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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SX8J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00432

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245562**

2.STATE VENDOR OR MEDICAID NO.
(L2) **507042200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELDERS HOME INC**
(L4) **SOUTH TOUSLEY, PO BOX 188**
(L5) **NEW YORK MILLS, MN** (L6) **56567**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/16/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NE II 04/10/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 07/21/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2017
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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

MDH
Minnesota Department of Health

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, effective February 28, 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 Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245562 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0166	Correction	ID Prefix F0225	Correction
Reg. # 483.10(d)(3)(g)(1)(4)(5) (13)(16)-(18)	Completed	Reg. # 483.10(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 F0253	Correction	ID Prefix F0283	Correction
Reg. # 483.12(b)(1)-(3), 483.95(c)(1)-(3)	Completed	Reg. # 483.10(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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GA/mm	04/10/2017	37905	03/16/2017
REVIEWED BY 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? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245562	A. Building 01 - 01 MAIN BUILDING B. Wing	3/1/2017

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0223	Correction Completed 02/28/2017	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 02/03/2017	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 01/26/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 04/10/2017	**SIGNATURE OF SURVEYOR** 36536	**DATE** 03/01/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 1/11/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

Minnesota Department of Health

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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00432 Y1	A. Building 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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20680	Correction	ID Prefix	21390	Correction	ID Prefix	21695	Correction
Reg. #	MN Rule 4658.0465 Subp. 1	Completed	Reg. #	MN Rule 4658.0800 Subp. 4 A-I	Completed	Reg. #	MN Rule 4658.1415 Subp. 4	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 626.557 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		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY 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? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SX8J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00432

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245562**

2.STATE VENDOR OR MEDICAID NO.
(L2) **507042200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELDERS HOME INC**
(L4) **SOUTH TOUSLEY, PO BOX 188**
(L5) **NEW YORK MILLS, MN** (L6) **56567**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/17/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NE II 02/08//2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/09/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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;

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by 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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245562	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	2/8/17 OK Gail anderson	
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156		2/3/17

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

Electronically 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.

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F 156	Continued From page 1 (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and	F 156		

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F 156	Continued From page 2 as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email),	F 156		

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F 156	Continued From page 3 and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.	F 156		

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F 156	Continued From page 4 (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 156		

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F 156	Continued From page 5 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure 1 of 3 residents (R57) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123, which informed residents of their rights to an appeal, and expedited review of their Medicare	F 156	Correction: 1. The policy and procedure for Issuance of required Notice of Medicare Non-Coverage Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123 was reviewed, and is current.	

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F 156	Continued From page 6 coverage, 48 hours prior to discontinuation of the skilled services which were covered by the Medicare Part A benefit. Findings include: 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. On 1/11/17, at 2:58 p.m. the business office manager (BOM) verified R57 had received Medicare part A benefits while receiving skilled services at the facility. The BOM confirmed R57 had not received the required CMS Form 10123, 48 hours prior to discontinuation of the skilled services which were covered by the Medicare Part A benefit. On 1/17/17, at 9:10 a.m. the director of nursing (DON) stated she expected staff to give the required 48 hour notice when a resident is discharged from skilled services covered by Medicare Part A, so the resident could choose if they wanted to appeal the decision. The DON confirmed R57 had not received the required notice 48 hours prior to discontinuation of the skilled services which were covered by the Medicare Part A benefit. The facility's Medicare Advance Beneficiary	F 156	2. Form 10123 for R57 was discussed verbally with resident's daughter via telephone and a copy of the original was mailed via USPS. 3. "ABN Notification" has been added to the Weekly Medicare meeting minute's outline to ensure that notification and documentation is given to resident and/or resident's representative within 48 hours prior to discontinuation of the skilled services which are covered by the Medicare Part A benefit. Education: 1. CMS Regulation and Policy and Procedure was reviewed with staff responsible for issuance of Form 10123 on 01/31/17. (MDS Coordinator/ Business Office/Therapy Representative). Audits: 1. Audit of potentially affected current residents in the last 3 months who were on skilled services through Medicare and would have required an ABN, with correction of any identified as being out of compliance. 2. Weekly audits x8 of current residents as determined during weekly Medicare meeting to be completed by the Director of Nursing. 3. Ongoing audits monthly x3 of current residents completed by Director of	

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F 156	Continued From page 7 Notice (SNF-ABN) Denial Notices policy, dated 1/17/17, indicated the facility would issue a timely and appropriate ABN (Advance Beneficiary Notice) to the Medicare beneficiary informing him/her of changes in Medicare coverage based on the facility adherence to Federal regulations.	F 156	Nursing/designee. 4. Audits results will be brought to the QA Committee for review and recommendations on a quarterly basis.	
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may	F 166		2/17/17

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F 166	Continued From page 8 be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be	F 166		

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F 166	Continued From page 9 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure prompt efforts by the facility to thoroughly investigate a report of missing dentures had been completed for 1 of 1 residents (R14) in the facility that was reviewed for personal property. Findings include: R14's annual Minimum Data Set (MDS) dated 10/14/16, indicated R14 had moderately impaired cognition and indicated R14 was edentulous (had no natural teeth). R14's care plan dated 2/8/16, indicated R14 had no natural teeth, and wore upper and lower dentures. R14's dental exam dated 1/7/16, indicated R14's upper and lower dentures fit reasonably well.	F 166	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 form was updated to include current regulatory guidance and forms are placed	

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F 166	Continued From page 10 During observation on 1/11/17, at 6:40 p.m. R14 was provided a nutritional supplement by licensed practical nurse (LPN)-C, and it was noted R14's upper and lower dentures were not in place. On 1/12/17, at 9:14 a.m. R14 was observed eating oatmeal and toast while seated in a wheelchair, and R14's upper and lower dentures were not in place. On 1/12/17, at 9:38 a.m. licensed practical nurse (LPN)-A entered R14's room to administer R14 a nutritional supplement. LPN-A did not question why R14's upper and lower dentures were not in place. On 1/13/17, at 9:51 a.m. activity assistant (AA)-A assisted R14 into the activity room, R14's upper and lower dentures were not in place. On 1/17/17, at 9:53 a.m. R14 was observed seated in a wheelchair in the hallway and did not have upper or lower dentures in place. On 1/11/17, at 2:24 p.m. a telephone interview was conducted with family member (FM)-A who reported R14's upper and lower dentures had been missing for the past two months, and confirmed she had informed a facility staff member of the missing dentures at that time. FM-A could not recall which staff member she had reported the missing dentures to, and stated 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	F 166	in prominent locations throughout the facility for resident/family/visitor and staff access. Education: 1. Direct Care staff were provided and educated on updated Policy and Procedures for grievance/complaint/missing items management through Nursing Staff meetings being held 02/01/2017 and 02/08/2017. All other departments will be educated on the updated policy and procedures on 02/15/17. Audits: 1. Weekly x8 weeks, random resident and family interviews will be conducted by Social Services designee. 2. Ongoing random audits will be conducted monthly, x3 of resident/family/staff interviews completed and reviewed by Social Service designee and quarterly QA meetings.	

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also stated they told another staff member about the missing dentures, and stated, " that staff member did not give a rip." FM-B was unable to identify the name of the second staff that the missing dentures were reported to. FM-B reported R14 did wear her dentures everyday when she had them. Family member (FM)-C was interviewed at the same time as FM-B, both FM-B and FM-C confirmed the facility administration and/or social services had not approached them regarding R14's missing dentures.

On 1/17/17, at 9:55 a.m. LPN-A confirmed she was the charge nurse and also responsible for R14's care. LPN-A stated she had not noticed R14's upper and lower dentures were not in place, and confirmed she does not check residents for denture placement. LPN-A reported she was not aware of R14's missing dentures, and stated she had been working with R14 since November of 2016. LPN-A stated when staff realize dentures are missing, staff initially ask the resident what could have happened, then call the nursing assistants that were working the night before to interview them.

On 1/17/17, at 9:58 a.m. nursing assistant (NA)-B confirmed she helped R14 with morning cares on 1/17/17. NA-B reported R14 required assistance of one for all activities of daily living (ADL's), except R14 was able to eat independently. NA-B reported R14 was not wearing upper or lower dentures because they were missing, and was not sure how long the dentures had been missing. NA-B stated staff had searched for R14's missing dentures, and confirmed the facility was aware they were missing.

On 1/17/17, at 10:04 a.m. nursing assistant

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(NA)-C confirmed R14's dentures had been missing for over two months. NA-C stated she was not the staff member who initially realized the dentures were missing, and stated she thought R14's missing dentures had been reported. NA-C stated all missing items are to be reported to the nurse, then complete a search for the missing item is initiated, and report to the social service department is made if needed.

On 1/17/17, at 10:06 a.m. the director of nursing (DON) was not aware of R14's missing dentures and stated the nurse should look for any reported missing items, alert other departments as necessary, and update the social service department.

