.				
		unknown origin which was no ed to the SA or thoroughly	t			
	was cognitively imp assist of one or two	dated 12/7/16, indicated R8 baired, required extensive staff with ADL's, and had re, manic depression, and				
	R8 was a vulnerabl communication, an impairment. The ca engage R8 in conve allow R8 to voice ca a relationship that e difficulties and expe indicated R8 was d tasks due to impair diagnoses of Alzhe dementia, arthritis, incontinence. The c	care plan further indicated R8 related to severe cognitive &				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		00432	B. WING	B. WING		17/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ELDERS	HOME INC		TOUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ige 16	21980			
	12:00 a.m. indicate wheelchair by the n restless. R8's perso a.m. and R8 was for floor in front of the indicated R8's pant blankets were foun There were no with identified. The report that included a lace measured 0.5 cent the forehead that m near the right eye/o cm x 3 cm, and R8 and painful with no indicated the medic	hent Report, dated 3/14/16, at d R8 was seated in a hurses station due to being boal alarm sounded at 12:00 bund laying on back on the wheelchair. The report s, incontinent brief, and d down around the ankles. lesses of this incident ort indicated R8 had injuries eration near the right eye that imeters (cm), an abrasion of heek area that measured 4 's left ankle was very tender bruising noted. The report cal doctor and the power of re notified of the incident on				
	10:38 a.m. indicate x-ray of the left ank X-ray the Perham h reported R8 had a	es notes dated 3/14/16, at d R8's POA agreed to have le due to pain. Following the nospital called at 3:15 p.m. and distal tibia and fibula fracture ich had been splinted.	1			
	the SA was not imn of unknown origin,	8's medical record revealed nediately notified of R8's injury and a thorough investigation o I incident had not been				
	had a unwitnessed the left ankle area.	1 a.m. the DON Confirmed R8 fall and sustained fractures to The DON also verified the ported to the SA and she was				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00432	B. WING		01/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ELDERS	HOME INC		TOUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
		age 17 e R8 fell. The DON confirmed	21980			
	the SA should of been notified when they found out R8 had a fracture of her ankle and a investigation should of been conducted.					
	confirmed the SA h unwitnessed fall with this should of been also indicated that unwitnessed fall with	3 a.m. the administrator ad not been notified of R8's th fractures and stated " yes reported." The administrator any time there was an th a injury it needed to be ely and investigated.				
	during cares, and t	legation of rough treatment he facility failed to thoroughly rt R58's allegation of abuse to				
	R58 was cognitively included: seizure di the cervical spine ( sensation to one si	S dated 11/29/16, identified y intact, had diagnoses that isorder, sprain of ligaments of neck) with resulting decreased de of the body, and required ded maneuvering of the limbs ing.				
	alert and oriented to assistance with dre	ted 12/6/16, identified R58 was o person, required extensive ssing, and was vulnerable to an directed staff to allow R58 or worries.	5			
	Complaint," forms v report dated 11/24/	ilities "Concern and/or were reviewed and included a 16, at 7:30 p.m. that indicated legation of "rough treatment" to				

NAME OF EARLOY CONTROLLED.       A. BUILDING:       Other Earloy       Other Earloy         00432       B. WING       01/17/2017         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       SOUTH TOUSLEY, PO BOX 188         ICM, ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         IMAGE       SUMMARY STATEMENT OF DEFICIENCIES       ID       PREVIX       CACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         TAG       SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX       CONFRECTIVE ACTION SHOULD BE       COMPLET         21980       Continued From page 18       21980       21980       Continued From page 18       21980         21980       Continued From page 18       21980       21980       Continued From page 18       21980         (11/25/16, Dis neck was still sore/tender. The report further indicated R58 related facility staff were overwhelmed and had lots of people to take care of, and didn't want to get anybody in trouble.       On 1/12/17, at 1:59 p.m. administrator stated she was aware R58 had complained of rough treatment and confirmed a facility, "Concern and/or Complaint Form," dated 11/25/16 h ad been completed. The administrator stated R58 was interviewed following the allegation and felt R58 rescinded the allegation, therefore determined R58's allegation of rough treatment would not be reported to the SA. The DON       Confirmed there was no documentation or follow <th>STATEMEN</th> <th>Dia Department of He NT OF DEFICIENCIES OF CORRECTION</th> <th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th> <th></th> <th>CONSTRUCTION</th> <th></th> <th>E SURVEY PLETED</th>	STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
VAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SOUTH TOUSLEY, PO BOX 188       SUMMARY STATEMENT OF DEFICIENCIES         ICAN DE TAG       SUMMARY STATEMENT OF DEFICIENCIES         ICAN DE TAG       ID         PREFIX       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE         ICAN DE VORK MILLS, MN 56567       ID         ITAG       SUMMARY STATEMENT OF DEFICIENCIES         ICAN DE VORK MILLS, MN 56567       ID         ITAG       SUMMARY STATEMENT OF DEFICIENCIES         ITAG       ID       PREFIX         ITAG       SOUTH TOUSLEY, PO BOX 188         ITAG       SOUTH TOUSLEY, TAG         ITAG       SOUTH TOUSLEY, PO BOX 188         ITAG       SOUTH TOUSLEY, INT, STATE, ZIP CODE         ITAG       SUMMARY STATEMENT OF DEFICIENCIES         ITAG       SUMMARY STATEMENT OF DEFICIENCIN			00/32	_		01/	17/2017
SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567         (Y4) ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (000000000000000000000000000000000000							17/2017
Image: Construct of the second sec	NAME OF I	PROVIDER OR SUPPLIER					
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       complete DATE         21980       Continued From page 18       21980         therapy staff the morning of 11/25/16. The report identified therapy staff reported the allegation of abuse to the social services designee (SSD), who then interviewed R58. The report further indicated R58 reported, "rough treatment," on 11/24/16, when staff assisted R58 with removing a sweatshirt. R58 stated the next morning (11/25/16), his neck was still sore/tender. The report further indicated R58 realized facility staff were overwhelmed and had lots of people to take care of, and didn't want to get anybody in trouble.       On 1/12/17, at 1:59 p.m. administrator stated she was aware R58 had complained of rough treatment and confirmed a facility. "Concern and/or Completed. The administrator stated R58 was interviewed following the allegation and felt R58 rescinded the allegation, therefore determined R58's allegation of rough treatment would not be reported to the SA. The DON	ELDERS	HOME INC					
21980       Continued From page 18       21980         21980       therapy staff the morning of 11/25/16. The report identified therapy staff reported the allegation of abuse to the social services designee (SSD), who then interviewed R58. The report further indicated R58 reported, "rough treatment," on 11/24/16, when staff assisted R58 with removing a sweatshirt. R58 stated the next morning (11/25/16.) his neck was still sore/tender. The report further indicated R58 realized facility staff were overwhelmed and had lots of people to take care of, and didn't want to get anybody in trouble.         On 1/12/17, at 1:59 p.m. administrator stated she was aware R58 had complained of rough treatment and confirmed a facility, "Concern and/or Complaint Form," dated 11/25/16 had been completed. The administrator stated R58 was interviewed following the allegation and felt R58 rescinded the allegation, therefore determined R58's allegation of rough treatment would not be reported to the SA. The DON	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	COMPLET
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confirmed there was no decumentation or follow.		identified therapy si abuse to the social then interviewed RS R58 reported, "roug when staff assisted sweatshirt. R58 sta (11/25/16,) his neck report further indica were overwhelmed care of, and didn't v On 1/12/17, at 1:59 was aware R58 had treatment and confi and/or Complaint F been completed. Th was interviewed fol R58 rescinded the determined R58's a would not be report	taff reported the allegation of services designee (SSD), who 58. The report further indicated gh treatment," on 11/24/16, R58 with removing a ted the next morning was still sore/tender. The ated R58 realized facility staff and had lots of people to take want to get anybody in trouble. p.m. administrator stated she d complained of rough irmed a facility, "Concern form," dated 11/25/16 had he administrator stated R58 lowing the allegation and felt allegation, therefore allegation of rough treatment ted to the SA. The DON				
		am telling the truth, night." R58 indicate a scratch on the ba just didn't like it, I w R58 explained that	I was treated roughly that ed he had most likely suffered ck of the neck and stated, "I vas trying to get ready for bed." the night of the incident he				
sweatshirt because it was too tight. R58 stated, "I am telling the truth, I was treated roughly that night." R58 indicated he had most likely suffered a scratch on the back of the neck and stated, "I just didn't like it, I was trying to get ready for bed." R58 explained that the night of the incident he had fallen asleep when the NA finally came into		his room to assist v	vith evening cares, and felt the ry to get done so she could go				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, STA	TE, ZIP CODE		
		SOUTH	OUSLEY, PO E	OX 188		
ELDERS	HOME INC	NEW YO	RK MILLS, MN	56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ge 19	21980			
	assist after helping stated he didn't like night, and stated he upset with the treat	probably had 10 residents to him get ready for bed. R58 the treatment received that a hadn't told the NA he was ment received, and was t the room and was gone.				
