

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted August 6, 2020

Administrator Elim Home 701 First Street Princeton, MN 55371

RE: CCN: 245494 Cycle Start Date: July 20, 2020

Dear Administrator:

On July 20, 2020, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 18, 2020, the situation of immediate jeopardy to potential health and safety cited at F0600 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 20, 2020.

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This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 20, 2020 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 20, 2020 (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Elim Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 20, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 West Division Street, Suite 212 St. Cloud, Minnesota 56301 Email: susie.haben@state.mn.us Phone: 320-223-7356

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

Elim Home August 6, 2020 Page 4 VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 20, 2021 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address: Elim Home August 6, 2020 Page 5

> Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

> Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

Feel free to contact me if you have questions.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

DEPAR		APPROVED					
	RS FOR MEDICARE	& MEDICAID SERVICES	1	0	OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION	Сом	E SURVEY PLETED	
		245494	B. WING			C 20/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ELIM HO	ME			701 FIRST STREET			
				PRINCETON, MN 55371			
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E 000	Initial Comments		E 000	0			
F 000	Infection Control su facility by the Minne (MDH) to determine Preparedness regu Home was found to requirement. Because you are en signature is not req page of the CMS-23 correction is require acknowledged rece documents. INITIAL COMMENT On 7/16/20 to 7/20	pit of the electronic	F 000				
	the Minnesota Depi conduct complaint i was found not to be Part 483, Requirem Facilities. In addition, a COVI Control survey was MDH to determine Infection Control. E in compliance. The survey resulted (IJ), and substanda when a credible alle resident(s) and stat required parties, ac protection provided locked memory car	artment of Health (MDH) to investigation(s). Elim Home e in compliance with 42 CFR nents for Long Term Care D-19 Focused Infection conducted at the facility by compliance with §483.80 lim Home was found not to be d in an immediate jeopardy rd quality of care, at F600 egation of abuse voiced by f had not been reported to the ted upon, investigated and to resident(s) at risk in the e unit to ensure they remained	NATURE	TITLE		(X6) DATE	
	ically Signed			···· 		08/17/2020	
LIECTION	ically Signed					00/17/2020	

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

PRINTED: 08/24/2020

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8					FORM	08/24/2020 APPROVED 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	245494	B. WING				C 20/2020
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HOME				01 FIRST STREET RINCETON, MN 55371		
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director of nursing (D (RN)-A were notified p.m. The IJ was remo- non-compliance rema- than minimal harm wi- jeopardy at a pattern an extended survey w The following compla- substantiated: H5494042C; with no- However, unrelated n- identified and cited at H5494043C; with no- H5494044C; with no- H5494045C; with no- H5494045C; with no- H5494045C; with no- H5494046C; with def F689. H5494048C; with no-	dministrator (via telephone), DON) and registered nurse of the IJ on 7/17/20, at 4:26 oved on 7/18/20; however, ained with potential for more which is not immediate level (Level E). In addition, was conducted on 7/20/20. aint(s) were found to be deficiencies issued. non-compliance was t F610. deficiencies issued. non-compliance was t F636 and F744. deficiencies issued. ficiencies issued at F684 and deficiencies issued. deficiencies issued. ficiencies issued. deficiencies issued.	FC	000	DEFICIENCY		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI COM	E SURVEY PLETED
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F 000	Continued From pa H5494047C	ge 2	F 0	00			
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an a on-site revisit of you validate substantial regulations has been your verification. Free from Abuse ar	acceptable electronic POC, an ur facility may be conducted to compliance with the en attained in accordance with nd Neglect	F 6	600			8/25/20
SS=K	Exploitation The resident has th neglect, misapprop and exploitation as includes but is not l corporal punishmer any physical or che treat the resident's	rom Abuse, Neglect, and e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to medical symptoms.					
	physical abuse, cor involuntary seclusic This REQUIREMEN by: Based on interview	ise verbal, mental, sexual, or poral punishment, or			Regarding cited resident: • Resident #10- Investigation into)	

Facility ID: 00375

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		E CONSTRUCTION	MB NO.	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· ·				PLETED
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		245494	B. WING				20/2020
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	0//2	20/2020
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F 600	Continued From pa	age 3	F 60	00			
1 000	•	ted to the required person(s)	FOU	00	findings initiated on 7/17/20.		
		stigated and adequate			 Staff involved in the reported in 	ncident	
	protection provided to ensure freedom from				were suspended pending completion		
		sidents (R9, R10, R11) whose			the investigation.		
		viewed. These findings			TMA-A was terminated.		
		ediate jeopardy (IJ) situation			RN-A was removed from leade	ership	
		I to affect 16 of 16 residents			position.		
		Rum River Place secured			Resident #9 and #11 assessed		
		time of the survey as TMA-A despite allegations of abuse			signs of psychosocial distress or fe no ongoing distress noted.	ar. wiur	
	towards residents.				no ongoing disticas noted.		
					Actions taken to identify other pote	ntial	
	The IJ began on 6/	27/20, when an employee			residents having similar occurrence		
		aide (TMA)-A) was witnessed			5		
		sped around R9's wrists while			QAPI committee convened to p	perform	
		ent, "You're not going to hit me			Root Cause Analysis of F600 and		
		bing this tonight!" Following the			associated tags. Committee memb		
		re-education was completed			attendance: Administrator, DON, D		
		subsequent audits or			of Corporate Compliance, Director		
		are was implemented to mained free of abuse. On			Operations, Clinical Directors of SN Services and Human Resources.		
		20, a second incident was			 Conducted interviews with those 		
		orted to the unit manager			residents residing within the demer		
		where she had been witnessed			and who were able to verbalize cor		
		nean" to a different resident in			All cognitively intact residents		
		care unit. This allegation was			interviewed regarding customer se	rvice	
	not acted upon, rep	ported or investigated and			experience and any concerns of		
		o work unsupervised with no			abuse/neglect.		
		peing implemented to ensure					
		locked unit remained safe and			Measures put in place to ensure de	eficient	
		MA-A. The administrator (via			practice does not recur:	iov	
		r of nursing (DON) and RN)-A were notified of the IJ on			 Reviewed Vulnerable Adult pol Staff training on the revised VA 		
		n. The IJ was removed on			with a focus on the requirement to		
		m. when the facility			witnessed or potential occurrences		
		mented a removal plan;			abuse or neglect.		
		pliance remained at a pattern			 Weekly auditing throughout the 	•	
		I for more than minimal harm			building-2 audits per unit, per week		
		liate jeopardy (Level E).			weeks then 1 audit per unit per we		

Facility ID: 00375

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		0938-039 E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED	
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		245494	B. WING			20/2020	
NAME OF F	PROVIDER OR SUPPLIER	·	5	STREET ADDRESS, CITY, STATE, ZIP CO	-		
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371			
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F 600	Continued From pa	age 4	F 600				
	Findings include:			weeks which includes both re interview and staff care obser POC binder for questions and	vations (see		
		State agency (SA) report, ntified an allegation of physical		observations). Results will be and reviewed for necessary a	tabulated		
	intended to produc handling." The repo 7:40 p.m. an incide the locked memory "[R9] was attemptin staff intervened an	9 which read, "Conduct e pain/injury or rough ort identified on 6/27/20, at ent happened in the hallway of / care unit which included, ng to walk another resident d [R9] was upset about being		 Results of these audits w reviewed until substantial com achieved and they will make t if further monitoring/audits are recommended. 	npliance is he decision		
	grabbed the reside to stay out here.' A [TMA-A] said, 'We The report identifie	mpted to hit [TMA-A]. [TMA-A] nt's wrist and stated, 'you need nother staff reported that are not doing this tonight.'" d the supervisor was notified ent home until further be completed.					
	Investigation (VOI) completed an invest submitted to the S/ outlined, "[R9] was resident and verba toileting, staff inter- about being distract	ndated Verification of report identified the facility stigation into the allegation A on 6/27/20. The report attempting to walk another lized intent to assist with vened and [R9] was upset cted and attempted to hit					
	[TMA-A]. [TMA-A] grabbed [R9's] wrist and stated, 'you need to stay out here.' Another staff reported that [TMA-A] said, 'we are not doing this tonight." The report identified the supervisor was notified of the incident and TMA-A was sent home pending further investigation. R9 expressed feeling safe at the nursing home; however, when questioned if she was afraid of anyone at the						

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	DON, social worker notified of the incide statements were lis from multiple staff r assistant (NA)-A, N recorded interview of witnessed "with a g pulling her aggress? NA-A instructed TN TMA-A responded, her hands up in the immediately followin seemed scared." Fu with an, "Investigati TMA-A had intercep which " was inter [TMA-A's] part by a intervened" The on customer service communication. The submitted SA in dated 7/3/20, was re care plan was revie the facility policy wh followed," and no cl incident occurred. T investigation was on detail(s) in large, ar attached which dem provided with a vert with education on c professional behavit the DON on 6/29/20 having verbally ack telephone call on 6/	r, physician and SA were all ent, and a series of witness ted which included statements members including nursing A-B, and TMA-A. NA-A's described TMA-A as being rip on [R9's] wrist and she was ively, and [R9] almost tripped." IA-A to be gentle to which "I am so done," as she threw air. NA-A described R9 ng the incident as, "She urther, the report concluded on Summary," which outlined oted R9's attempt to strike her preted as rough behavior on nother staff member who DON then re-educated TMA-A e and professional nvestigation (5-Day Report), eviewed and identified R9's wed and followed, along with hich was listed as, " hanges were made after the The facility's completed utlined which reflected the VOI nd an additional form was nonstrated TMA-A had been bal disciplinary action along ustomer service and for. The form was signed by 0, and TMA-A was listed as nowledged the form through a /29/20. The space provided for sign the form was left blank	F 6	00			

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
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F 600	subsequent SA inve TMA-A had been for facility's abuse polic what constitutes ab understanding beha which could increase respond. A provided resident identified a total of Rum River Unit (loc including R9, R10 a R9's annual Minimu 4/8/20, identified R9 impairment; howeve or physical behavio kicking). On 7/17/20 interviewed in her re sure how long she I and just replied, "Ne concerns with staff On 7/17/20, at 10:5 -A was interviewed with TMA-A on the stayed late to help p explained R9 was a wandered into a spe their bathroom and however, at approx she had come out of witnessed TMA-A's "squeezing" around struggle to free her shaking and pulling immediately told TM	t listing, dated 7/16/20, 16 residents resided on the cites and procedures including outputs of abuse and how to	F	600			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 600 Continued From page 7 F 600 wrists, so NA-A quickly tossed the linens in her hands into a resident room and returned to R9 and TMA-A who remained in the hallway. TMA-A then released R9's wrists and yelled, "I'm so done" as she walked away from R9. NA-A proceeded to help R9 to use a bathroom on the opposite end of the unit and R9 was upset immediately following the incident, R9 even voiced she thought TMA-A had left bruising on her. NA-A completed R9's cares and then reported the allegation and incident to the working supervisor who subsequently reported it to the DON. NA-A voiced TMA-A was not allowed to complete her shift the night of the incident involving R9 as she was sent home; however, expressed significant concern as TMA-A had subsequently returned to work on the dementia unit on an unsupervised basis. NA-A expressed following TMA-A's return to work, a second incident had happened where TMA-A had potentially abused residents. NA-A stated she knew R11 had expressed concern to a homemaker (HMK)-A that she (R11) had observed TMA-A to place her hands on and shout at another resident (R10) in the memory care unit just a few days after the incident with R9 on 6/27/20. NA-A stated, to her knowledge, HMK-A and R11 did report these concerns to the registered nurse unit manager (RN)-B; however, added she was concerned as, "I don't know if they even looked into that much." NA-A stated she had known TMA-A to be "verv aggressive" at times with residents with her tone of voice; however, had never witnessed her be physically abusive with residents until the incident on 6/27/20, adding, "I saw what I saw." Further, NA-A reiterated she was concerned TMA-A would continue to potentially abuse residents on the locked memory care unit as TMA-A continued to