On 1/17/17, at 10:09 a.m. AA-A confirmed she was aware of R14's missing dentures, and stated she thought they had been found. AA-A stated she had reported the missing dentures to the head nurse at that time.

On 1/17/17, at 10:15 a.m. the social service designee (SSD) stated she was not aware of R14's missing dentures until five minutes ago, when R14's family informed her during care conference. SSD reported the family stated R14's dentures had been missing for the past two months. The SSD established she had been employed by the facility for greater than two months, but was not aware of any facility protocols regarding missing personal items. The SSD confirmed she had not dealt with any reports of missing items from any residents since her employment began at the facility.

On 1/17/17, at 10:19 a.m. the director of nursing (DON) confirmed she was not aware of R14's

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F 166	Continued From page 13 missing dentures. The DON stated she expected staff to report missing items to the charge nurse, and the charge nurse was expected to report missing items to the social service department. The DON stated the facility has had many staff changes over the past few months, and confirmed there was a break in the communication regarding R14's missing dentures. A facility policy regarding missing personal items was requested, but not provided.	F 166		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee,	F 225		2/17/17

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F 225	Continued From page 14 which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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F 225	Continued From page 15 Based on interview and document review, the facility failed to ensure allegations of abuse and injuries of unknown origin were immediately reported to the State agency (SA) and were thoroughly investigated for 3 of 4 residents (R7, R8, and R58) whose allegations of abuse incidents were reviewed. Findings include: R7's admission Minimum Data Set (MDS) dated 12/21/16, indicated R7 was cognitively intact, required extensive assist of one staff with activities of daily living (ADL's) and had diagnoses of anxiety and depression. R7's current care plan dated 12/14/16, indicated R7 was a vulnerable adult related to communication, physical & cognitive impairment, and directed staff to engage resident in conversation while providing cares, allow resident to voice concerns or worries, establish a relationship which encouraged resident to share difficulties and experiences. The care plan also indicated R7 had ADL self care performance deficit related to being developmentally/intellectually disabled, and required staff assistance with all ADL's Review of the CONCERN AND/OR COMPLAINT REFERRAL FORM, dated 1/11/17, indicated licensed practical nurse (LPN)-A reported to social worker (SW) that nursing assistant (NA)-A had slapped her last night. Further review of the CONCERN AND/OR COMPLAINT REFERRAL	F 225	The facility will ensure that all allegations of abuse and injuries of unknown origin are immediately reported to the State agency and thoroughly investigated. Correction: 1. The policy and procedure for Abuse Prevention, which includes the procedure for reporting and investigation, was reviewed to ensure it is in compliance with current regulatory guidance. 2. Affected incidents involving R7, R8, and R58, were reviewed, investigated, completed and documented to resident and family satisfaction. 3. Abuse Prevention Policy and Procedure training is included in the New Hire orientation process. 4. Abuse Prevention Policy and Procedure training included in yearly all staff training schedule. 5. A daily IDT (Interdisciplinary Team)Review form has been created and used daily at morning standup. This includes grievances/complaints/concerns; incidents; falls; pressure sores; pain/comfort; resident change in condition; infections; behaviors; and staffing concerns. Education: 1. All staff were provided and educated	

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F 225	Continued From page 16 FORM indicated on 1/11/17, at 10:30 a.m. the SW interviewed R7 who indicated NA-A "grabbed her arm too hard and also slapped her." R7 indicated "NA-A is mean to her and gets rough with her, she is awful mean to me." R7 also 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 cares or services. The CONCERN AND/OR COMPLAINT REFERRAL FORM further indicated steps taken to investigate R7's alleged complaints of NA-A's abuse, however, had not identified the SA had been immediately notified of R7's alleged allegations of abuse. The vulnerable adult (VA) reports for R7 were reviewed, and a VA report to the state agency had not been made on 1/11/17, when R7 reported allegations of abuse to LPN-A, rather a VA report was found submitted to the state agency dated 1/12/17. On 1/11/17 at 7:47 p.m. the director of nursing (DON) indicated she was aware of R7's allegations of abuse by NA-A, and confirmed the facility had not immediately reported R7's allegations of abuse to the state agency. On 1/12/17 at 11:22 a.m. the administrator confirmed she was immediately notified of R7's allegations of abuse by NA-A, and confirmed the facility had not immediately reported R7's allegations of abuse to the state agency. R8 had an injury of unknown origin which was not	F 225	on the current Policy and Procedure for Abuse Prevention with focus on guidelines for reporting, procedure for reporting and investigation process, on 02/01/17 for Nurses, 02/08/17 for CNA's, and on 02/15/17 for all other disciplines. 2. Continuation of individual direct care staff education at time of incident on reporting guidelines and investigation process by DON/SW/designee if deficiencies are found. Audits: 1. Nursing notes and risk management notes in PCC are reviewed daily by the DON and/or charge nurse. These are then reviewed by the IDT team for additional information and follow up. Administrator to keep daily notes of IDT meetings in a binder and reviewed weekly to ensure compliance of any reportable VA concerns. 2. Weekly x8 weeks of random audits of facility staff to ensure understanding of the Abuse Prevention Policy and Procedure manual. Also weekly audits of IDT meeting notes to identify trends of timely reporting, and investigating appropriately per policy and procedure completed by the Director of Nursing. 3. Monthly ongoing audits, x3 months of facility staff to ensure understanding of Abuse Prevention Policy and Procedure, along with review of IDT meeting notes weekly to identify trends, completed by the	

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F 225	Continued From page 17 immediately reported to the SA or thoroughly investigated. R8's quarterly MDS dated 12/7/16, indicated R8 was cognitively impaired, required extensive assist of one or two staff with ADL's, and had diagnoses of fracture, manic depression, and Alzheimer. R8's current care plan dated 12/13/16, indicated R8 was a vulnerable adult related to impaired communication, and physical & cognitive impairment. The care plan directed staff to engage R8 in conversation while providing cares, allow R8 to voice concerns/worries, and establish a relationship that encouraged R8 to share difficulties and experiences. The care plan indicated R8 was dependent upon staff for ADL tasks due to impaired mobility secondary to diagnoses of Alzheimer ' s disease, severe dementia, arthritis, and functional incontinence. The care plan further indicated R8 was at risk for falls related to severe cognitive & physical impairments. The Risk Management Report, dated 3/14/16, at 12:00 a.m. indicated R8 was seated in a wheelchair by the nurses station due to being restless. R8's personal alarm sounded at 12:00 a.m. and R8 was found laying on back on the floor in front of the wheelchair. The report indicated R8's pants, incontinent brief, and blankets were found down around the ankles. There were no witnesses of this incident identified. The report indicated R8 had injuries that included a laceration near the right eye that	F 225	Director and Nursing, and report quarterly to QA Committee for review and recommendations.	

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measured 0.5 centimeters (cm), an abrasion of the forehead that measured 2 cm, an abrasion near the right eye/cheek area that measured 4 cm x 3 cm, and R8's left ankle was very tender and painful with no bruising noted. The report indicated the medical doctor and the power of attorney (POA) were notified of the incident on 3/14/16.

Review of the nurses notes dated 3/14/16, at 10:38 a.m. indicated R8's POA agreed to have x-ray of the left ankle due to pain. Following the X-ray the Perham hospital called at 3:15 p.m. and reported R8 had a distal tibia and fibula fracture of the left ankle which had been splinted.

Further review of R8's medical record revealed the SA was not immediately notified of R8's injury of unknown origin, and a thorough investigation of the aforementioned incident had not been completed.

On 1/13/17 at 10:01 a.m. the DON Confirmed R8 had a unwitnessed fall and sustained fractures to the left ankle area. The DON also verified the incident was not reported to the SA and she was not here at the time R8 fell. The DON confirmed the SA should of been notified when they found out R8 had a fracture of her ankle and a investigation should of been conducted.