	a.m. and stated after of rough treatment of the DON and admir instructed the SSD complaint form. The to investigate R58's treatment, however assist R58 on 11/24 NA-D reported she investigation. The S NA-D's interview to thought she was do investigation, and the rest of the investigat not documented an allegation of rough form was completed the SSD regarding form was completed the SSD regarding form was completed the SSD regarding form was a completed the SSD regarding for a completed the SSD regarding form was a complet	viewed on 1/17/17, at 10:39 er R58 reported the allegation on 11/24/16, the SSD spoke to histrator on 11/25/16, who to complete a concern and/or e SSD stated she called NA-D s allegations of rough , NA-D told her she did not k/16, at 7:30 p.m. and stated had nothing else to add to the SSD stated she then reported the DON, and stated she ne with her part of the ne DON would complete the tion. The SSD stated she had ything else related to R58's treatment after the concern d. During further interview with the facility's vulnerable adult re, the SSD stated any e including rough treatment tely reported to the SA, and egation of rough treatment ted to the SA, even though mistreatment met their policy to the SA. The SSD able adult report or any further follow up related R58's treatment had not been	ł			

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00432	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		SOUTH T	OUSLEY, PO	BOX 188		
ELDERS	HOME INC	NEW YOF	RK MILLS, MI	N 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 20	21980			
	The DON was inter a.m. and stated she she becoming awar treatment on 11/25/ staff were rushed th apologetic and state stated NA-F, NA-E, evening of 11/24/16 interviewed via the denied being rushe manner. The DON had not identified w evening cares. Add produce a thorough allegation of rough with the DON confir practice for address included the followin allegation of abuse, reported to the nurs information gatherin to the DON, who we allegation was repor confirmed all report be reported right aw R58's allegation sh right away and conf further follow up wa allegation of mistreat The facility's Abuse 12/22/16, was revie individual has the ri sexual, physical, an injuries of unknown the resident propert mistreatments, neg and financial or mat	viewed on 1/17/17, at 11:01 e had interviewed R58 after re of the allegation of rough (16, and R58 reported facility hat night, and R58 was very ed he misspoke. The DON and NA-G worked the 6, and all 3 of NA's were telephone and all of the NA's d or treating R58 in a rough had not interviewed NA-D, and thich NA assisted R58 with itionally, the DON could not investigation of R58's treatment. Further interview rmed the facilities customary sing allegations of abuse ng: after the resident made an the allegation would be se, who would then do initial ng and report the information buld then determine if the rtable to the SA. The DON is of rough treatment should way to the SA. The DON stated bould have reported to the SA firmed documentation and is not documented for R58's				

Minneso	ta Department of He	alth			FORIV	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ELDERS	HOME INC		OUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21980	misappropriations s nursing home admi administrator or des incidents of abuse a of unknown origin to and federal required directs the facility to investigation and an abuse, neglect, inju	streatment, neglect, or shall immediately report to nistrator. The nursing home signee will immediately report and neglect including injuries to the state agency per state ments. Additionally, the policy o conduct a root cause nalysis of all allegations of ries of unknown origin, and	21980			
	The Director of Nur could review policy regarding the imme completion of a tho maltreatment, abus origins. The Quality (QAA) committee c ensure compliance	HOD OF CORRECTION: sing (DON) and/or designee and provide education for staff diate reporting and/or the rough investigation related to e and inuries of unknown y Assessment and Assurance ould do random audits to				
22000	MN St. Statute 626 Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. Th assessment of the environment, and it	5.557 Subd. 14 (a)-(c) tment of Vulnerable Adults prevention plans. (a) Each e health agencies and dant services providers, shall ce an ongoing written abuse he plan shall contain an physical plant, its s population identifying encourage or permit abuse,	22000			2/17/17