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

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Facility ID: 00375

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PRINTED: 08/24/2020

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	TE SURVEY	
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:		G) ´co	MPLETED	
		245494	B. WING		C 07/20/2020		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		12012020	
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 600	•	Continued From page 8		0			
	work, as of that day unsupervised basis [shift]."	y (7/17/20), on an s for "eight hours of the night					
	R11 had severe co demonstrated no d When interviewed of stated she had live approximately four her diabetes manay no concerns about however, expresse female staff memb in a wheelchair. R1 as "grabbing her ar her arms and wrists described TMA-A a people and voiced issue with TMA-A; people [residents] t cognitive impairme she had observed I as something she f right." R11 express about the incident; remember who, bu	S, dated 6/15/20, identified gnitive impairment; however, elusions or hallucinations. on 7/17/20, at 11:25 a.m. R11 d at the nursing home for years as she needed help with gement. R11 stated she had the way staff treated her; d she had recently seen a er (TMA-A) abusing a resident 1 described TMA-A's actions and pushing her" while holding is up to the surveyor. R11 as "loud" while she helped she, herself, had never had an however, added "the other hey're not talking [due to nt]." R11 reiterated the incident between a resident and TMA-A felt was "not nice" and "not ted she told a staff member however, was not able to t added she reported TMA-A ne who was "mean" and					
	and verified R11 ha approximately "two TMA-A had "grabbe described R11's re TMA-A was "yelling her arm and pulled	" p.m. HMK-A was interviewed ad reported a concern to her weeks ago" which alleged ed another resident." HMK-A ported concern to her as g at this other resident and took her." HMK-A stated she told o go and report the incident to					

If continuation sheet Page 9 of 53

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 600	reporting it and "alm between words." HI fearful of retaliation she "[didn't] want he HMK-A verified the reported to her by F manager (RN-B); he specific follow-up w there had already b reported" pertaining time frame." Furthe never personally wir physically abusive t witnessed her to be before and seem "a providing direction of On 7/17/20, at 2:02 and stated her curre at the nursing home in worked during the of described the incide involved R9. TMA-A re-direct her which attempt to hit out at then grabbed R9's a "You're not going to today." At the same had walked out of a interaction while dir you need to be nice feel she had grabbe around her wrists, h she grabbed her art TMA-A stated she o specifics from the e	she was talking very fast while nost manic and not breathing MK-A explained R11 was by TMA-A and told HMK-A er [TMA-A] mad at me." incident witnessed and R11 was reported to the unit owever, she was unsure of hich had been completed as een "a different incident to TMA-A around the "same r, HMK-A stated she had tnessed TMA-A to be to a resident; however, had come impatient with residents little frustrated" while	F	600			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HO	ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	DON on things "like professionalism." T DON had also discu- acts, including place the incident on 6/27 abuse and would no denied any further i memory care unit a work alone on the n overnight shift. TMA of being placed on a cares or monitoring adding she had just was scheduled to w When interviewed or registered nurse (R on the overnight shi full-time with TMA-A RN-D acknowledge incident involving R occurred in the pas witness it or recall s had not been instru monitoring or obser demeanor while at left alone for her job working as they we adding, "Most days On 7/17/20, at 2:33 interviewed and exp administrator was of time of the survey. understanding of th and R9 on 6/27/20, trying to walk anoth TMA-A attempted to	mannerisms and MA-A added she thought the ussed with her the various ing hands on a resident like //20 outlined, could constitute by be acceptable. TMA-A ncidents with residents on the nd voiced she continued to nemory care unit on the A-A stated she was not aware any formal buddy-systems for of the care she provided, worked last on 7/15/20, and vork again in the coming days. on 7/17/20, at 2:29 p.m. N)-D stated they typically work ift and verified working A adding, "She's my TMA." d they were aware of an 9 and TMA-A which had t weeks; however, did not specifics. RN-D stated they cted or directed to do any ving of TMA-A's cares or work. RN-D verified TMA-A is o "most of the time" while re often on a different unit	F	500			

Facility ID: 00375

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		0. 0938-039 TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED	
			/			С	
		245494	B. WING		07/20/2020		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIOI DATE	
F 600	Continued From pa	age 11	F 60	00			
	her [R9] wrists" to prevent her from striking out. NA-A had walked out of a room in the middle of the incident and observed the "grabbing of the wrists" and so she reported it to the supervisor, TMA-A was sent home, and the incident report was filed to the SA. The DON stated she was unsure of the exact manner or specifics regarding TMA-A's hands and the subsequent grip she had						
	on the wrists or a c she did not question members; howeve constitute abuse do is grabbed and how	(i.e. open hand pushing down closed fist around the wrists) as in it at the time with the staff r, voiced such actions could epending on how the resident w aggressive the overall					
	they interviewed TI incident as part of TMA-A felt her acti DON verbalized sh be perceived as ab	e moment. The DON explained MA-A regarding the 6/27/20, their overall investigation, and ons were not abusive. The le told TMA-A her actions could busive and then had a "lengthy					
	customer service a 6/27/20; however, her any formal Reli training) courses o	TMA-A on professionalism and as a result of the incident on she did not complete or assign ias (computerized healthcare n abuse, vulnerable adult (VA) d policies and procedures. The					
	DON verified TMA- on an unsupervise monitoring of her c implemented. RN-	A returned to work on 7/1/20, d basis with no formal audits or are being completed or B recalled R9 had voiced					
	on 6/27/20. As part attempted to interv locked memory car	nediately following the incident t of the investigation, RN-B had iew other residents on the re unit she felt would be able to t which included R11. RN-B					
	stated R11 did not about TMA-A; how following their disc	initially report any concerns ever, within a couple days ussion, R11 and HMK-A id reported a second allegation					

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	of abuse involving T (R10). RN-B stated with R11, as part of follow-up, had plant which caused her to as R11 had a histor she could not recall allegation HMK-A a however, recalled s a personal note-pao reported to her. An taken notes was pro TMA-A's name at th one-line sentences "Always pulling [R10 "Just happened a c "She's mean," "She's mean," "She's nice to me," "Yells-too aggressiv "[R11] pulled [HMK- agressively [sic]." The interview contin would not consider historian (despite ha interview as part of added things R11 h seemed to "always questioned how the handled and investi not immediately rep administrator or DC	TMA-A and a different resident she felt the initial discussion f the 6/27/20, incident ted a seed in R11's mind o report the second allegation ry of paranoia. RN-B stated I specifics of the second and R11 had shared with her; she had taken notes about it on d when the allegation was undated, untitled copy of the ovided. The notes identified he top along with various which included: 0] - come here,"	F	600			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 600 Continued From page 13 F 600 RN-B stated she placed no formal monitoring of TMA-A's cares, nor did she complete any re-education with TMA-A as part of the second allegation and verified, as of 7/17/20, TMA-A remained working unsupervised on the night shift with the resident population on the Rum River Unit. The DON stated this was "the first time I am hearing of the second event [allegation]" and voiced, had she and the administrator been told of it, she would have reported it as an allegation of abuse and investigated it as such in accordance with their abuse prevention policy. RN-B and the DON expressed that, to their knowledge, the facility's administrator had no knowledge of the second allegation being reported to RN-B. A provided Vulnerable Adult Report / Tracking Log, dated 10/17/19 to 7/16/20, identified all facility reported incidents (FRI) to the State agency. The listing lacked evidence R11's allegation of abuse pertaining to TMA-A was reported to the State agency. TMA-A's undated training transcript identified TMA-A was hired at the nursing home on 2/20/20. A course named, "Abuse & Neglect Self-Paced," was listed as being completed on 2/20/20. A second course with the same name was listed which was not completed; however, listed a 'Due Date' of 7/31/20. There was no evidence on TMA-A's transcript or any other provided documentation demonstrating TMA-A had been formally re-educated on the definitions of abuse, nor subsequent strategies to handle behaviors from cognitively impaired residents after the allegation of abuse was reported and investigated, ending on 7/3/20. Further, there were several classes listed, including

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 08/24/2020

		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 600	Behavior Managem dates' prior to 7/1/2 not completed and identified. In additio provided during the had been placed or her return to work to therapeutic approace not engage in poter towards them despi abuse being reports A provided Schedul identified TMA-A ha 7:15 a.m. on the fol 7/7/20, 7/10/20, 7/1 Further, the schedul to be scheduled for 7/20/20, 7/21/20, 7/ The facility's Vulner 10/31/19, identified suspected or allege added, "The admini implementation of ti residents have a rig physical abuse and were considered vul directed, "Each emp suspected/alleged v immediately, but no allegation is made, allegation is made, allegations which were prevent allegations	se and Related Disorders: ient," which had listed 'due 0; however, the classes were no completion date was in, there was no evidence survey demonstrating TMA-A in any formal monitoring upon to ensure she completed ches for the residents and did initially abusive behavior(s) ite multiple allegations of ed pertaining to her. le dated 7/1/20 to 7/31/20, ad worked from 6:45 p.m. to lowing days: 7/1/20, 7/6/20, 1/20, 7/12/20, and 7/15/20. Ile outlined TMA-A continued the same shift hours on	Fθ	;00			

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245494	B. WING					C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZI	PCODE		
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 600	prohibition plan alor behaviors (i.e. roug language) and adde time displays suspect the supervisor must appropriate action." Protection During Ir directed to provide resident(s) upon ide actions which include removing the reside perpetrator (AP) ca Further, the policy of suspected or allege promptly and thorout included collecting of physical examination of abuse and intervistaff members. The the results of the intri- incident on a facility. The IJ which began 7/18/20, at 5:25 p.m successfully implent included removing to reporting and begin allegation in accord and educating staff process to ensure a residents were report SA. On 7/18/20, fro- interview(s) were co- management staff to been successfully in	and the facility' abuse ng with identify inappropriate h handling, derogatory ed, "If a staff member at any ject or inappropriate behavior, t intervene and take A section labeled, "Resident nvestigation," was listed which immediate safety of the entification by completing ded, but were not limited to, ent from the alleged re or suspending them. directed all reports of ed abuse would be " ughly investigated," which data around the incident, a on of the resident(s) for signs iews with other residents and a policy directed to document vestigation and log the revent Summary. and 6/27/20, was removed on h. when the facility nented a removal plan which the AP from resident care, ning the investigation of R11's ance with their facility's policy, members on the reporting all allegations made by orted to the administrator and m 4:14 p.m. to 5:13 p.m. ompleted with direct care and o ensure these items had mplemented.		500				0/05/00
	Reporting of Allege CFR(s): 483.12(c)(FØ	609				8/25/20