On 1/13/17 at 10:03 a.m. the administrator confirmed the SA had not been notified of R8's unwitnessed fall with fractures and stated " yes this should of been reported." The administrator

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F 225	Continued From page 19 also indicated that any time there was an unwitnessed fall with a injury it needed to be reported immediately and investigated. R58 reported an allegation of rough treatment during cares, and the facility failed to thoroughly investigate or report R58's allegation of abuse to the SA. R58's quarterly MDS dated 11/29/16, identified R58 was cognitively intact, had diagnoses that included: seizure disorder, sprain of ligaments of the cervical spine (neck) with resulting decreased sensation to one side of the body, and required staff to provide guided maneuvering of the limbs to assist with dressing. R58's care plan dated 12/6/16, identified R58 was alert and oriented to person, required extensive assistance with dressing, and was vulnerable to abuse. The care plan directed staff to allow R58 to voice concerns or worries. On 1/12/17, the facilities "Concern and/or Complaint," forms were reviewed and included a report dated 11/24/16, at 7:30 p.m. that indicated R58 reported an allegation of "rough treatment" to 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	F 225		

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F 225	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 overwhelmed and probably had 10 residents to assist after helping him get ready for bed. R58 stated he didn't like the treatment received that night, and stated he hadn't told the NA he was upset with the treatment received, and was thankful the NA left the room and was gone. The SSD was interviewed on 1/17/17, at 10:39	F 225		

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F 225	Continued From page 21 a.m. and stated after R58 reported the allegation of rough treatment on 11/24/16, the SSD spoke to the DON and administrator on 11/25/16, who instructed the SSD to complete a concern and/or complaint form. The SSD stated she called NA-D to investigate R58's allegations of rough treatment, however, NA-D told her she did not assist R58 on 11/24/16, at 7:30 p.m. and stated NA-D reported she had nothing else to add to the investigation. The SSD stated she then reported NA-D's interview to the DON, and stated she thought she was done with her part of the investigation, and the DON would complete the rest of the investigation. The SSD stated she had not documented anything else related to R58's allegation of rough treatment after the concern form was completed. During further interview with the SSD regarding the facility's vulnerable adult policy and procedure, the SSD stated any allegations of abuse including rough treatment should be immediately reported to the SA, and confirmed R58's allegation of rough treatment had not been reported to the SA, even though R58's allegation of mistreatment met their policy criteria for reporting to the SA. The SSD confirmed a vulnerable adult report or any further documentation and follow up related R58's allegation of rough treatment had not been completed. The DON was interviewed on 1/17/17, at 11:01 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	F 225		

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F 225	Continued From page 22 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. The facility's Abuse Prevention policy dated 12/22/16, was reviewed and indicated each individual has the right to be free from verbal , sexual, physical, and mental abuse, (including injuries of unknown source, misappropriation of the resident property, corporal punishment, mistreatments, neglect, involuntary seclusion, and financial or material exploitation.) Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, or 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	F 225		

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F 225	Continued From page 23 directs the facility to conduct a root cause investigation and analysis of all allegations of abuse, neglect, injuries of unknown origin, and financial exploitation.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse	F 226		2/17/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 24 prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure vulnerable adult policies were implemented for allegations of abuse and/or injuries of unknown origin for 3 of 4 residents (R7, R8, and R58) whose allegations of abuse incidents were reviewed. Findings include: R7's admission Minimum Data Set (MDS) dated 12/21/16, indicated R7 was cognitively intact, required extensive assist of one staff with activities of daily living (ADL's) and had diagnoses of anxiety and depression. R7's current care plan dated 12/14/16, indicated R7 was a vulnerable adult related to communication, physical & cognitive impairment, and directed staff to engage resident in conversation while providing cares, allow resident to voice concerns or worries, establish a relationship which encouraged resident to share difficulties and experiences. The care plan also indicated R7 had ADL self care performance deficit related to being developmentally/intellectually disabled, and required staff assistance with all ADL's. Review of the CONCERN AND/OR COMPLAINT REFERRAL FORM, dated 1/11/17, indicated licensed practical nurse (LPN)-A reported to social worker (SW) that nursing assistant (NA)-A	F 226	The facility will ensure that their written policies and procedures that prohibit abuse, neglect, mistreatment and misappropriation of property are implemented and that all allegations of abuse and injuries of unknown origin are immediately reported to the State agency and thoroughly investigated. The facility will ensure that all allegations of abuse and injuries of unknown origin are immediately reported to the State agency and thoroughly investigated. Correction: 1. The policy and procedure for Abuse Prevention, which includes the procedure for reporting and investigation, was reviewed to ensure it is in compliance with current regulatory guidance. 2. Affected incidents involving R7, R8, and R58, were reviewed, investigated, completed and documented to resident and family satisfaction. 3. Abuse Prevention Policy and Procedure training is included in the New Hire orientation process. 4. Abuse Prevention Policy and Procedure training included in yearly all staff training schedule. 5. A daily IDT (Interdisciplinary	

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F 226	Continued From page 25 had slapped her last night. Further review of the CONCERN AND/OR COMPLAINT REFERRAL FORM indicated on 1/11/17, at 10:30 a.m. the SW interviewed R7 who indicated NA-A "grabbed her arm too hard and also slapped her." R7 indicated "NA-A is mean to her and gets rough with her, she is awful mean to me." R7 also 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 cares or services. The CONCERN AND/OR COMPLAINT REFERRAL FORM further indicated steps taken to investigate R7's alleged complaints of NA-A's abuse, however, had not identified the State agency (SA) had been immediately notified of R7's alleged allegations of abuse. The vulnerable adult (VA) reports for R7 were reviewed, and a VA report to the state agency had not been made on 1/11/17, when R7 reported allegations of abuse to LPN-A, rather a VA report was found submitted to the state agency dated 1/12/17. On 1/11/17 at 7:47 p.m. the director of nursing (DON) indicated she was aware of R7's allegations of abuse by NA-A, and confirmed the facility had not immediately reported R7's allegations of abuse to the state agency. On 1/12/17 at 11:22 a.m. the administrator confirmed she was immediately notified of R7's allegations of abuse by NA-A, and confirmed the facility had not immediately reported R7's allegations of abuse to the state agency.	F 226	Team)Review form has been created and used daily at morning standup. This includes grievances/complaints/concerns; incidents; falls; pressure sores; pain/comfort; resident change in condition; infections; behaviors; and staffing concerns. Education: 1. All staff were provided and educated on the current Policy and Procedure for Abuse Prevention with focus on guidelines for reporting, procedure for reporting and investigation process, on 02/01/17 for Nurses, 02/08/17 for CNA's, and on 02/15/17 for all other disciplines. 2. Continuation of individual direct care staff education at time of incident on reporting guidelines and investigation process by DON/SW/designee if deficiencies are found. Audits: 1. Nursing notes and risk management notes in PCC are reviewed daily by the DON and/or charge nurse. These are then reviewed by the IDT team for additional information and follow up. Administrator to keep daily notes of IDT meetings in a binder and reviewed weekly to ensure compliance of any reportable VA concerns. 2. Weekly x8 weeks of random audits of facility staff to ensure understanding of	

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F 226	Continued From page 26 R8 had an injury of unknown origin which was not immediately reported to the SA or thoroughly investigated according to the facility policy. R8's quarterly MDS dated 12/7/16, indicated R8 was cognitively impaired, required extensive assist of one or two staff with ADL's, and had diagnoses of fracture, manic depression, and Alzheimer. R8's current care plan dated 12/13/16, indicated R8 was a vulnerable adult related to impaired communication, and physical & cognitive impairment. The care plan directed staff to engage R8 in conversation while providing cares, allow R8 to voice concerns/worries, and establish a relationship that encouraged R8 to share difficulties and experiences. The care plan indicated R8 was dependent upon staff for ADL tasks due to impaired mobility secondary to diagnoses of Alzheimer ' s disease, severe dementia, arthritis, and functional incontinence. The care plan further indicated R8 was at risk for falls related to severe cognitive & physical impairments. The Risk Management Report, dated 3/14/16, at 12:00 a.m. indicated R8 was seated in a wheelchair by the nurses station due to being restless. R8's personal alarm sounded at 12:00 a.m. and R8 was found on the laying on back on the floor in front of the wheelchair. The report indicated R8's pants, incontinent brief, and	F 226	the Abuse Prevention Policy and Procedure manual. Also weekly audits of IDT meeting notes to identify trends of timely reporting, and investigating appropriately per policy and procedure completed by the Director of Nursing. 3. Monthly ongoing audits, x3 months of facility staff to ensure understanding of Abuse Prevention Policy and Procedure, along with review of IDT meeting notes weekly to identify trends, completed by the Director and Nursing, and report quarterly to QA Committee for review and recommendations.	

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blankets were found down around the ankles. There were no witnesses of this incident identified. The report indicated R8 had injuries that included a laceration near the right eye that measured 0.5 centimeters (cm), an abrasion of the forehead that measured 2 cm, an abrasion near the right eye/cheek area that measured 4 cm x 3 cm, and R8's left ankle was very tender and painful with no bruising noted. The report indicated the medical doctor and the power of attorney (POA) were notified of the incident on 3/14/16.

Review of the nurses notes dated 3/14/16, at 10:38 a.m. indicated R8's POA agreed to have x-ray of the left ankle due to pain. Following the X-ray the Perham hospital called at 3:15 p.m. and reported R8 had a distal tibia and fibula fracture of the left ankle which had been splinted.

Further review of R8's medical record revealed the SA was immediately notified of R8's of known origin, and a thorough investigation of the aforementioned incident had not been completed.

On 1/13/17 at 10:01 a.m. the DON confirmed R8 had an unwitnessed fall and sustained fractures to the left ankle area. The DON also verified the incident was not reported to the SA and she was not here at the time R8 fell. The DON confirmed the SA should of been notified when they found out R8 had a fracture of her ankle and a investigation should of been conducted.