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00432			01/	17/2017
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
ELDERS	HOME INC		OUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
22000	to minimize the risk comply with any rul promulgated by the (b) Each facility, agency and person providers, shall dew prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indi vulnerable adults; ( other vulnerable ad specific measures f risk of abuse to tha adults. For the pur term "abuse" includ (c) If the facility, and personal care a knows that the vuln violent crime or an toward others, the i plan must detail the minimize the risk the reasonably be expect facility and persons unsupervised. Unc of a vulnerable adu misconduct or phy such information fro	specific measures to be taken of abuse. The plan shall es governing the plan including a home health care al care attendant services relop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the les self-abuse. except home health agencies attendant services providers, ierable adult has committed a act of physical aggression ndividual abuse prevention e measures to be taken to iat the vulnerable adult might ected to pose to visitors to the outside the facility, if ler this section, a facility knows It's history of criminal sical aggression if it receives om a law enforcement				
	another facility, and	a medical record prepared by other health care provider, or g assessments of the				

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00432	B. WING		01/1	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ELDERS	HOME INC		OUSLEY, PO K MILLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 23	22000			
	by: Based on interview facility failed to ensi- were implemented injuries of unknown	ent is not met as evidenced and document review, the ure vulnerable adult policies for allegations of abuse and/or origin for 3 of 4 residents (R7, e allegations of abuse ewed.		Corrected		
	Findings include:					
	12/21/16, indicated required extensive	imum Data Set (MDS) dated R7 was cognitively intact, assist of one staff with ing (ADL's) and had diagnoses ession.				
	R7 was a vulnerabl communication, phy and directed staff to conversation while to voice concerns of relationship which e difficulties and expe- indicated R7 had Al deficit related to be developmentally/int	ysical & cognitive impairment, o engage resident in providing cares, allow resident or worries, establish a encouraged resident to share eriences. The care plan also DL self care performance				
Minnesota D	REFERRAL FORM licensed practical n	CERN AND/OR COMPLAINT , dated 1/11/17, indicated urse (LPN)-A reported to that nursing assistant (NA)-A				

Minneso	ota Department of He	alth			T ON M	APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ELDERS	HOME INC		OUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
22000	had slapped her las CONCERN AND/O FORM indicated on SW interviewed R7 her arm too hard ar indicated "NA-A is r with her, she is awf indicated to the SW tongue out at her, a provide any further cares or services. T COMPLAINT REFE indicated steps take complaints of NA-A identified the State immediately notified abuse. The vulnerable adu reviewed, and a VA not been made on allegations of abuse was found submitte 1/12/17. On 1/11/17 at 7:47 (DON) indicated sh allegations of abuse facility had not imm allegations of abuse facility had not imm	ge 24 st night. Further review of the R COMPLAINT REFERRAL 1/11/17, at 10:30 a.m. the who indicated NA-A "grabbed nd also slapped her." R7 nean to her and gets rough ul mean to me." R7 also ' that NA-A also stuck her and R7 did not want NA-A to assistance with personal 'he CONCERN AND/OR ERRAL FORM further en to investigate R7's alleged 's abuse, however, had not agency (SA) had been d of R7's alleged allegations of It (VA) reports for R7 were report to the state agency had 1/11/17, when R7 reported e to LPN-A, rather a VA report d to the state agency dated p.m. the director of nursing e was aware of R7's e by NA-A, and confirmed the ediately reported R7's e to the state agency.		DEFIGIENCY	<u>,</u>	

Minnesc	ta Department of He	alth	1			APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FI DERS	HOME INC		OUSLEY, PO			
	1		RK MILLS, MN	N 56567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	ge 25	22000			
	immediately reporte	unknown origin which was not ed to the SA or thoroughly ling to the facility policy.				