Facility ID: 00375

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM A	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			X3) DATE COMF	E SURVEY PLETED
		245494	B. WING			C 07/2	; 20/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • •	
ELIM HO	ME				01 FIRST STREET RINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From pa	ge 16	Fe	609			
		nse to allegations of abuse, n, or mistreatment, the facility					
	§483.12(c)(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.						
	designated represe accordance with St Survey Agency, with incident, and if the a appropriate correcti This REQUIREMEN by:	ort the results of all e administrator or his or her ntative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ve action must be taken. NT is not met as evidenced and document review, the			Regarding cited resident:		
	facility failed to ensight physical abuse was and State agency (S	ure an allegation of potential reported to the administrator SA) within two hours, as residents (R11) whose			 Review of resident #11 care plan updates made to reflect resident stat and history of reporting incidents to s on behalf of other residents. Initiated an investigation regardir resident #10. Resident assessed for of psychological distress or fear. 	tus staff ng	

Event ID:8VDD11

Facility ID: 00375

TATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	· /		G		PLETED	
							C	
		245494	B. WING			07/2	20/2020	
NAME OF I	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ELIM HC	ME				01 FIRST STREET RINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 609	Continued From pa	age 17	F 6	09				
	R11's quarterly MD R11 had severe co demonstrated no d When interviewed of stated she had live approximately four her diabetes mana no concerns about however, expresse female staff memb in a wheelchair. R1 as "grabbing her ar her arms and wrists described TMA-A a people and voiced issue with TMA-A; people [residents] t cognitive impairme she had observed I as something she f right." R11 express about the incident; remember who, bu to them as someon screams at people. On 7/17/20, at 1:47 and verified R11 ha approximately "two TMA-A had "grabbo described R11's re TMA-A was "yelling	PS, dated 6/15/20, identified gnitive impairment; however, elusions or hallucinations. on 7/17/20, at 11:25 a.m. R11 d at the nursing home for years as she needed help with gement. R11 stated she had the way staff treated her; d she had recently seen a er (TMA-A) abusing a resident 1 described TMA-A's actions nd pushing her" while holding s up to the surveyor. R11 as "loud" while she helped she, herself, had never had an however, added "the other they're not talking [due to nt]." R11 reiterated the incident between a resident and TMA-A felt was "not nice" and "not sed she told a staff member however, was not able to t added she reported TMA-A ne who was "mean" and " " p.m. HMK-A was interviewed ad reported a concern to her weeks ago" which alleged ed another resident." HMK-A ported concern to her as g at this other resident and took her." HMK-A stated she told			 Staff involved in the reported in suspended pending completion of investigation. RN-A was removed from leader position. TMA-A terminated from her positions taken to identify other poteresidents having similar occurrence. QAPI committee convened to provide the convent of the convent o	the ership sition. ntial es: perform pers in pirector of NF ple on ent ents tomer		

Facility ID: 00375

	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		0938-039 E SURVEY
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		NG	` ´co∧	IPLETED
						С
		245494	B. WING			20/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 609	Continued From pa	age 18	F 6	09		
	fearful of retaliation she "[didn't] want h	by TMA-A and told HMK-A er [TMA-A] mad at me." incident witnessed and		interviews with a minimum of active staff.	of 90% of	
	reported to her by I manager (RN-B); h	R11 was reported to the unit owever, she was unsure of which had been completed as		• Staff to complete Abuse Relias training.	e/Neglect	
		been "a different incident g to TMA-A around the "same		 Audit all VA reports sub 7/20/20 to ensure submission accordance with the VA pol state/federal requirements. 	on in	
	Log, dated 10/17/1 facility reported inc agency. The listing allegation of abuse voiced to RN-B had R11's medical reco allegation had been	ble Adult Report / Tracking 9 to 7/16/20, identified all idents (FRI) to the State g lacked evidence R11's pertaining to TMA-A she d been reported. Further, ord lacked any evidence the n reported to the administrator ing voiced to HMK-A and		 Effective implementation of monitored by: QAPI committee will revresults until substantial com achieved and a decision is regarding a time-period for auditing/ monitoring. 	view audit pliance is made	
	nursing (DON) wer the facility' adminis vacation at the time explained she had different allegation; following their discu- approached her an of abuse involving different resident. F recall specifics of the and R11 had share she had taken note note-pad when the An undated, untitle provided. The note	B p.m. RN-B and the director of e interviewed and expressed trator was off campus on e of the survey. RN-B interviewed R11 as part of a however, within a couple days ussion, R11 and HMK-A d reported a second allegation the same staff member and a RN-B stated she could not he second allegation HMK-A ed with her; however, recalled es about it on a personal allegation was reported to her. d copy of the taken notes was s identified TMA-A's name at various one-line sentences				

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPL	LE CONSTRUCTION		E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Continued From pa	ige 19	F 6	09			
	"Always pulling [R1	0] - come here,"					
	"Just happened a c	ouple of days ago,"					
	"She's mean,"						
	"She's nice to me,"						
	"Yells-too aggressiv	ve. Threatens them," and,					
	"[R11] pulled [HMK agressively [sic]."	-A's] arm to demo - quite					
	credible historian, b reported in the past basis of truth." Whe allegation was hand stated she did not in allegation to the ad didn't feel it was cree [R11], that's why." T first time I am heari [allegation]" and vo administrator been reported it as an all accordance with the RN-B and the DON knowledge, the faci knowledge of the se reported to RN-B.	eir abuse prevention policy. I expressed that, to their ility' administrator had no econd allegation being					
	10/31/19, identified suspected or allege added, "The admin implementation of t	able Adult - MN policy, revised all staff members must report ed abuse immediately and istrator is responsible for the he policy." The policy outlined abut to be free from verbal and					

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PRINTED: 08/24/2020

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	OMB PLE CONSTRUCTION (X3)) DATE SURVEY
D PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED
		245494	B. WING		C 07/20/2020
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07720/2020
	ME			701 FIRST STREET PRINCETON, MN 55371	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE
	were considered vu directed, "Each em suspected/alleged immediately, but no allegation is made, allegation involve a injury," and, "The immediately." Investigate/Prevent	all residents of the facility unerable adults. The policy ployee is responsible to report violations of mistreatment b later than 2 hours after the if the events that cause the buse or result in serious bodily e Administrator will be notified	F 609		8/25/20
SS=E	§483.12(c) In response neglect, exploitation must:	onse to allegations of abuse, n, or mistreatment, the facility e evidence that all alleged			
		ent further potential abuse, n, or mistreatment while the rogress.			
	designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct This REQUIREMEN by:	ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced		Regarding cited resident:	
	facility failed to ens physical abuse and investigated and ac (R11, R6) whose a	ure allegation(s) of potential /or neglect were thoroughly ddressed for 2 of 6 residents llegations were reviewed. This ect 16 of 16 residents identified		 Initiated investigations related to residents #6 (11/14/19) and #11 (7/17) Staff involved in the reported incid were suspended pending completion of the investigation. 	ent

Facility ID: 00375

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	MB NO.	E SURVEY	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G		PLETED	
					0	5	
		245494	B. WING			20/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				701 FIRST STREET			
ELIM HO				PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 610	Continued From pa	age 21	F 61	0			
1 010	- 1	m River Unit (locked memory	FUI	 TMA-A terminated (#11). 			
	care unit).			 RN-A removed from leadership position (#11).)		
	Findings include:						
	-			Actions taken to identify other poter			
		t listing, dated 7/16/20,		residents having similar occurrence			
		16 residents resided on the		The QAPI committee convened			
		cked memory care unit)		conduct Root Cause Analysis of F6	10 and		
	including R11.			associated tags. Committee members in attendance			
	R11's quarterly MD	S, dated 6/15/20, identified		Administrator, DON, Director of Co			
		gnitive impairment; however,		Compliance, Director of Operations			
	demonstrated no d	elusions or hallucinations.		Clinical Directors of SNF services a	ind		
		on 7/17/20, at 11:25 a.m. R11		Human Resources.			
		d at the nursing home for		Staff provided with the Vulneral			
		years as she needed help with		Adult policy and staff interviews init			
		gement. R11 expressed she a female staff member		 on Vulnerable Adult policy/reporting Audited vulnerable adult report 			
		resident in a wheelchair by		OHFC allegation. Updated log temp			
		oushing her." R11 described		based off audit findings.	Jidito		
		hile she helped people and		Ensure monitoring system is in	place		
		, had never had an issue with		for any staff with allegations upon			
		added "the other people		returning to work (see measure put			
		not talking [due to cognitive		place – internal investigation work s	sheet		
		reiterated the incident she had a resident and TMA-A as		template). Measures put in place to ensure de	ficient		
		was "not nice" and "not right."		practice does not recur:	noient		
	Ű,	e told a staff member about the		Vulnerable Adult policy reviewe	d on		
	incident; however,	was not able to remember		07/17/20.			
		e reported TMA-A to them as					
	someone who was people.	"mean" and screams at		Staff retrained on updated polic	-		
	On 7/17/00 -1 4:47			VA investigative work sheet up			
		' p.m. HMK-A was interviewed ad reported a concern to her		with area to include report related fo	WOIIC		
		weeks ago" which alleged		up action.Conduct vulnerable adult report	tina		
		ed another resident." HMK-A		 Conduct vulnerable adult reporting interviews with a threshold of 90% of the 			
		ported concern to her as		active staff.			
		at this other resident and took	1	Staff will complete the 2020			

Facility ID: 00375

		& MEDICAID SERVICES	r			. 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	CON	E SURVEY
		245494	B. WING		07/	C 20/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 701 FIRST STREET PRINCETON, MN 55371	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 610	her arm and pulled R11 they needed to the unit manager and it [the incident]," as reporting it and "alm between words." HI fearful of retaliation she "[didn't] want he HMK-A verified the reported to her by F manager (RN-B); h specific follow-up w there had already b reported" pertaining time frame." Further never personally wi physically abusive to witnessed her becco before and seem "a providing direction of On 7/17/20, at 2:33 nursing (DON) were the facility' administivacation at the time explained she had different allegation; following their discu approached her and of abuse involving to different resident. F recall specifics of th and R11 had share she had taken note note-pad when the An undated, untitled provided. The notes	her." HMK-A stated she told o go and report the incident to nd described R11 as "upset by she was talking very fast while nost manic and not breathing MK-A explained R11 was by TMA-A and told HMK-A er [TMA-A] mad at me." incident witnessed and R11 was reported to the unit owever, she was unsure of which had been completed as been "a different incident g to TMA-A around the "same er, HMK-A stated she had thessed TMA-A to be to a resident; however, had ome impatient with residents a little frustrated" while	F 6	 Abuse/Neglect Relias tr In person and by Zo Training available to all external presenter. Effective implementatio compliance of corrective monitored on an ongoin quarterly QAPI meeting Review current resi and staff care audits to compliance. Determine necessa further auditing/monitori 	oom VA Reporting staff through an n and continued e actions will be g basis at s: dent interviews determine ry action for	

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				201 FIRST STREET PRINCETON, MN 55371		
	SUMMARY STA	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 610	Continued From pa	age 23	F 6	610			
	"Always pulling [R1	0] - come here,"					
	"Just happened a c	ouple of days ago,"					
	"She's mean,"						
	"She's nice to me,"						
	"Yells-too aggressi	ve. Threatens them," and,					
	"[R11] pulled [HMK agressively [sic]."	-A's] arm to demo - quite					
	credible historian, b reported in the pass basis of truth." Whe allegation was hand stated she did not i allegation to the ad didn't feel it was cre was "the first time I event [allegation]" a administrator been investigated it as an accordance with the RN-B and the DON knowledge, the fac	ould not consider R11 to be a but added things R11 had t seemed to "always [have] a en questioned how the second dled and investigated, RN-B mmediately report the ministrator or DON as she edible. The DON stated this am hearing of the second and voiced, had she and the told of it, she would have n allegation of abuse in eir abuse prevention policy. I expressed that, to their ility' administrator had no econd allegation being					
	Log, dated 10/17/19 facility reported inci agency. The listing allegation of abuse voiced to RN-B had	ble Adult Report / Tracking 9 to 7/16/20, identified all idents (FRI) to the State 9 lacked evidence R11's 9 pertaining to TMA-A she 1 been reported or er, no documented evidence					