On 1/13/17 at 10:03 a.m. the administrator

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confirmed the SA had not been notified of R8's unwitnessed fall with fractures and stated "yes this should of been reported." The administrator also indicated that any time there is a unwitnessed fall with a injury it needs to be reported immediately and investigated.

R58 reported an allegation of rough treatment during cares and the facility failed to follow their Vulnerable Adult Policy related to the immediate reporting to the SA, and had not conducted a thorough investigation of alleged abuse.

R58 reported an allegation of rough treatment during cares, and the facility failed to thoroughly investigate or report R58's allegation of abuse to the SA.

R58's quarterly MDS dated 11/29/16, identified R58 was cognitively intact, had diagnoses that included: seizure disorder, sprain of ligaments of the cervical spine (neck) with resulting decreased sensation to one side of the body, and required staff to provide guided maneuvering of the limbs to assist with dressing.

R58's care plan dated 12/6/16, identified R58 was alert and oriented to person, required extensive assistance with dressing, and was vulnerable to abuse. The care plan directed staff to allow R58 to voice concerns or worries.

On 1/12/17, the facilities "Concern and/or Complaint," forms were reviewed and included a report dated 11/24/16, at 7:30 p.m. that indicated

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F 226	Continued From page 29 R58 reported an allegation of "rough treatment" to 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 state agency (SA). The interim director of nurses 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	F 226		

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F 226	Continued From page 30 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 overwhelmed and probably had 10 residents to assist after helping him get ready for bed. R58 stated he didn't like the treatment received that night, and stated he hadn't told the NA he was upset with the treatment received, and was thankful the NA left the room and was gone. The SSD was interviewed on 1/17/17, at 10:39 a.m. and stated after R58 reported the allegation of rough treatment on 11/24/16, the SSD spoke to the DON and administrator on 11/25/16, who instructed the SSD to complete a concern and/or complaint form. The SSD stated she called NA-D to investigate R58's allegations of rough treatment, however, NA-D told her she did not assist R58 on 11/24/16, at 7:30 p.m. and stated NA-D reported she had nothing else to add to the investigation. The SSD stated she then reported NA-D's interview to the DON, and stated she thought she was done with her part of the investigation, and the DON would complete the rest of the investigation. The SSD stated she had not documented anything else related to R58's allegation of rough treatment after the concern form was completed. During further interview with the SSD regarding the facility's vulnerable adult policy and procedure, the SSD stated any allegations of abuse including rough treatment should be immediately reported to the SA, and confirmed R58's allegation of rough treatment had not been reported to the SA, although R58's allegation of mistreatment met their policy criteria for reporting to the SA. The SSD confirmed a vulnerable adult report or any further documentation and follow up related R58's	F 226		

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F 226	Continued From page 31 allegation of rough treatment had not been completed. The DON was interviewed on 1/17/17, at 11:01 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. The facility's Abuse Prevention policy dated 12/22/16, was reviewed and indicated each individual has the right to be free from verbal , sexual, physical, and mental abuse, (including	F 226		

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F 226	Continued From page 32 injuries of unknown source, misappropriation of the resident property, corporal punishment, mistreatments, neglect, involuntary seclusion, and financial or material exploitation.) Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, or 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.	F 226		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adequate housekeeping and maintenance services were provided for 17 of 28 resident rooms (Rm306, Rm201, Rm228, Rm222, Rm203, Rm212, Rm316, Rm314, Rm214, Rm217, Rm308, Rm315, Rm202, Rm211, Rm301, Rm208, Rm304) observed with environmental concerns. Findings include: On 1/13/17, at 1:57 p.m. an environmental tour of	F 253	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 bed will be repaired and painted, the	2/28/17

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F 253	Continued From page 33 the facility was conducted with maintenance assistant (MA)-A and the housekeeping supervisor (HS)-A. Both MA-A and HS-A confirmed the following findings: -Room 306, bathroom faucet had thick lime scale build up.. -Room 201, the wall next to the bed had an area of 1-2 feet in diameter with several black marks and nail holes above the bed. The bathroom wall had several nails and nail holes present and the faucet had thick lime scale build up with black spots present. -Room 228, the bathroom door had several large scrapes with stain missing. Thick lime scale build up was noted on the bathroom faucet. -Room 222, the bathroom faucet had corrosion and the paint on the wall to the right side of the sink was cracking and peeling. -Room 203, the wall near the bed had several black scrape marks. The bathroom wall had an area approximately 8 X 10 inches with yellow glue like substance present. Thick lime scale build up was noted on the faucet. The faucet was dripping. -Room 212, the bathroom faucet was corroded and had thick lime scale build present. The faucet was dripping. -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	F 253	bathroom walls will be repaired and painted, and the facet will be replaced. Room 228 - the bathroom door will be repaired and stained, bathroom faucet will be replaced. Room 222 - bathroom faucet will be replaced and the wall to the right of the sink repaired and painted. Room 203 - wall marks by the bed will be removed, bathroom wall area with yellow glue like substance will be removed, and bathroom faucet will be replaced. Room 212 - bathroom faucet will be replaced. Room 316 - wall around the outlet near the bed will be painted. Room 314 - grout around the toilet will be replaced. Room 214 - bathroom faucet will be replaced. Room 217 - bathroom faucet will be replaced and the bathroom floor sanded and varnished. Room 308 - bathroom faucet will be replaced. Room 303 - bathroom faucet will be replaced. Room 315 - grout around the floor will be	

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F 253	Continued From page 34 observed in several areas. -Room 214, the bathroom faucet had corrosion and thick lime scale build up. -Room 217, the bathroom faucet had corrosion and thick lime scale build up. R18's bathroom floor had dark stains near the toilet. -Room 308, the bathroom faucet had thick lime scale present. -Room 303, the bathroom faucet had thick lime scale present. -Room 315, The grout around the floor was peeling and a dark brown/black substance was observed in several areas. -Room 202, the bathroom faucet had thick lime scale was present. Grey spotted area approximately 1 foot in diameter was on the floor in front of the toilet. -Room 211, the bathroom faucet had thick lime scale was present. -Room 301, the bathroom faucet had thick lime scale was present. -Room 208, the bathroom faucet had thick lime scale was present. A dark brown/black substance observed in several places on the grout around the toilet. -Room 304, the bathroom faucet had thick lime scale was present. The bathroom doorknob was dented.	F 253	replaced and remove dark brown/black substance observed in several areas. Room 202 - bathroom faucet will be replaced, grey spotted area on floor in front of toilet sanded and varnished. Room 211 - bathroom faucet will be replaced. Room 301 - bathroom faucet will be replaced. Room 208 - bathroom faucet will be replaced, grout around the toilet. Room 304 - bathroom faucet will be replaced, and bathroom doorknob replaced. Education: Housekeeping and Maintenance Directors conducted a mandatory in-service for all Housekeeping, Laundry and Maintenance staff on 02/02/17 to review the survey results. Housekeeping staff were in-serviced on the requirement that they report any maintenance and/or safety concern to the Maintenance Department by completing the newly created Housekeeping Audit tool on a daily basis. The housekeeping audit tool will be reviewed by the Housekeeping Director, who will then write all repairs in the Maintenance log book located at the nurses' station. Maintenance will check daily for repairs, and reviewed by the Administrator monthly.	

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F 253	Continued From page 35 During the tour, at 1:57 p.m. MA-A verified the above findings and stated he was unaware of above findings. MA-A indicated the maintenance department was notified of concerns by the maintenance log kept at the nurses desk. He stated they checked this daily, often 2-3 times per day. MA-A indicated staff also notified them of concerns verbally. MA-A indicated he did not know of the schedule for painting walls, however, the maintenance director, who was not present at time of tour, may have one written down somewhere. HS-A also confirmed the findings and stated the facility utilized a light acid cleaner and disinfectant bathroom cleaner and tried to do the best they could to keep the lime scale from building up. During interview on 1/13/17, at 2:30 p.m. the administrator verified the housekeeping staff tried to do the best they could to keep lime scale removed. The administrator indicated some of the faucets would be replaced as needed, but they were unable to replace them all at once. The administrator indicated at this time, there was no current plan was in place to replace the faucets. On 1/17/17, at 2:13 p.m. the maintenance log was reviewed from August 2016, to current date. The aforementioned findings were not identified on the maintenance repair log. Review of facility policy titled, Maintenance Repair Request, undated, directed staff to notify maintenance department of needed repairs and	F 253	Audits: 1. Weekly audits, x8 by housekeeping staff using the Housekeeping Audit tool. Audits will be turned in daily. Housekeeping Director will review daily and track in the Maintenance log when repairs or safety concerns are noted. Maintenance will review daily and complete repairs in a timely manner. Administrator will review and conduct random audits to visually inspection rooms, and the facility on a weekly basis, along with the audit documentation tool for accuracy and completion. 2. Monthly audits, x3 by housekeeping staff using the Housekeeping Audit tool with above protocol, conducting monthly audits by the Administrator. Findings will be reported to the QA committee quarterly for review and recommendations.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 36 services by documenting on request slips, kept in the "Maintenance Log Book". All requests must be written unless emergency repairs to vital equipment or hazardous violations to safety standards, in those cases staff are directed to notify the maintenance director immediately. Review of facility policy titled, Housekeeping Policies and Procedures, undated, directed the housekeeping staff to clean sinks in resident rooms daily. It also directed the housekeeping staff to examine the resident rooms for any repairs needed to be done while cleaning and note on clipboard on cart to be reported to maintenance department.	F 253		
F 283 SS=D	483.21(c)(2)(i)-(iii) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS (c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge	F 283		2/10/17