	was cognitively imp assist of one or two	dated 12/7/16, indicated R8 aired, required extensive staff with ADL's, and had re, manic depression, and				
	R8 was a vulnerabl communication, and impairment. The ca engage R8 in conve allow R8 to voice co a relationship that e difficulties and expe indicated R8 was de tasks due to impair diagnoses of Alzhei dementia, arthritis, incontinence. The co	are plan further indicated R8 related to severe cognitive &				
	12:00 a.m. indicate wheelchair by the n restless. R8's perso a.m. and R8 was fo the floor in front of t indicated R8's pant blankets were found	tent Report, dated 3/14/16, at d R8 was seated in a urses station due to being onal alarm sounded at 12:00 ound on the laying on back on the wheelchair. The report s, incontinent brief, and d down around the ankles. esses of this incident				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ELDERS	HOME INC		TOUSLEY, PO			
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET DATE
22000	Continued From pa	age 26	22000			
	that included a lace measured 0.5 cent the forehead that n near the right eye/c cm x 3 cm, and R8 and painful with no indicated the medic	ort indicated R8 had injuries eration near the right eye that imeters (cm), an abrasion of neasured 2 cm, an abrasion cheek area that measured 4 's left ankle was very tender bruising noted. The report cal doctor and the power of re notified of the incident on				
	10:38 a.m. indicate x-ray of the left ank X-ray the Perham H reported R8 had a	es notes dated 3/14/16, at ed R8's POA agreed to have de due to pain. Following the nospital called at 3:15 p.m. and distal tibia and fibula fracture ich had been splinted.	1			
	the SA was immed origin, and a thorou	88's medical record revealed iately notified of R8's of known ugh investigation of the cident had not been completed				
	had an unwitnesse to the left ankle are incident was not re not here at the time the SA should of be out R8 had a fractu	1 a.m. the DON confirmed R8 d fall and sustained fractures ea. The DON also verified the ported to the SA and she was e R8 fell. The DON confirmed een notified when they found ure of her ankle and a d of been conducted.				
	confirmed the SA h unwitnessed fall wi	3 a.m. the administrator ad not been notified of R8's th fractures and stated "yes reported." The administrator				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
ELDERS	HOME INC		TOUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 27	22000			
		any time there is a th a injury it needs to be ely and investigated.				
	during cares and th Vulnerable Adult Po reporting to the SA	legation of rough treatment ne facility failed to follow their olicy related to the immediate , and had not conducted a tion of alleged abuse.				
	during cares, and t	legation of rough treatment he facility failed to thoroughly rt R58's allegation of abuse to				
	R58 was cognitivel included: seizure d the cervical spine ( sensation to one si	OS dated 11/29/16, identified y intact, had diagnoses that isorder, sprain of ligaments of neck) with resulting decreased de of the body, and required ded maneuvering of the limbs sing.				
	alert and oriented t assistance with dre	ted 12/6/16, identified R58 was o person, required extensive essing, and was vulnerable to an directed staff to allow R58 or worries.	5			
	Complaint," forms report dated 11/24/ R58 reported an all therapy staff the m	cilities "Concern and/or were reviewed and included a (16, at 7:30 p.m. that indicated legation of "rough treatment" to orning of 11/25/16. The report taff reported the allegation of				

STATEME	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00432	B. WING		01/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
			OUSLEY, PO			
ELDERS	HOME INC		RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	ae 28	22000			
	then interviewed R R58 reported, "roug when staff assisted sweatshirt. R58 sta (11/25/16,) his neck report further indica were overwhelmed care of, and didn't w On 1/12/17, at 1:59 was aware R58 had treatment and confi and/or Complaint F been completed. Th was interviewed fol R58 rescinded the determined R58's a would not be report The interim director	services designee (SSD), who 58. The report further indicated gh treatment," on 11/24/16, R58 with removing a ted the next morning was still sore/tender. The ated R58 realized facility staff and had lots of people to take want to get anybody in trouble. p.m. administrator stated she d complained of rough irmed a facility, "Concern form," dated 11/25/16 had he administrator stated R58 lowing the allegation and felt allegation, therefore allegation of rough treatment ted to the state agency (SA). r of nurses confirmed there tion or follow up after R58 was				
	and confirmed the a and stated he felt th her temper when sl sweatshirt because am telling the truth, night." R58 indicate a scratch on the ba just didn't like it, I w R58 explained that had fallen asleep w his room to assist v NA was in a big hur on her way. R58 sta	5 a.m. R58 was interviewed, allegation of rough treatment he nursing assistant (NA) lost he assisted with removing the hit was too tight. R58 stated, " I was treated roughly that ed he had most likely suffered ck of the neck and stated, "I vas trying to get ready for bed." the night of the incident he when the NA finally came into with evening cares, and felt the rry to get done so she could go ated the NA acted probably had 10 residents to				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM	PLETED