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610	Continued From pa was provided during had been investigat A completed Nursir Incident Report Sur identified the facility State agency (SA) or report outlined an a Mental Abuse," and it had been identifie was potentially tran and not in accordar was re-educated, h went back into R6's voiced, "Thanks a le because of you." Th upset and cry. A corresponding un Investigation (VOI) incident involving the identified R6 was in concern for "possib because she had to [the NA] always tran lift by herself." The administrator and S	nge 24 g the survey demonstrating it ted. ng Home Incident Reporting - mmary 33157, printed 7/16/20, y had submitted a report to the on 11/14/19, involving R6. The illegation of, "Emotional or d described an incident where ed a nursing assistant (NA) sferring R6 inappropriately nee with her care plan. The NA owever, it was alleged the NA s room at a later date and ot. I might be losing my job his caused R6 to become ndated Verification of form identified the 11/14/19 he NA and R6. The report interviewed and expressed by costing [the NA] her job old the [night] supervisor that insferred her in the 2 pt [point] report identified the SA were notified of the	1	310	DEFICIENCY)		
	provided which inclust staff member and the labeled, "Investigation completed investigation along with a plan with StandUp Lift policy immediate re-education R6's care plan. How subsequent summary	on labeled, "Witnesses," was uded interviews from another he NA involved. A section ion Summary," identified the ation timeline for the allegation hich included reviewing the with the NA, providing ation to the NA and reviewing wever, the report and ary lacked any evidence other were completed to help					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
ELIM HO	ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610	aside from R6; nor steps taken demon would be monitored were implementing harm or injury to res A completed SA inv 11/18/19, identified submitted to the SA completed investiga plan which was liste completed investiga other resident interv determine potential aside from R6; nor steps taken demon would be monitored were implementing harm or injury to res R6's quarterly Minin 6/25/20, identified F required extensive a When interviewed of recalled the inciden being upset or feart for at the nursing ho incident, staff had of people to transfer h On 7/17/20, at 10:3 (DON) was interview on 11/14/19. The D evidence in the inve corresponding VOI residents had been placed under any for	other allegations of neglect did it list any procedures or strating the NA identified l or audited to ensure they care plans correctly to prevent sidents. restigation (5-Day), dated the investigation was which outlined the facility' ation along with the identical ed on the VOI Form. This ation lacked any evidence views were completed to help other allegations of neglect did it list any procedures or strating the NA identified or audited to ensure they care plans correctly to prevent sidents.	F	\$10			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 610 Continued From page 26 F 610 plans were being followed. The DON voiced she would speak to the unit manager and follow-up. A subsequent interview was held with the DON on 7/17/20, at 12:35 p.m. and she voiced investigation(s) typically included other resident interviews to help determine the scope of the allegation and see if additional allegations are identified. The DON expressed these interviews are done using an audit tool, and provided some completed "Customer Service Audits" for a total of three other residents which were used as part of their investigation in to R6's allegation. However, all of these provided audits were dated 11/22/19 (four days after the investigation was completed and submitted to the SA). The DON stated she was "not aware" why they were done after the investigation was completed and the NA identified had already returned to work. Further, the DON verified R6 was to have two people present for transfers per her care plan which was in-effect at the time of the incident on 11/14/19. The NA was re-educated: however, there was no documented evidence she could find demonstrating any subsequent monitoring or audits had been completed of the NA's care since to ensure care plans were being followed. The facility' Vulnerable Adult - MN policy, revised 10/31/19, identified all staff members must report suspected or alleged abuse immediately and added, "The administrator is responsible for the implementation of the policy." The policy directed all reports of suspected or alleged abuse would be " ... promptly and thoroughly investigated," which included collecting data around the incident, a physical examination of the resident(s) for signs of abuse and interviews with other residents and staff members. The policy directed, "Document the results of the investigation," and

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ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245494			· ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		B. WING _		C 07/20/2020			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 610	Continued From pa	-	F 61	0			
F 636 SS=D	log the incident on a facility Event Summary. Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)		F 63	6		8/25/20	
	a comprehensive, a	nduct initially and periodically accurate, standardized sment of each resident's					
	§483.20(b)(1) Resi A facility must make assessment of a re goals, life history ar resident assessment by CMS. The asse the following: (i) Identification and (ii) Customary routi (iii) Cognitive patter (iv) Communication	sident's needs, strengths, nd preferences, using the nt instrument (RAI) specified ssment must include at least I demographic information ne. ns.					
	 (ix) Continence. (x) Disease diagnos (xi) Dental and nutr (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications. 	vell-being. oning and structural problems. sis and health conditions. itional status. s.					
	(xvi) Discharge plan (xvii) Documentatio regarding the additi	nning. n of summary information onal assessment performed iggered by the completion of					

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 636 Continued From page 28 F 636 (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the Regarding cited resident: Resident #1 was deceased prior to visit. facility failed to ensure triggered Care Area Assessments (CAAs) on a significant change in status Minimum Data Set (MDS) were completed Actions taken to identify other potential to ensure a comprehensive resident assessment residents having similar occurrences: for 1 of 2 residents (R1) reviewed for dementia Weekly audits of CAA's to verify MDS care and services. nurse completion x 4 weeks. Perform audit of all Admission, Findings include: Significant Change, and annual MDS's completed since 7/20/20 to ensure The Centers for Medicare & Medicaid (CMS) completion of CAA's Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated Measures put in place to ensure deficient 10/2018, identified the RAI helps nursing home practice does not recur:

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

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Facility ID: 00375

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CENTERS FOR MEDICARE & MEDICAID SERVICES					(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/S			· /	. BUILDING		(X3) DATE SURVEY COMPLETED	
					C 07/20/2020		
		B. WING					
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD			
ELIM HOME				701 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLE	
F 636	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 6	36	 MDS nurses perform a cross of each other's assigned MDS's week weeks to ensure the completion of CAA's Review results of audits and determine the need for further auditing/monitoring. 	dy X 4	

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT COM	E SURVEY IPLETED
		245494	B. WING	i			C 20/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 636	completed. When interviewed c	them identifying them as on 7/20/20, at 10:28 a.m.	F 6	636			
	who completed and 10/28/19. RN-C star medical record and the triggered CAA(s explained the facility was responsible to CAAs, and added s noticed they were n she sends e-mails t be completed, howe follow-back to ensu expressed the facili processes or done are completed befo since R1's MDS wa was important to en they're "part of the v						
F 684 SS=D	requested; however Quality of Care	CAA(s) completion was r, none was received.	F (684			8/25/20
	applies to all treatm facility residents. Ba assessment of a re- that residents receive accordance with pro- practice, the compri- care plan, and the r	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered					

Facility ID: 00375

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	T OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
				······	- (С
		245494	B. WING _			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST		
				701 FIRST STREET		
ELIM HC	DME			PRINCETON, MN 5537	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE (CIENCY)	(X5) COMPLETIO DATE
F 684	Continued From pa	age 31	F 68	a		
	by:	290 0 1	1 00			
		w and document review, the		Regarding cited rea	sident:	
	facility failed to ens	sure care was appropriately		Resident #5 ex		
		n outside hematology clinic to				
		delayed treatment for 1 of 1 ewed with cognitive impairment		Actions taken to ide residents having sir		
		to a medical appointment			plement a policy	
		sing confusion on the reason(s)			who require escort to	
		tment to be provided.		appointments.		
					lents to determine the	
	Findings include:				scort to appointments.	
	A Common Entry F	Point Intake Form, dated		assessment outcon	t care plans to reflect	
		a concern received by the			103.	
		regarding R5. The report		Measures put in pla	ce to ensure deficient	
		en brought to an off campus		practice does not re		
		ent with no supervision and was			itside appointments	
		why he was there to the staff or king, " how much the vet bill		each week for 4 we	eks to ensure the eds were met Discuss	
		5 had a listed guardian who		at weekly IDT meet		
		acility' staff he was unable to			rly audits of 50% of	
		ment, so he was waiting to hear		outside appointmer	ts thereafter.	
		heduled. The report outlined,			escort policy changes	
		any decision maker available		as they occur.		
		ever, other labs weren't a was unable to give consent."		Monitoring over tim	- .	
					POC appointment	
	R5's admission Mi	nimum Data Set (MDS), dated			ntation of escort policy	
		R5 had severe cognitive		for compliance and	baseline for future	
		al medical diagnoses including		audits.	· C	
		artery disease (CAD) and heart corded episodes of shortness			ctive and consistent	
		iring the review period.		implementation of t through quarterly at 		
	R5's Referral Form	n, dated 11/7/19, identified R5		improvement and n		
		nt at 3:00 p.m. that day with a			egarding audit process	
	physician off camp	us at the clinic. A section		and frequency of au	idits once 100%	
		tes/Reason For Referral," was		compliance is achie	ved for two	
	provided which did	not list any reasons for the		consecutive audits.		

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		AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	visit to the physician however, merely lis unit coordinator (HU manager (RN)-B's in number. The physic 11/7/19 and provide "Labs," and, "T Born diagnosed with a B pancytopenia (low of blood cells: red blood platelets). R5's corresponding note, dated 11/8/19 for an episodic care as the main concer "came to follow up of [R5] today. Spoke w out what and why la was at the appoint was there, [R5] did with. Has known Pa per orders. Nursing oncologist office or about the results ar information came fr The note identified sitting out in the cor respond to simple of loss, staff anticipate note listed several of diuretic medication, reeducation of antip R5's progress noted recorded entries: O nursing home. R5 w the place or time up	n or notes to be addressed; sted the nursing home' health UC) and registered nurse unit name(s) and a telephone cian signed the note on ed dictation which read, ne Marrow Biopsy." R5 was	F	584			