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	245562	A. BUILDING _____ B. WING _____	01/17/2017

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F 283	Continued From page 37 medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: 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. Findings include: 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. R9 had expired in the facility in August 2016. R9'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. R35 had expired in the facilty in September 2016. R35'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	F 283	When the facility anticipates discharge, a resident will have a discharge summary that includes a recapitulation of resident's stay, final summary of the resident's status at the time of discharge, and reconciliation of all pre-discharge and post-discharge medications. Correction: 1. The policy and procedure for Discharge Summary and Recapitulation reviewed and updated to ensure compliance with current regulatory guidance. 2. Affected discharge files involving R1, R9, and R25 were reviewed and discharge summary/recapitulation forms completed and forwarded to their Primary MD for review and signature. 3. Audit of all discharge charts in the last six (6) months for missing discharge summary/recapitulation forms. Any found to be deficient will be reviewed and discharge summary/recapitulation forms completed and forwarded to MD for review and signature. 4. Discharge summary/recapitulation forms reviewed and updated to include required information per current regulatory guidance.	

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F 283	Continued From page 38 results. 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 three of the aforementioned medical records lacked a recapitulation of their stay in the facility. She stated she normally included resident's admission information, admission diagnoses, rehabilitation plan, and a synopsis of their facility stay on the discharge summary form. On 1/17/17, at 11:01 a.m. the director of nurses (DON) confirmed LPN-B signed R1, R9 and R35's discharge summary forms, and confirmed they lacked admitting diagnoses, a summary of whether they received therapy or not, and decline in status. She stated the discharge summary needed to be more complete and should have told a story of the time period they were in the facility. She stated she would expect staff to complete a thorough and timely discharge summary for every discharge. Review of facility, "Discharge and Recapitulation Summary Form Instructions," identified the facility would complete a summary of the resident's stay at the facility upon discharge from the facility.	F 283	5. Discharge summary/recapitulation forms added to discharge checklist. Education: 1. Policy, Procedure and Regulatory Guidance education completed with staff responsible completion of discharge summary and recapitulation forms (responsible party MDS Coordinator). Audits: 1. Weekly audits x8 for all new discharged resident charts by the MDS Coordinator. 2. Monthly random audits x3 of discharged charted by MDS coordinator to ensure compliance. Monitored and reviewed by QA committee quarterly.	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 441		2/24/17

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F 441	Continued From page 39 a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 441		

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F 441	Continued From page 40 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly disinfect a communally used blood glucose monitor in order to prevent the possible transmission of blood-borne pathogens before and after use for one resident (R32) which had the potential to affect 5 residents who shared the glucometer. Findings include: On 1/12/17, at 11:25 a.m. licensed practical nurse (LPN)-A was observed to retrieve a blood glucose monitor labeled Assure Prism from the drawer of the medication cart, and wiped it down with an alcohol swab. LPN-A entered R32's room with	F 441	The facility will properly disinfect blood glucose monitors in order to prevent the possible transmission of blood-borne pathogens before and after use when glucometer's are shared. Correction: 1. R32 blood glucose monitor was cleansed per policy on 01/12/17 and LPN was educated on proper procedure. 2. Facility has created a new Glucometer Policy which instructs each resident will have their own individual glucometer stored in their individual rooms and cleansed with a germicidal wipe following	

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F 441	Continued From page 41 the glucometer and proceeded to draw a drop of blood from R32's finger and performed the blood glucose test using the blood glucose monitor. After she completed the blood glucose test, LPN-A returned to the medication cart and obtained an alcohol swab and began to wipe down the blood glucose monitor then laid it down on the cart for 1-2 minutes then placed it back into the medication cart drawer. During interview on 1/12/17, at 8:30 a.m. LPN-A confirmed the facility used the same blood glucose monitor for all of the residents who required blood glucose monitoring in the facility. LPN-A stated her practice was to clean the blood glucose monitor between residents by wiping it down with an alcohol swab before returning it back to the drawer of the medication cart. During interview on 1/13/17, at 1:10 p.m. the director of nursing (DON) confirmed the blood glucose monitor was shared by residents who required blood glucose monitoring. She stated she expected staff to follow facilty policy on proper disinfection of blood glucose monitors between residents. When asked of specific procedure, she stated the blood glucose monitor should be disinfected with a specific type of wipe, cover the machine with the wipe and then it should be set out, but she stated she could not give specific details. She stated they were working on policies for blood glucose monitors per manufactures recommendations for cleaning and auditing compliance, but the goal date for the completion of them was set for 1/20/17, therefore had not been not completed yet.	F 441	use per manufacturer guidelines. Education: 1. All RN's, LPN's, and TMA's will be educated on the new Glucometer Policy with competency by 02/24/17 by individual in-service training. Audit: 1. Infection Control Nurse is responsible for assigning the blood glucose machines to new and current residents. A meter tracking system has been implemented. This system tracks the machines assigned to each resident by serial number. In addition, a process for tracking Quality Assurance has been implemented. This will also be monitored by the Infection Control Nurse. If a meter is determined to not be within control limits, it will be removed from use and a new machine issued to that resident. The new machine serial number will be documented on the meter tracking form. Monthly the machine serial number's and resident names will be verified by Infection Control Nurse. 2. Audit weekly x8, those individuals completing blood glucose testing for competency by direct supervision completed by the Director of Nursing. 3. Monthly x3, random blood glucose testing of staff competency by direct observation completed by the Director of Nursing and report findings to QA	

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F 441	Continued From page 42 Review of the Cleansing and Disinfecting your Assure Prism Multi Blood Glucose Meter System instruction sheet, Arkray USA, dated 01/15, identified the meter must have a disinfection procedure completed to prevent the transmission of blood-borne pathogens. It stated any disinfectant product with the EPA registration number of 67619-12 may be used on the devise. The procedure included wiping the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood-born pathogens with the towelette. Allow exterior to remain wet for 1 minute, then wipe the meter using a dry cloth. On 1/13/17, a policy on cleansing and disinfecting blood glucose monitors shared by residents was requested, but the facility did not provide a current policy.	F 441	committee quarterly for review and recommendations.	

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K 000	INITIAL COMMENTS	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Elders Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99)

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to:

EPOC

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Elders Home is a 1-story building with a partial basement. The original building was constructed in 1959 and was determined to be of Type II(111) construction. In 1993, an addition was added to the south that was determined to be of Type II (111). In 1999 an addition was added onto the Dinning Room to the west which is Type V (111). The building is divided into 4 smoke zones divided by 30 minute and 90 minute fire barriers. The facility was surveyed as one building due to the lack of a 2 hour fire barrier between the two types of construction as stated in the 2012 Life Safety Code section 8.2.1.3 and the existing structure meets the requirements of chapter 19. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems. The facility has a manual fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for	K 000		

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K 000	Continued From page 2 automatic fire department notification, installed in accordance with NFPA 72 "The National Fire Alarm Code". Other hazardous areas have automatic fire detectors. The sleeping rooms have single smoke detectors that are battery operated. The facility has a capacity 48 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=E	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide the required self closer's on hazardous rooms as state in the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.4. This deficient practice could allow smoke to enter the corridor making it unusable or difficult for exiting. This could affect 7 of the 33 residents and an undetermined amount of staff and visitors.	K 223	The facility will provide the required self closer's on hazardous rooms as stated in the 2012 Life Safety Code. Correction: 1. Self-closing hinges for the doors on two storage rooms have been ordered,	2/28/17

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K 223	Continued From page 3 Findings include: 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, 47 & 29 that did not have self closer's. This deficient condition was confirmed by the Director of Maintenance.	K 223	02/01/17, and will be installed in storage rooms #47 and #29. 2. Completion date for the installation will be complete by 02/28/2017. Education: 1. Maintenance director has reviewed the 2012 Life Safety Code manual for the required education concerning self-closer's on hazardous rooms in skilled nursing facilities. 2. Maintenance director is responsible for ordering, installing, and maintaining the self-closing hinges. Audits: 1. Audits will be completed monthly that closures are in good working order and added to the Maintenance Prevention monthly check list.	
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353		2/3/17