		00432	B. WING		01/	17/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ELDERS	HOME INC		OUSLEY, PO RK MILLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 29	22000			
	stated he didn't like night, and stated he upset with the treat thankful the NA left The SSD was inter a.m. and stated aft of rough treatment the DON and admi instructed the SSD complaint form. Th to investigate R58's treatment, howeve assist R58 on 11/2 NA-D reported she investigation. The S NA-D's interview to thought she was do investigation, and t rest of the investigat not documented ar allegation of rough form was complete the SSD regarding policy and procedu allegations of abus should be immedia confirmed R58's al	him get ready for bed. R58 e the treatment received that e hadn't told the NA he was tment received, and was ft the room and was gone. viewed on 1/17/17, at 10:39 ter R58 reported the allegation on 11/24/16, the SSD spoke to nistrator on 11/25/16, who to complete a concern and/or to SSD stated she called NA-D s allegations of rough r, NA-D told her she did not 4/16, at 7:30 p.m. and stated that nothing else to add to the SSD stated she then reported the DON, and stated she one with her part of the the DON would complete the ation. The SSD stated she had nything else related to R58's treatment after the concern ad. During further interview with the facility's vulnerable adult are, the SSD stated any the including rough treatment ately reported to the SA, and legation of rough treatment tred to the SA, although R58's				
	for reporting to the vulnerable adult re documentation and	eatment met their policy criteria SA. The SSD confirmed a port or any further d follow up related R58's treatment had not been				
		rviewed on 1/17/17, at 11:01				
inesota De ATE FORM	epartment of Health		6899 <b>S</b>	X8J11	If continuati	

Minneso	ta Department of He	alth	1				
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00432				CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		01/	17/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
		SOUTH T	OUSLEY, PO	BOX 188			
ELDERS	HOME INC		RK MILLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETE DATE	
22000	Continued From page 30		22000				
	Continued From page 30 a.m. and stated she had interviewed R58 after she becoming aware of the allegation of rough treatment on 11/25/16, and R58 reported facility staff were rushed that night, and R58 was very apologetic and stated he misspoke. The DON stated NA-F, NA-E, and NA-G worked the evening of 11/24/16, and all 3 of NA's were interviewed via the telephone and all of the NA's denied being rushed or treating R58 in a rough manner. The DON had not interviewed NA-D, and had not identified which NA assisted R58 with evening cares. Additionally, the DON could not produce a thorough investigation of R58's allegation of rough treatment. Further interview with the DON confirmed the facilities customary practice for addressing allegations of abuse included the following: after the resident made an allegation of abuse, the allegation would be reported to the nurse, who would then do initial information gathering and report the information to the DON, who would then determine if the allegation was reportable to the SA. The DON confirmed all reports of rough treatment should be reported right away to the SA. The DON stated R58's allegation should have reported to the SA right away. and confirmed documentation and further follow up was not documented for R58's allegation of mistreatment.						
	and financial or ma home employee or	lect, involuntary seclusion, terial exploitation.) Any nursing volunteer who becomes streatment, neglect, or					

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00432		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/17/2017	
		00432	B. WING			
			DRESS, CITY, ST	ATE. ZIP CODE		
	HOME INC		OUSLEY, PO			
ELDENG		NEW YO	RK MILLS, MN	56567		-1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
22000	Continued From page 31		22000			
	misappropriations shall immediately report to nursing home administrator. The nursing home administrator or designee will immediately report incidents of abuse and neglect including injuries of unknown origin to the state agency per state and federal requirements. Additionally, the policy directs the facility to conduct a root cause investigation and analysis of all allegations of abuse, neglect, injuries of unknown origin, and financial exploitation.					
	The administrator, designee(s) could r necessary the polic the process of repo of abuse, maltreatm The administrator, designee (s) could appropriate staff or procedures to ensu The administrator, designee (s) could abuse are being rep	THOD FOR CORRECTION: DON, social services or eview and revise as sies and procedures regarding pring/investigating allegations nent or injuries of unknown. DON, social services or provide training for all these policies and ure the policy is implemented. DON, social services or monitor to assure all reports of ported and investigated. R CORRECTION: Twenty one				
	epartment of Health					