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245494	B. WING			07/2	_ 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	R5. He scored 8/30 this indicates deme laboratory called and for R5's platelets are was notified of thes progress notes from the hematology clin on 12/24/19. R5's medical record evidence the facility outside hematology information or guida prevent delays in tra appointment on 11/ known cognitive im no evidence in the r family had been cord at the appointment communication and the facility's behalf. During interview on nursing assistant (N residing on the Run care unit) and desc easily re-directable. resident on the unit bring the resident a to the van driver an there typically was r present when they I van adding, "I don't she was not sure w were sent to appoint added, "That's a go	which the note outlined, " intia." On 11/8/19, the ad reported a critical lab value ad hemoglobin. The physician e. There were no recorded in the appointment R5 had with ic on 11/8/19; and R5 expired d was reviewed and lacked y had sent or provided the y clinic with adequate ance to facilitate care and eatment pertaining to R5's (8/19; despite R5 having pairment. Further, there was record demonstrating R5's intact and agreed to meet R5 to help facilitate d treatment with the clinic on 7/16/20, at 11:22 a.m. VA)-A stated she recalled R5 in River Unit (locked memory ribed him as forgetful, but . NA-A explained when a has an appointment, the staff nd a prepared envelope down d send them. NA-A stated not a staff member or family bring the resident down to the believe so." NA-A expressed thy residents from the unit atments unsupervised and hod question." Further, NA-A es appointments for the	Fδ	684			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Continued From page 34 F 684 When interviewed on 7/16/20, at 11:31 a.m. licensed practical nurse (LPN)-A explained the process for getting residents on the Rum River Unit to their appointments. LPN-A stated sometimes the family will take them, otherwise they go to off campus appointments using a "HandiVan" service which the HUC will arrange. LPN-A verified staff members do not routinely attend appointments with cognitively impaired residents and stated someone from the nursing home should be contacting family prior to the appointment to ensure someone is going to be there; however, LPN-A acknowledged she "[didn't] know if that actually happens." LPN-A voiced she could "vaguely remember" an episode in the past where a resident had been sent to an appointment and did not know why they were there when they arrived. LPN-A stated she could not recall any revisions or re-education being completed since that incident; however, expressed it was important to ensure someone was with residents at their appointments to advocate for them and ensure accurate reporting is provided to the physicians. On 7/16/20. at 11:45 a.m. HUC-A was interviewed and verified she made the appointments for the residents residing on the Rum River Unit. HUC-A explained "depending on [a resident's] cognitivity" they will call family and set-up appointments with them to ensure someone meets them at the site. HUC-A voiced she did not make the decision on who did or did not need to be accompanied to appointments, as that was the unit manager' responsibility. HUC-A stated she typically makes a note on the resident's appointment card regarding if family is meeting someone or not, however, these are not saved or placed in the medical record. Further,

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HO	ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	re-education compl on the unit adding s incident where R5 h appointment unsup someone should be supervised." When interviewed of HandiVan driver (H up from the nursing an envelope which desk at the clinic or service was basical and someone from checks them in. HV meet residents from clinic; however, it w [percent]" of the tim hair memory" of the what he could recal at the clinic on 11/8 responsible party w him inside, but did r HVD stated since th never been contact discuss the situation ensure residents ar when left unsupervit On 7/16/20, at 1:25 manager (RN)-B wa explained family wa appointments with r lot of the times they the HandiVan driver residents at the clinic added once they're	had not been any revisions or eted with her since R5 resided the was unaware of an had been sent to a medical ervised. HUC-A voiced e present "so they are on 7/16/20, at 12:09 p.m. the VD) stated he picks residents home and typically is given he provides to the reception hospital. He expressed his ly a "desk to desk" service, the clinic takes over after he D voiced family, at times, will in the nursing home at the as only "maybe 60/40 e. HVD stated he recalled "a incident with R5 and, from I, thought he dropped him off /19, and R5's son or as not there so he brought not remain with him. Further, he incident with R5, he had ed by the nursing home to n or revise any procedures to e met by family or kept safe	F	\$84			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Continued From page 36 F 684 planning becomes the clinic's responsibility and not the nursing homes. RN-B stated there were some residents on the locked memory care unit she "would hesitate" to send alone to appointments, and voiced while the HUC and her do speak about residents and appointments. there was no formal system to decide who needs supervision and who doesn't for appointments. RN-B added, "It's not our policy to make sure somebody's with them." RN-B then reviewed R5's incident from 11/8/19. RN-B explained R5 had dementia and could self-propel in his wheelchair. RN-B stated R5 was a resident who probably should have had family or a staff member present with him at off campus appointments as he would likely not give the physician accurate information on his condition(s), RN-B recalled R5's 11/8/19 appointment and stated the clinic had contacted her via telephone when he arrived and she remembered them "being upset" and questioning why R5 was at the clinic. RN-B stated clinic's calling and not having adequate information or having situations where the resident is unable to provide the necessary input for the physician had happened before; however, RN-B felt it was "very rarely." When guestioned on her follow-up actions to ensure a similar situation like R5's incident on 11/8/19 did not reoccur, RN-B stated she did "probably nothing;" however, in hindsight, should have brought the clinic' concerns to someone's attention so they could review their system for sending people to appointments. On 7/16/20, at 2:26 p.m. the director of nursing (DON) and RN-B were interviewed. The DON voiced the nursing home's responsibility was to setup the appointment and arrange transportation

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Continued From page 37 F 684 and she "cannot verify" if anyone from the nursing home contacts family to ensure they will be attending with the resident or not. DON added, "I assume they would," and she felt that was occurring. The DON stated she felt the incident with R5 on 11/8/19 happened due to miscommunication between the physician office and R5's family as the nursing home "did our part" and arranged the transportation for R5. RN-B and the DON verified they had not reviewed their systems or procedures for sending residents to appointments and ensuring care is coordinated and needed information relayed to the providers. The DON voiced she "didn't know this was a thing" and "had we known" she would have acted on it and "maybe put something in place." A facility policy on coordination of care with outside providers was not provided. F 689 Free of Accident Hazards/Supervision/Devices F 689 8/25/20 SS=D CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the Regarding cited resident: facility failed to ensure precautions and Resident # 5 has expired. appropriate supervision was provided to reduce the risk of accidents or injuries for 1 of 1 residents Actions taken to identify other potential (R5) reviewed who had severe cognitive residents having similar occurrences: impairment and was sent to a medical Develop and implement a policy

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				01 FIRST STREET RINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	11/10/19, identified State agency (SA) r outlined R5 had bee medical appointmen unable to explain w physician even aski would cost him." R5 had expressed to fa attend the appointm if it had been re-sch concern as sending nobody present cou R5's admission Min 11/5/19, identified F impairment and req with transfers. Furth sustained a fall with months. R5's undated 48 Ho identified R5 was on experienced halluci dictation present rea there, Has conversa Further, the care pla of frequent falls and R5's Referral Form, had an appointmen physician off campu- labeled, "Nurse Not	oint Intake Form, dated a concern received by the regarding R5. The report en brought to an off campus nt with no supervision and was hy he was there to the staff or ing, " how much the vet bill b had a listed guardian who acility' staff he was unable to nent, so he was waiting to hear heduled. The report outlined R5 to the appointment with ld be unsafe. imum Data Set (MDS), dated R5 had severe cognitive uired extensive assistance her, the MDS identified R5 had a fracture within the past six our Initial Plan of Care rientated to self and nations with handwritten ading, "Thinks something is ations no one there [sic]." an identified R5 had a history d wandering. , dated 11/7/19, identified R5 t at 3:00 p.m. that day with a us at the clinic. A section hes/Reason For Referral," was	Fé	\$89	regarding residents who require est appointments. • Assess all residents to determine potential need for escort to appoint • Update resident care plans to reassessment outcomes. Measures put in place to assess depractice: • Audit 50% of outside appointment each week for 4 weeks to ensure the residents escort needs were met. If at weekly IDT meeting. • Perform quarterly audits of 50% outside appointments thereafter. • Develop guideline for staff to for when making resident appointment provide to staff who schedule appointments. Monitoring over time: • Monitor policy and guideline implementation compliance over the through review of quarterly audits of scheduled external appointments. • Identify opportunities for process improvement and make recommendations for process char • Determine the need for ongoing based on consistent compliance with policy.	ne the ments. eflect eficient ents ne Discuss 6 of ollow s and ne f ss nge. g audit	
	provided which did	not list any reasons for the n or notes to be addressed;					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM HO	ME				701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	unit coordinator (HU manager (RN)-B's r number. The physic 11/7/19 and provide "Labs," and, "T Bon diagnosed with a B' pancytopenia (low c blood cells: red blood platelets). There wa including level of as for R5, to ensure he campus at the apport R5's corresponding note, dated 11/8/19 for an episodic care as the main concert "came to follow up v [R5] today. Spoke v out what and why la was at the appointn was there, [R5] did with." The note ider wheelchair and sittif adding, "Will respor his memory loss, st needs." The note lis which included diurn monitoring and reed medication dosing. R5's progress note(recorded entries: O nursing home. R5 v the place or time up SLUMs test (cogniti R5. He scored 8/30	ted the nursing home' health JC) and registered nurse unit name(s) and a telephone sian signed the note on ad dictation which read, e Marrow Biopsy." R5 was 12 deficiency and counts for all three types of od cells, white blood cells, and as no recorded directions, sistance and any precautions e remained safe while off intment. Fairview Geriatric Services , identified R5 had been seen e visit with pancytopenia listed h. The note outlined R5, with labs that were done on <i>v</i> ith the nurse manager to find bs. [R5] saw [physician] and nent alone. Not clear why he not know and family did not go	F	589			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ELIM HO	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	for R5's platelets ar was notified of thes progress notes from the hematology clin on 12/24/19. R5's medical record evidence the facility to accompany R5 to 11/8/19, despite be cognitive impairmer and falls. Further, th facility had commun needed levels of as precautions to ensu- of accidents if he ne the restroom, or atte unsupervised. When interviewed of nursing assistant (N residing on the Run care unit) and desc easily re-directable. resident on the unit bring the resident a to the van driver an there typically was no present when they I van adding, "I don't she was not sure w were sent to appoin added, "That's a go stated R5 used to o home and she could at the appointment	d reported a critical lab value ad hemoglobin. The physician e. There were no recorded in the appointment R5 had with ic on 11/8/19; and R5 expired d was reviewed and lacked y had arranged family or staff o his medical appointment on ing identified with severe int and a history of wandering he record lacked evidence the hicated to the clinic staff on sistance or any needed safety ure R5 was kept safe and free eeded to be transferred, use empted to leave the clinic on 7/16/20, at 11:22 a.m. NA)-A stated she recalled R5 in River Unit (locked memory ribed him as forgetful, but NA-A explained when a has an appointment, the staff nd a prepared envelope down d send them. NA-A stated hot a staff member or family bring the resident down to the believe so." NA-A expressed hy residents from the unit atments unsupervised and od question." Further, NA-A often verbalize he wanted to go d see R5 becoming confused and "wondering why he isn't	F	589			
		g to go home" then trying to					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				70	01 FIRST STREET		
ELIM HO	ME				PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 41	F6	89			
	Rum River Unit. HL a residents cognition set-up appointment someone meets the she did not make the not need to be accor- that was the unit ma- stated she typically resident's appointme- meeting someone of saved or placed in the HUC-A stated there re-education compli- on the unit adding s- incident where R5 h appointment unsup someone should be supervised." When interviewed of HandiVan driver (H up from the nursing an envelope which desk at the clinic or service was basical and someone from checks them in. HV meet residents from						
	remain with the per and if no family is p resident see the ph recalled "a hair mer	e. HVD verified he does not son while they're at the clinic, resent, he leaves then let's the ysician. HVD stated he mory" of the incident with R5 could recall, thought he					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 689 Continued From page 42 F 689 dropped him off at the clinic on 11/8/19, and R5's son or responsible party was not there so he brought him inside, but did not remain with him. Further, HVD stated since the incident with R5, he had never been contacted by the nursing home to discuss the situation or revise any procedures to ensure residents are met by family or kept safe when left unsupervised at the clinic. On 7/16/20, at 1:25 p.m. registered nurse unit manager (RN)-B was interviewed. RN-B explained family was always able to attend appointments with residents; however, added "a lot of the times they do go alone." RN-B voiced the HandiVan driver(s) typically waited for the residents at the clinic to her understanding, and added once they're checked in to the clinic appointments, the resident' safety and care planning becomes the clinic's responsibility and not the nursing homes. RN-B stated there were some residents on the locked memory care unit she "would hesitate" to send alone to appointments, and voiced while the HUC and her do speak about residents and appointments, there was no formal system to decide who needs supervision and who doesn't for appointments. RN-B added, "It's not our policy to make sure somebody's with them." RN-B then reviewed R5's incident from 11/8/19. RN-B explained R5 had dementia and could self-propel in his wheelchair. RN-B added, at times, she recalled R5 as someone who did become confused and search for people to take him to various places. RN-B stated R5 was a resident who probably should have had family or a staff member present with him at off campus appointments as he would likely not give the physician accurate information on his condition(s). RN-B stated she didn't think much, if any, information on activities of daily