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K 353	Continued From page 4 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 9:00 am to 1:00 pm on 01/11/2017 observations and staff interview revealed a two sprinkler heads covered in lint. One in the kitchen dish washing area and one in the laundry room. This deficient condition was confirmed by the Director of Maintenance.	K 353	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: 1. Maintenance Director reviewed the 2012 Life Safety Code manual for the standard for testing and maintenance of the sprinkler systems. Audits: 1. Maintenance Director is responsible for keeping the sprinkler heads clean. 2. Inspection of the sprinkler heads has been added to the Daily Preventive Maintenance checklist and reported to the Administrator of any concerns or issues on a monthly basis.	
K 521 SS=C	NFPA 101 HVAC	K 521		1/26/17

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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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain proper exhaust throughout all resident wings as required by the 2012 Life Safety Code (NFPA 101) section 9.2.2 and NFPA 91 Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids. This deficient practice could negatively affect all of the 33 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 1:00 pm on 01/11/2017 observations and staff interview revealed the bathroom exhaust in the resident rooms were not operable. This deficient condition was confirmed by the Director of Maintenance.	K 521	The facility will maintain proper exhaust throughout all residents wings as required by the 2012 Life Safety Code. Correction: 1. The exhaust system motor was rebuilt and new belts were installed at the same time and is in working order as of 01/26/17. 2. All resident bathroom exhaust systems are presently working. Education: 1. Maintenance Director reviewed the 2012 Life Safety Code for proper exhaust maintenance throughout all residents wings, (reviewed at time of installation). Audits: 1. Maintenance Director is responsible for maintenance of the exhaust system. 2. Weekly Preventive Maintenance Checklist will be used to conduct audits of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245562	A. BUILDING **01 - 01 MAIN BUILDING** B. WING _____	**01/11/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERS HOME INC	**SOUTH TOUSLEY, PO BOX 188** **NEW YORK MILLS, MN 56567**

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K 521	Continued From page 6	K 521	exhaust performance. 2. Random audits will be conducted weekly x8 for proper exhaust in resident rooms.	

MDH
Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00432	A. BUILDING: _____ 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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 10th, 11th, 12th, 13th and 17th 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 680	MN Rule 4658.0465 Subp. 1 Transfer, Discharge, and Death: Dis. Summay Subpart 1. Discharge summary at death. When a resident dies, the nursing home must compile a discharge summary that includes the date, time, and cause of death. This MN Requirement is not met as evidenced by: 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. Findings include: 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. R9 had expired in the facility in August 2016. R9's medical record lacked a discharge summary which included a recapitulation of the residents	2 680	Corrected	2/10/17

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2 680	Continued From page 3 stay that included but was not limited to: diagnoses, course of illness/treatment or therapy and pertinent lad, radiology and consultation results. R35 had expired in the facilty in September 2016. R35'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. 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 three of the aforementioned medical records lacked a recapitulation of their stay in the facility. She stated she normally included resident's admission information, admission diagnoses, rehabilitation plan, and a synopsis of their facility stay on the discharge summary form. On 1/17/17, at 11:01 a.m. the director of nurses (DON) confirmed LPN-B signed R1, R9 and R35's discharge summary forms, and confirmed they lacked admitting diagnoses, a summary of whether they received therapy or not, and decline in status. She stated the discharge summary needed to be more complete and should have told a story of the time period they were in the facility. She stated she would expect staff to complete a thorough and timely discharge summary for every discharge. Review of facility, "Discharge and Recapitulation	2 680		

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2 680	Continued From page 4 Summary Form Instructions," identified the facility would complete a summary of the resident's stay at the facility upon discharge from the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise discharge summary procedures and provide education to staff in order to ensure completeness of the summary, as require. The DON or designee could conduct auditing of the discharge summaries to ensure compliance. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 680		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of	21390		2/24/17

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21390	Continued From page 5 employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly disinfect a communally used blood glucose monitor in order to prevent the possible transmission of blood-borne pathogens before and after use for one resident (R32) which had the potential to affect 5 residents who shared the glucometer. Findings include: On 1/12/17, at 11:25 a.m. licensed practical nurse (LPN)-A was observed to retrieve a blood glucose monitor labeled Assure Prism from the drawer of the medication cart, and wiped it down with an alcohol swab. LPN-A entered R32's room with the glucometer and proceeded to draw a drop of blood from R32's finger and performed the blood glucose test using the blood glucose monitor. After she completed the blood glucose test, LPN-A returned to the medication cart and obtained an alcohol swab and began to wipe down the blood glucose monitor then laid it down on the cart for 1-2 minutes then placed it back into the medication cart drawer.	21390	Corrected	

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21390	Continued From page 6 During interview on 1/12/17, at 8:30 a.m. LPN-A confirmed the facility used the same blood glucose monitor for all of the residents who required blood glucose monitoring in the facility. LPN-A stated her practice was to clean the blood glucose monitor between residents by wiping it down with an alcohol swab before returning it back to the drawer of the medication cart. During interview on 1/13/17, at 1:10 p.m. the director of nursing (DON) confirmed the blood glucose monitor was shared by residents who required blood glucose monitoring. She stated she expected staff to follow facilty policy on proper disinfection of blood glucose monitors between residents. When asked of specific procedure, she stated the blood glucose monitor should be disinfected with a specific type of wipe, cover the machine with the wipe and then it should be set out, but she stated she could not give specific details. She stated they were working on policies for blood glucose monitors per manufactures recommendations for cleaning and auditing compliance, but the goal date for the completion of them was set for 1/20/17, therefore had not been not completed yet. Review of the Cleansing and Disinfecting your Assure Prism Multi Blood Glucose Meter System instruction sheet, Arkray USA, dated 01/15, identified the meter must have a disinfection procedure completed to prevent the transmission of blood-borne pathogens. It stated any disinfectant product with the EPA registration number of 67619-12 may be used on the devise. The procedure included wiping the entire surface	21390		

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21390	Continued From page 7 of the meter 3 times horizontally and 3 times vertically to remove blood-born pathogens with the towelette. Allow exterior to remain wet for 1 minute, then wipe the meter using a dry cloth. On 1/13/17, a policy on cleansing and disinfecting blood glucose monitors shared by residents was requested, but the facility did not provide a current policy. SUGGESTED METHOD OF CORRECTION: The director of nursing could implement a policy on disinfection of blood glucose meters per manufactures recommendations. Audits could be conducted to ensure staff are disinfecting per policy. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21390		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and record	21695	Corrected	2/28/17

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21695	Continued From page 8	21695		

review, the facility failed to ensure adequate housekeeping and maintenance services were provided for 17 of 28 resident rooms (Rm306, Rm201, Rm228, Rm222, Rm203, Rm212, Rm316, Rm314, Rm214, Rm217, Rm308, Rm315, Rm202, Rm211, Rm301, Rm208, Rm304) observed with environmental concerns.

Findings include:

On 1/13/17, at 1:57 p.m. an environmental tour of the facility was conducted with maintenance assistant (MA)-A and the housekeeping supervisor (HS)-A. Both MA-A and HS-A confirmed the following findings:

-Room 306, bathroom faucet had thick lime scale build up..

-Room 201, the wall next to the bed had an area of 1-2 feet in diameter with several black marks and nail holes above the bed. The bathroom wall had several nails and nail holes present and the faucet had thick lime scale build up with black spots present.

-Room 228, the bathroom door had several large scrapes with stain missing. Thick lime scale build up was noted on the bathroom faucet.

-Room 222, the bathroom faucet had corrosion and the paint on the wall to the right side of the sink was cracking and peeling.

-Room 203, the wall near the bed had several black scrape marks. The bathroom wall had an area approximately 8 X 10 inches with yellow glue

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21695	Continued From page 9 like substance present. Thick lime scale build up was noted on the faucet. The faucet was dripping. -Room 212, the bathroom faucet was corroded and had thick lime scale build present. The faucet was dripping. -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 bathroom faucet had corrosion and thick lime scale build up. -Room 217, the bathroom faucet had corrosion and thick lime scale build up. R18's bathroom floor had dark stains near the toilet. -Room 308, the bathroom faucet had thick lime scale present. -Room 303, the bathroom faucet had thick lime scale present. -Room 315, The grout around the floor was peeling and a dark brown/black substance was observed in several areas. -Room 202, the bathroom faucet had thick lime scale was present. Grey spotted area approximately 1 foot in diameter was on the floor in front of the toilet. -Room 211, the bathroom faucet had thick lime scale was present. -Room 301, the bathroom faucet had thick lime	21695		

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21695	Continued From page 10 scale was present. -Room 208, the bathroom faucet had thick lime scale was present. A dark brown/black substance observed in several places on the grout around the toilet. -Room 304, the bathroom faucet had thick lime scale was present. The bathroom doorknob was dented. During the tour, at 1:57 p.m. MA-A verified the above findings and stated he was unaware of above findings. MA-A indicated the maintenance department was notified of concerns by the maintenance log kept at the nurses desk. He stated they checked this daily, often 2-3 times per day. MA-A indicated staff also notified them of concerns verbally. MA-A indicated he did not know of the schedule for painting walls, however, the maintenance director, who was not present at time of tour, may have one written down somewhere. HS-A also confirmed the findings and stated the facility utilized a light acid cleaner and disinfectant bathroom cleaner and tried to do the best they could to keep the lime scale from building up. During interview on 1/13/17, at 2:30 p.m. the administrator verified the housekeeping staff tried to do the best they could to keep lime scale removed. The administrator indicated some of the faucets would be replaced as needed, but they were unable to replace them all at once. The administrator indicated at this time, there was no current plan was in place to replace the faucets.	21695		

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21695	Continued From page 11 On 1/17/17, at 2:13 p.m. the maintenance log was reviewed from August 2016, to current date. The aforementioned findings were not identified on the maintenance repair log. Review of facility policy titled, Maintenance Repair Request, undated, directed staff to notify maintenance department of needed repairs and services by documenting on request slips, kept in the "Maintenance Log Book". All requests must be written unless emergency repairs to vital equipment or hazardous violations to safety standards, in those cases staff are directed to notify the maintenance director immediately. Review of facility policy titled, Housekeeping Policies and Procedures, undated, directed the housekeeping staff to clean sinks in resident rooms daily. It also directed the housekeeping staff to examine the resident rooms for any repairs needed to be done while cleaning and note on clipboard on cart to be reported to maintenance department. SUGGESTED METHOD OF CORRECTION: The director of maintenance could ensure a plan was in place to clean and replace faucets on a prioritized schedule. Audits could be conducted to ensure staff are cleaning and reporting timely repairs. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21695		

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	00432	A. BUILDING: _____ B. WING _____	01/17/2017

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21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that	21980		2/17/17

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21980	Continued From page 13 the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse and injuries of unknown origin were immediately reported to the State agency (SA) and were thoroughly investigated for 3 of 4 residents (R7, R8, and R58) whose allegations of abuse incidents were reviewed. Findings include: R7's admission Minimum Data Set (MDS) dated 12/21/16, indicated R7 was cognitively intact, required extensive assist of one staff with activities of daily living (ADL's) and had diagnoses of anxiety and depression. R7's current care plan dated 12/14/16, indicated R7 was a vulnerable adult related to communication, physical & cognitive impairment, and directed staff to engage resident in conversation while providing cares, allow resident to voice concerns or worries, establish a relationship which encouraged resident to share	21980	Corrected	

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21980	Continued From page 14 difficulties and experiences. The care plan also indicated R7 had ADL self care performance deficit related to being developmentally/intellectually disabled, and required staff assistance with all ADL's Review of the CONCERN AND/OR COMPLAINT REFERRAL FORM, dated 1/11/17, indicated licensed practical nurse (LPN)-A reported to social worker (SW) that nursing assistant (NA)-A had slapped her last night. Further review of the CONCERN AND/OR COMPLAINT REFERRAL FORM indicated on 1/11/17, at 10:30 a.m. the SW interviewed R7 who indicated NA-A "grabbed her arm too hard and also slapped her." R7 indicated "NA-A is mean to her and gets rough with her, she is awful mean to me." R7 also 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 cares or services. The CONCERN AND/OR COMPLAINT REFERRAL FORM further indicated steps taken to investigate R7's alleged complaints of NA-A's abuse, however, had not identified the SA had been immediately notified of R7's alleged allegations of abuse. The vulnerable adult (VA) reports for R7 were reviewed, and a VA report to the state agency had not been made on 1/11/17, when R7 reported allegations of abuse to LPN-A, rather a VA report was found submitted to the state agency dated 1/12/17. On 1/11/17 at 7:47 p.m. the director of nursing (DON) indicated she was aware of R7's allegations of abuse by NA-A, and confirmed the	21980		

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21980	Continued From page 15 facility had not immediately reported R7's allegations of abuse to the state agency. On 1/12/17 at 11:22 a.m. the administrator confirmed she was immediately notified of R7's allegations of abuse by NA-A, and confirmed the facility had not immediately reported R7's allegations of abuse to the state agency. R8 had an injury of unknown origin which was not immediately reported to the SA or thoroughly investigated. R8's quarterly MDS dated 12/7/16, indicated R8 was cognitively impaired, required extensive assist of one or two staff with ADL's, and had diagnoses of fracture, manic depression, and Alzheimer. R8's current care plan dated 12/13/16, indicated R8 was a vulnerable adult related to impaired communication, and physical & cognitive impairment. The care plan directed staff to engage R8 in conversation while providing cares, allow R8 to voice concerns/worries, and establish a relationship that encouraged R8 to share difficulties and experiences. The care plan indicated R8 was dependent upon staff for ADL tasks due to impaired mobility secondary to diagnoses of Alzheimer ' s disease, severe dementia, arthritis, and functional incontinence. The care plan further indicated R8 was at risk for falls related to severe cognitive & physical impairments.	21980		

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21980	Continued From page 16	21980		

The Risk Management Report, dated 3/14/16, at 12:00 a.m. indicated R8 was seated in a wheelchair by the nurses station due to being restless. R8's personal alarm sounded at 12:00 a.m. and R8 was found laying on back on the floor in front of the wheelchair. The report indicated R8's pants, incontinent brief, and blankets were found down around the ankles. There were no witnesses of this incident identified. The report indicated R8 had injuries that included a laceration near the right eye that measured 0.5 centimeters (cm), an abrasion of the forehead that measured 2 cm, an abrasion near the right eye/cheek area that measured 4 cm x 3 cm, and R8's left ankle was very tender and painful with no bruising noted. The report indicated the medical doctor and the power of attorney (POA) were notified of the incident on 3/14/16.

Review of the nurses notes dated 3/14/16, at 10:38 a.m. indicated R8's POA agreed to have x-ray of the left ankle due to pain. Following the X-ray the Perham hospital called at 3:15 p.m. and reported R8 had a distal tibia and fibula fracture of the left ankle which had been splinted.

Further review of R8's medical record revealed the SA was not immediately notified of R8's injury of unknown origin, and a thorough investigation of the aforementioned incident had not been completed.

On 1/13/17 at 10:01 a.m. the DON Confirmed R8 had a unwitnessed fall and sustained fractures to the left ankle area. The DON also verified the incident was not reported to the SA and she was

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21980	Continued From page 17 not here at the time R8 fell. The DON confirmed the SA should of been notified when they found out R8 had a fracture of her ankle and a investigation should of been conducted. On 1/13/17 at 10:03 a.m. the administrator confirmed the SA had not been notified of R8's unwitnessed fall with fractures and stated " yes this should of been reported." The administrator also indicated that any time there was an unwitnessed fall with a injury it needed to be reported immediately and investigated. R58 reported an allegation of rough treatment during cares, and the facility failed to thoroughly investigate or report R58's allegation of abuse to the SA. R58's quarterly MDS dated 11/29/16, identified R58 was cognitively intact, had diagnoses that included: seizure disorder, sprain of ligaments of the cervical spine (neck) with resulting decreased sensation to one side of the body, and required staff to provide guided maneuvering of the limbs to assist with dressing. R58's care plan dated 12/6/16, identified R58 was alert and oriented to person, required extensive assistance with dressing, and was vulnerable to abuse. The care plan directed staff to allow R58 to voice concerns or worries. On 1/12/17, the facilities "Concern and/or Complaint," forms were reviewed and included a report dated 11/24/16, at 7:30 p.m. that indicated R58 reported an allegation of "rough treatment" to	21980		

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21980	Continued From page 18 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 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	21980		

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21980	Continued From page 19 overwhelmed and probably had 10 residents to assist after helping him get ready for bed. R58 stated he didn't like the treatment received that night, and stated he hadn't told the NA he was upset with the treatment received, and was thankful the NA left the room and was gone. The SSD was interviewed on 1/17/17, at 10:39 a.m. and stated after R58 reported the allegation of rough treatment on 11/24/16, the SSD spoke to the DON and administrator on 11/25/16, who instructed the SSD to complete a concern and/or complaint form. The SSD stated she called NA-D to investigate R58's allegations of rough treatment, however, NA-D told her she did not assist R58 on 11/24/16, at 7:30 p.m. and stated NA-D reported she had nothing else to add to the investigation. The SSD stated she then reported NA-D's interview to the DON, and stated she thought she was done with her part of the investigation, and the DON would complete the rest of the investigation. The SSD stated she had not documented anything else related to R58's allegation of rough treatment after the concern form was completed. During further interview with the SSD regarding the facility's vulnerable adult policy and procedure, the SSD stated any allegations of abuse including rough treatment should be immediately reported to the SA, and confirmed R58's allegation of rough treatment had not been reported to the SA, even though R58's allegation of mistreatment met their policy criteria for reporting to the SA. The SSD confirmed a vulnerable adult report or any further documentation and follow up related R58's allegation of rough treatment had not been completed.	21980		