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	08/24/2020 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		СОМ	E SURVEY PLETED
		245494	B. WING					_ 20/2020
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STAT	E, ZIP CODE		
ELIM HO	ME				1 FIRST STREET RINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 689	were sent with resid "We don't do a who RN-B recalled R5's stated the clinic had when he arrived an "being upset" and q clinic. When questif to ensure a similar 11/8/19 did not reco "probably nothing;" have brought the cl attention so they co sending people to a they're supervised a On 7/16/20, at 2:26 (DON) and RN-B w voiced the nursing f setup the appointm and she "cannot ve home contacts fam attending with the re assume they would occurring. RN-B an not reviewed their s sending residents to care is coordinated The DON voiced sh thing" and "had we on it and "maybe put A facility policy on s at appointments wa	nce or supervision prevent falls or elopements) dents on appointments adding, le lot of that kind of stuff." 11/8/19 appointment and d contacted her via telephone d she remembered them uestioning why R5 was at the oned on her follow-up actions situation like R5's incident on ccur, RN-B stated she did however, in hindsight, should inic' concerns to someone's ould review their system for appointments and make sure appropriately. p.m. the director of nursing ere interviewed. The DON home's responsibility was to ent and arrange transportation rify" if anyone from the nursing ily to ensure they will be esident or not. DON added, "I ," and she felt that was d the DON verified they had systems or procedures for o appointments and ensuring and supervision is provided. he "didn't know this was a known" she would have acted at something in place."	F 6					8/25/20
	CFR(s): 483.40(b)(44				0/20/20

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 744 Continued From page 44 F 744 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced bv: Regarding cited resident: Based on interview and document review, the facility failed to comprehensively reassess and Resident # 1 expired 1/16/20 develop interventions to reduce behaviors and promote well-being for 1 of 2 residents (R1) Actions taken to identify other potential reviewed who displayed exit seeking and residents having similar occurrences: delusional behaviors which were not effectively Review and update the Behavioral addressed. Health policy. Re-initiate dementia unit behavioral Findings include: meetinas. Review all residents over the next R1's significant change Minimum Data Set guarter to coincide with scheduled care (MDS), dated 10/28/19, identified R1 had short conferences. and long-term memory impairment along with severely impaired cognitive skills for daily Measures put in place to assess deficient decision making. The MDS identified R1 practice: demonstrated behavioral symptoms (i.e. hitting or Audit 100% of behavioral care plans scratching self, public sexual acts, screaming) over the next guarter to assess for during the review period; and the Care Area intervention effectiveness. Assessment (CAA) for cognition and behavioral Conduct guarterly audits of 100% of symptoms were listed as being triggered to be behavioral care plans. completed. Retrain staff on policy changes as they occur R1's care plan, last revised 5/5/20, identified R1 received mood stabilizing medication(s) and listed Monitoring over time: targeted behaviors which included anger. Conduct review of quarterly restlessness, disrobing in public and repeated behavioral care plan audit results to statements. A series of goals were listed for R1 identify deficient areas of practice. which included using less medications and having Determine opportunities for process less than two reports of anxious verbalizations improvement. daily. The care plan listed several interventions to meet the established goals which included documenting the resident's behaviors and mood,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/24/2020

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	08/24/2020 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
	245494	B. WING				C 20/2020
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ELIM HOME				01 FIRST STREET PRINCETON, MN 55371		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
reassurance to her was being reviewed status assessment. registered nurse unii identified, "Behavior charting crying was exhibiting anxiety was with redirection and not being effective. If X 5 days with reading offective. If reported daily with redirection and not being effective. Exit with redirection and R1's subsequent pro and identified the fol a verbal altercation of 11/27/19, R1 was ret "aggressive toward Resident has increa thoughts, and cursin administered, which Further, on 12/7/19, other resident' room her coloring box on R1 was recorded as R1's subsequent Ta flowsheets, dated 17 the following: November 2019: R1 seeking with each of the set of the se	ed, and providing 1:1 visits or when distressed. dated 10/28/19, identified R1 for a significant change in A note was completed by it manager (RN)-B which ": per the Target behavior reported on 1 day. Verbally as reported on 5 evenings offering a snack or activity Inability to sleep was reported ng material, TV, and snacks Delusional comments edirection and 1-1 visits not seeking reported on 2 days 1-1 not being effective."	F 7	'44			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 744 Continued From page 46 F 744 interventions were recorded the behavior was recorded as, "Unchanged." R1 had six episodes of crying and/or weeping recorded with interventions completed, including reassurance and offering snacks or activities, however, each time these interventions were recorded the behavior was recorded as. "Unchanged." R1 had 10 episodes of verbal complaints of anxiety recorded with each of the episodes having interventions completed. However, again, all of these recorded episodes had the behaviors recorded as, "Unchanged," despite the interventions. R1 had 13 episodes of inability to sleep recorded, each having interventions listed which included massage, warm packs and snacks; however, again, all of these episodes recorded the behavior as, "Unchanged," despite the interventions. Further, R1 had 22 episodes of delusional comments recorded with interventions being completed, including redirection and 1:1 visits, however each time these interventions were recorded the behavior was recorded as. "Unchanged." December 2019: R1 had eight episodes of exit seeking with each of the episodes having interventions completed, including coloring or taking R1 off the unit, however, only one of the episodes was recorded as these interventions being effective. The other episodes recorded the behavior as, "Unchanged." R1 had one episode of crving and/or weeping recorded with interventions completed, including reassurance and offering snacks or activities, however, these interventions were not effective and the behavior was recorded as, "Unchanged." R1 had four episodes of verbal complaints of anxiety recorded with each of the episodes having interventions completed. However, again, all of these recorded

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245494	B. WING	. <u> </u>			C 20/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ELIM HC	ME				01 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 744	episodes had the b "Unchanged," desp seven episodes of it each of the episode completed which in and snacks; howev recorded the behave the interventions. F delusional comment being completed, in visits, however eac were recorded the f "Unchanged." When interviewed of nursing assistant (N and verified she res (locked memory ca self-propel in her w attempted to use, of the unit. NA-D reca behaviors and woul "kicking, pounding of expressed R1 was not, the staff would helped "most of the any demonstrated b reported to the nurs behaviors had gotte the months leading 2020. R1's medical record evidence R1 had be reassessed and ne reduce R1's identifi behaviors, and imp recorded in the pro-	ge 47 ehaviors recorded as, ite the interventions. R1 had inability to sleep recorded with as having interventions cluded massage, warm packs er, again, all of these episodes rior as, "Unchanged," despite urther, R1 had 14 episodes of its recorded with interventions ocluding redirection and 1:1 h time these interventions ochavior was recorded as, on 7/16/20, at 10:17 a.m. NA)-D voiced she recalled R1 sided on the Rum River Unit re unit). R1 was able to heelchair and often used, or ther resident' bathrooms on lled R1 had exit seeking id often go around the unit on doors and swearing." NA-D re-directable at times, and if give her medications which a time." Further, NA-D stated behaviors from R1 were se(s) and added she felt R1's en "maybe slightly worse" in up to her death in January d was reviewed and lacked een comprehensively w interventions developed to ed behaviors despite the lemented interventions, being gress note(s) as not effective. al record lacked any evidence	F	744			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 744 Continued From page 48 F 744 a CAA had been completed for R5's cognition and behavioral symptoms despite being triggered on the 10/28/19 MDS (See F636 for additional information). On 7/16/20, at 2:01 p.m. RN-B was interviewed and verified she was R1's care manager during the last months of her life at the nursing home. RN-B explained when a resident displays behavior(s), the staff attempt to observe the behavior and try to intervene by coming up with "things they like." The unit used to have behavior meetings which helped in this process, however, they had not had a meeting for "a few months" as other things took priority. RN-B stated the facility typically accomplished the behavioral assessment by discussing them "informally." On 7/17/20, at 9:08 a.m. a subsequent interview was held with RN-B. The last time R1 had been reviewed at the behavior meetings, at least to which RN-B could find evidence supporting, was in July 2019. They decided at the meeting to implement a "calming activities" intervention, however, RN-B voiced it had never been added to the care plan and should have been. Further, RN-B reviewed the medical record and verified there was no comprehensive assessment completed regarding R1's behaviors, despite the implemented interventions being listed as not effective and R1 continuing to have the same behaviors, and reiterated the system in place for assessing behaviors was the monthly meetings which had "fallen by the wayside." A provided Behavioral Health Services policy, dated 5/31/19, identified behavioral health encompasses a resident's whole emotional and mental well-being. The facility was to use " ... a comprehensive assessment process for

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	T OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NC	TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED	
						С	
		245494	B. WING _		07	/20/2020	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	DDE		
ELIM HC	ME		701 FIRST STREET PRINCETON, MN 55371				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 744	Continued From pa	ige 49	F 74	4			
	psychosocial status	essing a resident's mental and s and providing are." This assessment included					
	obtaining information family and/or the re	on from medical records, sident on usual patterns of					
		and behavior; and, using the ent Instrument (RAI) process and CAA(s)					
F 880 SS=F	Infection Prevention	n & Control	F 88	0		8/25/20	
	infection prevention designed to provide comfortable environ	atablish and maintain an and control program a safe, sanitary and anment and to help prevent the ansmission of communicable					
	program. The facility must es	n prevention and control stablish an infection prevention n (IPCP) that must include, at owing elements:					
	identifying, reportin infections and com residents, staff, vol individuals providin arrangement based	stem for preventing, g, investigating, and controlling municable diseases for all unteers, visitors, and other g services under a contractual d upon the facility assessment ng to §483.70(e) and following standards;					
	procedures for the but are not limited t	en standards, policies, and program, which must include, o: reillance designed to identify					