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21980	Continued From page 20 The DON was interviewed on 1/17/17, at 11:01 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. The facility's Abuse Prevention policy dated 12/22/16, was reviewed and indicated each individual has the right to be free from verbal , sexual, physical, and mental abuse, (including injuries of unknown source, misappropriation of the resident property, corporal punishment, mistreatments, neglect, involuntary seclusion, and financial or material exploitation.) Any nursing home employee or volunteer who becomes	21980		

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21980	Continued From page 21 aware of abuse, mistreatment, neglect, or 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. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) and/or designee could review policy and provide education for staff regarding the immediate reporting and/or the completion of a thorough investigation related to maltreatment, abuse and inuries of unknown origins. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse,	22000		2/17/17

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22000	Continued From page 22	22000		

and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

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22000	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure vulnerable adult policies were implemented for allegations of abuse and/or injuries of unknown origin for 3 of 4 residents (R7, R8, and R58) whose allegations of abuse incidents were reviewed. Findings include: R7's admission Minimum Data Set (MDS) dated 12/21/16, indicated R7 was cognitively intact, required extensive assist of one staff with activities of daily living (ADL's) and had diagnoses of anxiety and depression. R7's current care plan dated 12/14/16, indicated R7 was a vulnerable adult related to communication, physical & cognitive impairment, and directed staff to engage resident in conversation while providing cares, allow resident to voice concerns or worries, establish a relationship which encouraged resident to share difficulties and experiences. The care plan also indicated R7 had ADL self care performance deficit related to being developmentally/intellectually disabled, and required staff assistance with all ADL's. Review of the CONCERN AND/OR COMPLAINT REFERRAL FORM, dated 1/11/17, indicated licensed practical nurse (LPN)-A reported to social worker (SW) that nursing assistant (NA)-A	22000	Corrected	

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22000	Continued From page 24 had slapped her last night. Further review of the CONCERN AND/OR COMPLAINT REFERRAL FORM indicated on 1/11/17, at 10:30 a.m. the SW interviewed R7 who indicated NA-A "grabbed her arm too hard and also slapped her." R7 indicated "NA-A is mean to her and gets rough with her, she is awful mean to me." R7 also 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 cares or services. The CONCERN AND/OR COMPLAINT REFERRAL FORM further indicated steps taken to investigate R7's alleged complaints of NA-A's abuse, however, had not identified the State agency (SA) had been immediately notified of R7's alleged allegations of abuse. The vulnerable adult (VA) reports for R7 were reviewed, and a VA report to the state agency had not been made on 1/11/17, when R7 reported allegations of abuse to LPN-A, rather a VA report was found submitted to the state agency dated 1/12/17. On 1/11/17 at 7:47 p.m. the director of nursing (DON) indicated she was aware of R7's allegations of abuse by NA-A, and confirmed the facility had not immediately reported R7's allegations of abuse to the state agency. On 1/12/17 at 11:22 a.m. the administrator confirmed she was immediately notified of R7's allegations of abuse by NA-A, and confirmed the facility had not immediately reported R7's allegations of abuse to the state agency.	22000		

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ELDERS HOME INC	SOUTH TOUSLEY, PO BOX 188 NEW YORK MILLS, MN 56567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 25 R8 had an injury of unknown origin which was not immediately reported to the SA or thoroughly investigated according to the facility policy. R8's quarterly MDS dated 12/7/16, indicated R8 was cognitively impaired, required extensive assist of one or two staff with ADL's, and had diagnoses of fracture, manic depression, and Alzheimer. R8's current care plan dated 12/13/16, indicated R8 was a vulnerable adult related to impaired communication, and physical & cognitive impairment. The care plan directed staff to engage R8 in conversation while providing cares, allow R8 to voice concerns/worries, and establish a relationship that encouraged R8 to share difficulties and experiences. The care plan indicated R8 was dependent upon staff for ADL tasks due to impaired mobility secondary to diagnoses of Alzheimer ' s disease, severe dementia, arthritis, and functional incontinence. The care plan further indicated R8 was at risk for falls related to severe cognitive & physical impairments. The Risk Management Report, dated 3/14/16, at 12:00 a.m. indicated R8 was seated in a wheelchair by the nurses station due to being restless. R8's personal alarm sounded at 12:00 a.m. and R8 was found on the laying on back on the floor in front of the wheelchair. The report indicated R8's pants, incontinent brief, and blankets were found down around the ankles. There were no witnesses of this incident	22000		

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22000	Continued From page 26	22000		

identified. The report indicated R8 had injuries that included a laceration near the right eye that measured 0.5 centimeters (cm), an abrasion of the forehead that measured 2 cm, an abrasion near the right eye/cheek area that measured 4 cm x 3 cm, and R8's left ankle was very tender and painful with no bruising noted. The report indicated the medical doctor and the power of attorney (POA) were notified of the incident on 3/14/16.

Review of the nurses notes dated 3/14/16, at 10:38 a.m. indicated R8's POA agreed to have x-ray of the left ankle due to pain. Following the X-ray the Perham hospital called at 3:15 p.m. and reported R8 had a distal tibia and fibula fracture of the left ankle which had been splinted.

Further review of R8's medical record revealed the SA was immediately notified of R8's of known origin, and a thorough investigation of the aforementioned incident had not been completed.

On 1/13/17 at 10:01 a.m. the DON confirmed R8 had an unwitnessed fall and sustained fractures to the left ankle area. The DON also verified the incident was not reported to the SA and she was not here at the time R8 fell. The DON confirmed the SA should of been notified when they found out R8 had a fracture of her ankle and a investigation should of been conducted.

On 1/13/17 at 10:03 a.m. the administrator confirmed the SA had not been notified of R8's unwitnessed fall with fractures and stated "yes this should of been reported." The administrator

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22000	Continued From page 27 also indicated that any time there is a unwitnessed fall with a injury it needs to be reported immediately and investigated. R58 reported an allegation of rough treatment during cares and the facility failed to follow their Vulnerable Adult Policy related to the immediate reporting to the SA, and had not conducted a thorough investigation of alleged abuse. R58 reported an allegation of rough treatment during cares, and the facility failed to thoroughly investigate or report R58's allegation of abuse to the SA. R58's quarterly MDS dated 11/29/16, identified R58 was cognitively intact, had diagnoses that included: seizure disorder, sprain of ligaments of the cervical spine (neck) with resulting decreased sensation to one side of the body, and required staff to provide guided maneuvering of the limbs to assist with dressing. R58's care plan dated 12/6/16, identified R58 was alert and oriented to person, required extensive assistance with dressing, and was vulnerable to abuse. The care plan directed staff to allow R58 to voice concerns or worries. On 1/12/17, the facilities "Concern and/or Complaint," forms were reviewed and included a report dated 11/24/16, at 7:30 p.m. that indicated R58 reported an allegation of "rough treatment" to therapy staff the morning of 11/25/16. The report identified therapy staff reported the allegation of	22000		

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22000	Continued From page 28 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 state agency (SA). The interim director of nurses 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 overwhelmed and probably had 10 residents to	22000		

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22000	Continued From page 29	22000		

assist after helping him get ready for bed. R58 stated he didn't like the treatment received that night, and stated he hadn't told the NA he was upset with the treatment received, and was thankful the NA left the room and was gone.

The SSD was interviewed on 1/17/17, at 10:39 a.m. and stated after R58 reported the allegation of rough treatment on 11/24/16, the SSD spoke to the DON and administrator on 11/25/16, who instructed the SSD to complete a concern and/or complaint form. The SSD stated she called NA-D to investigate R58's allegations of rough treatment, however, NA-D told her she did not assist R58 on 11/24/16, at 7:30 p.m. and stated NA-D reported she had nothing else to add to the investigation. The SSD stated she then reported NA-D's interview to the DON, and stated she thought she was done with her part of the investigation, and the DON would complete the rest of the investigation. The SSD stated she had not documented anything else related to R58's allegation of rough treatment after the concern form was completed. During further interview with the SSD regarding the facility's vulnerable adult policy and procedure, the SSD stated any allegations of abuse including rough treatment should be immediately reported to the SA, and confirmed R58's allegation of rough treatment had not been reported to the SA, although R58's allegation of mistreatment met their policy criteria for reporting to the SA. The SSD confirmed a vulnerable adult report or any further documentation and follow up related R58's allegation of rough treatment had not been completed.

The DON was interviewed on 1/17/17, at 11:01

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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. The facility's Abuse Prevention policy dated 12/22/16, was reviewed and indicated each individual has the right to be free from verbal , sexual, physical, and mental abuse, (including injuries of unknown source, misappropriation of the resident property, corporal punishment, mistreatments, neglect, involuntary seclusion, and financial or material exploitation.) Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, or	22000		

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22000	Continued From page 31 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. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the process of reporting/investigating allegations of abuse, maltreatment or injuries of unknown. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures to ensure the policy is implemented. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	22000		