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		I AND HUMAN SERVICES			FORM /	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245494	B. WING		07/2	_ 20/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pre (iv)When and how i resident; including & (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstance must prohibit emploid disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in the s483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must har transport linens so a infection. §483.80(f) Annual r The facility will cond IPCP and update the This REQUIREMEN	able diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact. stem for recording incidents facility's IPCP and the aken by the facility. ndle, store, process, and as to prevent the spread of review. duct an annual review of its heir program, as necessary. NT is not met as evidenced	F 88			
	Based on interview	, observation and document		Regarding cited resident:		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245494 B. WING 07/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET ELIM HOME PRINCETON, MN 55371 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 880 Continued From page 51 F 880 review the facility failed to ensure all employees Screen all residents for were being actively screened (other employees signs/symptoms of COVID-19 each shift verifying temperature readings during the to include temperature and symptom screening process) for the prevention and screen. Upon initiation of process, potential transmission of corona virus resident baseline was 100% negative for signs/symptoms. (COVID-19), in accordance with the Centers for Disease Control (CDC) guidelines. This had the potential to affect all 92 residents currently Actions taken to identify other potential residing in the facility at the time of the COVID-19 residents having similar occurrences: Staff training on COVID-19 Screening survey. policy. Findings Include: Root Cause Analysis A Centers for Medicare and Medicaid (CMS) COVID-19 Long-Term Care Facility Guidance, dated 4/2/20, identified procedures to be Place more comprehensive signage implemented to reduce the risk of COVID-19 at screening area, notifying staff of transmission in a long-term care setting. This screening requirements. included, " ... every individual regardless of reason entering a long-term care facility Assign staff to screening station at the (including residents, staff, visitors, outside beginning of each shift. During off times, healthcare workers, vendors, etc.) should be the receptionist will screen or, staff will call asked about COVID-19 symptoms and they must nursing staff to screen staff/outside essential workers/visitors who enter the also have their temperature checked." building. On 7/17/20, at approximately 8:55 a.m. survey Measures put in place to ensure deficient practice does not recur: team entered facility through the main doors. At Conduct observation audits of the that time, survey staff observed three facility employees self screening with no verification of screening station 4x/week for 1 week, their temperature or COVID screening questions 2x/week for 1 week and biweekly with another employee before entering the facility thereafter, until 100% compliance is despite an employee being present at the achieved. screening table at the time (employee was Review audit findings and alter screening survey staff). screening process, if necessary. When interviewed on 7/17/20, at 11:49 a.m. Effective implementation of actions will be dietary aide (DA-A) stated when arriving to work monitored by: she answered questions and took her own Review audit results to determine the temperature. DA-A said, "There is always need for further auditing/ monitoring.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00375

PRINTED: 08/24/2020

		HAND HUMAN SERVICES			FORM	08/24/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245494	B. WING			C 20/2020
NAME OF I	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ELIM HO	ME			701 FIRST STREET PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	Continued From pa	age 52	F 880			
	someone there to n screening." DA-A s anyone "needing to stated again she set temperature and do symptoms section of When interviewed of director of nursing (table there was alw assist with the screen explained the screen answering question temperature. DON monitoring was have temperature to verif was a schedule for and someone was assist with all screen DON stated she was verifying temperature employees had been process which inclu- employee verifying Policy entitled COV all CO sites states, complete a sympton having their temper	make sure you are doing the stated she did not know of o check my temperature". DA-A elf-administered her own ocumented the results in the of the screening process. on 7/17/20, at 1:29 p.m. the (DON) stated at the screening vays to be someone around to being process. DON ening process consisted of as about symptoms and taking a stated temperature ving "someone else" look at the fy result. DON stated there helping employees screen to be at the screening area to ening to verify information. as not aware of employees not tres. DON further explained en educated on the screening uded showing another temperature results. VID-19 Phase 2-All SNFs and "healthcare workers will m screening form, including rature checkedthese forms a facility designee prior to	F 880	• Other recommendations		

Facility ID: 00375

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 6, 2020

Administrator Elim Home 701 First Street Princeton, MN 55371

Re: State Nursing Home Licensing Orders Event ID: 8VDD11

Dear Administrator:

The above facility was surveyed on July 16, 2020 through July 20, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the

Elim Home August 6, 2020 Page 2

statement, "This MN Requirement 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:

Susie Haben, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 West Division Street, Suite 212 St. Cloud, Minnesota 56301 Email: susie.haben@state.mn.us Phone: 320-223-7356

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

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

Please feel free to call me with any questions.

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00375	B. WING		07/2) 0/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HO	ME		F STREET ON, MN 553	71		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
Ai	by surveyors from t Health (MDH) to de licensure in conjuct investigation(s) for H5494044C, H5494 H5494047C, H5494	20, a survey was conducted he Minnesota Department of termine compliance for state				
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

If continuation sheet 1 of 26

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00375	B. WING	B. WING		20/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ELIM HC	OME		T STREET TON, MN 5537	71		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CO(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	H5494050C.					
	As a result, the following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected. 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					
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a Department of Heal you electronically. is necessary for Sta enter the word "corn text. You must then State licensure proo completion date, the	o participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf elicensing orders are ttached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				

	ota Department of He					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
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		00375	B. WING	B. WING		20/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		701 FIRS	ST STREET			
ELIM HO	DME	PRINCE	TON, MN 5537	71		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 2	2 000			
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF TE STATUTES/RULES.				
2 540	MN Rule 4658.040 Resident Assessm	0 Subp. 1 & 2 Comprehensive ent	2 540			8/25/20
	conduct a compreh resident's needs, w capability to perforr significant impairm nursing assessmer Minnesota Statutes 15, may be used as resident assessme comprehensive res used to develop, re comprehensive pla 4658.0405. Subp. 2. Informa comprehensive res include at least the A. medically de medical history; B. medical stat C. physical and D. sensory and E. nutritional st F. special treat	ion;				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/20/2020	
		00375	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
ELIM HO	ME		T STREET	371		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLE DATE
2 540	Continued From pa	ge 3	2 540			
	K. rehabilitation L. cognitive sta M. drug therapy N. resident pre	itus; /; and				
	This MN Requirem	ent is not met as evidenced				
	Assessments (CAA status Minimum Da to ensure a compre- for 1 of 2 residents care and services. Findings include: The Centers for Me Long-Term Care Fa Instrument (RAI) 3. 10/2018, identified staff gather informa ensure care plans a The manual outline Assessment (CAA) the RAI consisted of includes the MDS, Utilization Guideline CAAs were require comprehensive ass annual, significant cha 10/28/19, identified depression along w memory impairmen consumed daily and medications, and d symptoms not direct	ure triggered Care Area as) on a significant change in ta Set (MDS) were completed thensive resident assessment (R1) reviewed for dementia edicare & Medicaid (CMS) acility Resident Assessment 0 User's Manual, dated the RAI helps nursing home ation on each resident to help are developed and revised. d, under Chapter 4: Care Area Process and Care Planning, of three components which the CAAs, and the RAI es. The manual identified d to be completed for OBRA sessments (i.e. admission, change in status, or significant r comprehensive). Inge in status MDS, dated R1 had anxiety disorder and rith both short and long-term tt. The MDS identified R1 it-anxiety and anti-depressant emonstrated other behavioral cted at others (i.e. hitting or lic sexual acts, disruptive				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURV COMPLETED			
		00375	B. WING		07/20/2020			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE				
ELIM HOME 701 FIRST STREET PRINCETON, MN 55371								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE		
2 540	Continued From pa	ge 4	2 540					
	with included, "02. (and, "09. Behavioral triggered CAA(s) have read, "See CAA sur R1's medical record evidence the trigger and behavioral sym Further, R1's CAAs 7/17/20, identified at of the CAA(s) which assessment along we colored checkmark "Completed." Howe and behavioral sym as triggered; there checkmark next to completed." Howe and behavioral sym as triggered; there checkmark next to completed. When interviewed of registered nurse (R who completed and 10/28/19. RN-C sta medical record and the triggered CAA(se explained the facilit was responsible to CAAs, and added so noticed they were me she sends e-mails to be completed befor since R1's MDS wat was important to er they're "part of the were A facility' policy on the requested; however	be completed were identified Cognitive Loss/Dementia," al Symptoms." Both of these ad dictation present which mmary." d was reviewed and lacked red CAA(s) for R1's cognition optoms had been completed. Summary listing, printed a red colored "!" next to each h had triggered for the with a corresponding green under the column titled, ever, despite both the cognition optoms CAA(s) being identified was no green colored them identifying them as on 7/20/20, at 10:28 a.m. N)-C verified she was the RN I signed R1's MDS dated ted she had reviewed R1's was unable to find evidence s) had been completed. RN-C y' social services department complete those assigned the had "once in awhile" not getting done. RN-C stated to persons when they need to ever, does not typically re they get done. RN-C ty had not reviewed their any education to ensure CAAs re the MDS' are submitted is completed, and added it nsure CAAs are being done as whole assessment." CAA(s) completion was r, none was received. THOD OF CORRECTION: The						

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	Сом	E SURVEY PLETED C
		00375	B. WING	· · · · · · · · · · · · · · · · · · ·	07/	20/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 553	71		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
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2 540	Continued From pa	ge 5	2 540			
	review applicable p Care Area Assessn inserivce staff and a	DON), or designee, could olices and procedures on nent (CAA) completion; then audit to ensure compliance. R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			8/25/20
	receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from th	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on interview facility failed to ensu coordinated with an reduce the risk of d residents (R5) revie and who was sent t unsupervised causi and course of treatu ensure precautions	ent is not met as evidenced and document review, the ure care was appropriately outside hematology clinic to elayed treatment for 1 of 1 ewed with cognitive impairmen o a medical appointment ng confusion on the reason(s) ment to be provided, failed to and appropriate supervision luce the risk of accidents or		Corrected		

8VDD11

If continuation sheet 6 of 26

STATEME	ta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00375	B. WING		07/20/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
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2 830	Continued From pa	ge 6	2 830	DENOIENO	· /	
	and failed to comp develop intervention promote well-being reviewed who displa delusional behavior addressed. Findings include: Coordination of car A Common Entry P 11/10/19, identified State agency (SA) in outlined R5 had beam medical appointment unable to explain w	e rener off campus unsupervised rehensively reassess and ns to reduce behaviors and for 1 of 2 residents (R1) ayed exit seeking and rs which were not effectively e oint Intake Form, dated a concern received by the regarding R5. The report en brought to an off campus nt with no supervision and was hy he was there to the staff or ing, " how much the vet bill				
	would cost him." R had expressed to fa attend the appointn if it had been re-sch "Due to not having and with him, howe	5 had a listed guardian who acility' staff he was unable to nent, so he was waiting to hea neduled. The report outlined, any decision maker available ver, other labs weren't a vas unable to give consent."	r			
	11/5/19, identified F impairment, severa anemia, coronary a failure; and had rec	imum Data Set (MDS), dated R5 had severe cognitive I medical diagnoses including rtery disease (CAD) and heart orded episodes of shortness ring the review period.				
	had an appointmen physician off campu labeled, "Nurse Not provided which did visit to the physician	, dated 11/7/19, identified R5 t at 3:00 p.m. that day with a us at the clinic. A section tes/Reason For Referral," was not list any reasons for the n or notes to be addressed; ted the nursing home' health				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00375	B. WING		07/20/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	manager (RN)-B's r number. The physic 11/7/19 and provide "Labs," and, "T Bon diagnosed with a B pancytopenia (low o blood cells: red bloo platelets). R5's corresponding note, dated 11/8/19 for an episodic care as the main concer "came to follow up v [R5] today. Spoke v out what and why la was at the appoint was there, [R5] did with. Has known Pa per orders. Nursing oncologist office or about the results ar information came fr The note identified sitting out in the cor respond to simple o	JC) and registered nurse unit name(s) and a telephone cian signed the note on ed dictation which read, ne Marrow Biopsy." R5 was				
	note listed several of diuretic medication, reeducation of antip R5's progress noted	orders for R5 which included laboratory monitoring and osychotic medication dosing. (s) identified the following n 10/30/19, R5 admitted to the				
	nursing home. R5 v the place or time up SLUMs test (cognit R5. He scored 8/30 this indicates deme	vas recorded as not knowing oon admission. On 11/7/19, a ion test) was administered to which the note outlined, " ntia." On 11/8/19, the ad reported a critical lab value				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00375	B. WING		C 07/20/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME	701 FIRST PRINCET	I STREET ON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	was notified of thes progress notes from	nd hemoglobin. The physician e. There were no recorded n the appointment R5 had with ic on 11/8/19; and R5 expired				
	evidence the facility outside hematology information or guida prevent delays in tra appointment on 11/ known cognitive im no evidence in the r family had been con at the appointment	d was reviewed and lacked whad sent or provided the vicinic with adequate ance to facilitate care and eatment pertaining to R5's 8/19; despite R5 having pairment. Further, there was record demonstrating R5's intact and agreed to meet R5 to help facilitate I treatment with the clinic on				
	nursing assistant (N residing on the Run care unit) and desc easily re-directable. resident on the unit bring the resident a to the van driver an there typically was n present when they i van adding, "I don't she was not sure w were sent to appoin added, "That's a go	7/16/20, at 11:22 a.m. NA)-A stated she recalled R5 n River Unit (locked memory ribed him as forgetful, but NA-A explained when a has an appointment, the staff nd a prepared envelope down d send them. NA-A stated not a staff member or family bring the resident down to the believe so." NA-A expressed hy residents from the unit atments unsupervised and od question." Further, NA-A es appointments for the m River Unit.				
	licensed practical n	on 7/16/20, at 11:31 a.m. urse (LPN)-A explained the residents on the Rum River ments, LPN-A stated				

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		00375	B. WING			20/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S ⁻	TATE, ZIP CODE		
ELIM HO	ME		r STREET ON, MN 5537	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page 9		2 830			
	they go to off camp "HandiVan" service LPN-A verified staff attend appointment residents and state home should be con appointment to ens there; however, LPI "[didn't] know if that voiced she could "v in the past where a appointment and di there when they arr not recall any revisi completed since that expressed it was im was with residents a	ily will take them, otherwise us appointments using a which the HUC will arrange. members do not routinely s with cognitively impaired d someone from the nursing ntacting family prior to the ure someone is going to be N-A acknowledged she actually happens." LPN-A aguely remember" an episode resident had been sent to an d not know why they were ived. LPN-A stated she could ons or re-education being at incident; however, nportant to ensure someone at their appointments to and ensure accurate reporting hysicians.				
	Rum River Unit. HL [a resident's] cognit set-up appointment someone meets the she did not make the not need to be acco	ified she made the e residents residing on the IC-A explained "depending on ivity" they will call family and s with them to ensure em at the site. HUC-A voiced he decision on who did or did ompanied to appointments, as				
	stated she typically resident's appointm meeting someone of saved or placed in t	anager' responsibility. HUC-A makes a note on the ent card regarding if family is or not, however, these are not the medical record. Further, a had not been any revisions or				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOWIDER.	A. BUILDING:		
		00375	B. WING		C 07/20/2020
NAME OF PROVIDER OR SUPPLIER STREET A			DDRESS, CITY, S	TATE, ZIP CODE	
		701 FIRS	ST STREET		
ELIM HO	ME	PRINCE	FON, MN 5537	'1	
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2 830	Continued From page 10		2 830		
	someone should be present "so they are supervised."				
	HandiVan driver (H up from the nursing an envelope which desk at the clinic or service was basica and someone from checks them in. HV meet residents from clinic; however, it w [percent]" of the tim hair memory" of the what he could reca at the clinic on 11/8 responsible party w him inside, but did HVD stated since the never been contact discuss the situatio ensure residents at when left unsuperv	on 7/16/20, at 12:09 p.m. the VD) stated he picks residents g home and typically is given he provides to the reception r hospital. He expressed his Ily a "desk to desk" service, the clinic takes over after he /D voiced family, at times, will n the nursing home at the vas only "maybe 60/40 he. HVD stated he recalled "a e incident with R5 and, from II, thought he dropped him off b/19, and R5's son or vas not there so he brought not remain with him. Further, he incident with R5, he had ted by the nursing home to n or revise any procedures to re met by family or kept safe ised at the clinic.			
	manager (RN)-B wa explained family wa appointments with lot of the times they the HandiVan drive residents at the clin	p.m. registered nurse unit as interviewed. RN-B as always able to attend residents; however, added "a / do go alone." RN-B voiced r(s) typically waited for the nic to her understanding, and checked in to the clinic			
	appointments, the r planning becomes not the nursing hon	resident' safety and care the clinic's responsibility and nes. RN-B stated there were the locked memory care unit to send alone to			

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C - 07/20/2020	
		00375	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	ge 11	2 830			
	supervision and wh	l system to decide who needs o doesn't for appointments. ot our policy to make sure em."				
	RN-B explained R5 self-propel in his wi a resident who prote or a staff member p appointments as he physician accurate condition(s). RN-B appointment and st her via telephone w remembered "being R5 was at the clinic and not having ade situations where the the necessary input happened before; h rarely." When quess to ensure a similar 11/8/19 did not reod "probably nothing;" have brought the cl	recalled R5's 11/8/19 ated the clinic had contacted then he arrived and she g upset" and questioning why c. RN-B stated clinic's calling quate information or having e resident is unable to provide t for the physician had nowever, RN-B felt it was "very tioned on her follow-up actions situation like R5's incident on ccur, RN-B stated she did however, in hindsight, should inic' concerns to someone's puld review their system for				
	(DON) and RN-B w voiced the nursing setup the appointm and she "cannot ve home contacts fam attending with the r assume they would	p.m. the director of nursing ere interviewed. The DON home's responsibility was to ent and arrange transportation rify" if anyone from the nursing ily to ensure they will be esident or not. DON added, "I ," and she felt that was N stated she felt the incident happened due to				

STATEME	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00375		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/20/2020	
	PROVIDER OR SUPPLIER	L	DRESS, CITY, ST			
		701 FIRS	T STREET			
			ON, MN 5537	PROVIDER'S PLAN OF (
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 12	2 830			
	part" and arranged RN-B and the DON their systems or pro- to appointments an and needed informa The DON voiced sh thing" and "had we on it and "maybe pu A facility policy on co- outside providers w Accidents A Common Entry P 11/10/19, identified State agency (SA) no outlined R5 had beamedical appointme unable to explain w physician even ask would cost him." R5 had expressed to fa attend the appointme if it had been re-sch concern as sending nobody present cou R5's admission Min 11/5/19, identified F impairment and rec with transfers. Furth	oint Intake Form, dated a concern received by the regarding R5. The report en brought to an off campus nt with no supervision and was hy he was there to the staff or ing, " how much the vet bill 5 had a listed guardian who acility' staff he was unable to nent, so he was waiting to hear neduled. The report outlined g R5 to the appointment with				
	identified R5 was o experienced halluci dictation present re	our Initial Plan of Care rientated to self and nations with handwritten ading, "Thinks something is ations no one there [sic]."				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00375			(X3) DATE SURVEY COMPLETED C 07/20/2020	
			DDRESS, CITY, STATE, ZIP CODE			20/2020
NAME OF I	PROVIDER OR SUPPLIER		T STREET	TATE, ZIP CODE		
ELIM HO	OME		ON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 13	2 830			
	Further, the care pl of frequent falls and	an identified R5 had a history d wandering.				
	physician off campulabeled, "Nurse Not provided which did visit to the physician however, merely lis unit coordinator (HU manager (RN)-B's in number. The physic 11/7/19 and provide "Labs," and, "T Bon diagnosed with a B pancytopenia (low of blood cells: red blood platelets). There w including level of as for R5, to ensure he campus at the appon	counts for all three types of od cells, white blood cells, and as no recorded directions, ssistance and any precautions e remained safe while off pintment.				
	note, dated 11/8/19 for an episodic care as the main concer "came to follow up [R5] today. Spoke v out what and why la was at the appointn was there, [R5] did with." The note ider	Fairview Geriatric Services , identified R5 had been seen e visit with pancytopenia listed n. The note outlined R5, with labs that were done on with the nurse manager to find abs. [R5] saw [physician] and nent alone. Not clear why he not know and family did not go ntified R5 as up in a ng out in the commons area				
	adding, "Will respon his memory loss, st needs." The note lis which included diur	nd to simple questions but with taff anticipate much of his sted several orders for R5 retic medication, laboratory ducation of antipsychotic				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМI	E SURVEY PLETED
		00375	B. WING		C 07/20/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ELIM HC	OME		T STREET ON, MN 5537	1		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 14	2 830			
	recorded entries: O nursing home. R5 v the place or time up SLUMs test (cognit R5. He scored 8/30 this indicates deme laboratory called an for R5's platelets ar was notified of thes progress notes from the hematology clin on 12/24/19.	(s) identified the following in 10/30/19, R5 admitted to the was recorded as not knowing bon admission. On 11/7/19, a ion test) was administered to 0 which the note outlined, " entia." On 11/8/19, the ind reported a critical lab value ind hemoglobin. The physician ite. There were no recorded in the appointment R5 had with itic on 11/8/19; and R5 expired				
	evidence the facility to accompany R5 to 11/8/19, despite be cognitive impairment and falls. Further, the facility had commune needed levels of as precautions to ensu- of accidents if he needed	A was reviewed and lacked A had arranged family or staff to his medical appointment on ing identified with severe Int and a history of wandering the record lacked evidence the hicated to the clinic staff on sistance or any needed safety ure R5 was kept safe and free eeded to be transferred, use empted to leave the clinic				
	nursing assistant (N residing on the Run care unit) and desc easily re-directable. resident on the unit bring the resident a to the van driver an there typically was n present when they n van adding, "I don't	on 7/16/20, at 11:22 a.m. NA)-A stated she recalled R5 n River Unit (locked memory ribed him as forgetful, but . NA-A explained when a . has an appointment, the staff nd a prepared envelope down d send them. NA-A stated not a staff member or family bring the resident down to the believe so." NA-A expressed thy residents from the unit				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00375	B. WING		07/20/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	1		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 15	2 830			
	added, "That's a go stated R5 used to c home and she coul at the appointment home" and "wanting leave the clinic. On 7/16/20, at 11:4 interviewed and ver appointments for th Rum River Unit. HL a residents cognitio set-up appointment someone meets the she did not make th not need to be acco that was the unit mas stated she typically resident's appointment meeting someone of saved or placed in the HUC-A stated there re-education compl on the unit adding s incident where R5 h appointment unsup					
	HandiVan driver (H up from the nursing an envelope which desk at the clinic or	on 7/16/20, at 12:09 p.m. the VD) stated he picks residents home and typically is given he provides to the reception hospital. He expressed his				
	and someone from checks them in. HV	ly a "desk to desk" service, the clinic takes over after he D voiced family, at times, will the nursing home at the as only "maybe 60/40				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMF	E SURVEY PLETED
		00375	B. WING		07/20/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LIM HO	ME		T STREET ON, MN 5537	71		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 16	2 830			
	remain with the per and if no family is p resident see the ph recalled "a hair mer and, from what he dropped him off at son or responsible brought him inside, Further, HVD state he had never been home to discuss th procedures to ensu or kept safe when I On 7/16/20, at 1:25 manager (RN)-B w explained family wa appointments with lot of the times they the HandiVan drive residents at the clir added once they're appointments, the r planning becomes not the nursing hon some residents on she "would hesitate appointments, and do speak about res there was no forma supervision and wh RN-B added, "It's n somebody's with th incident from 11/8/ dementia and could	he. HVD verified he does not rson while they're at the clinic, present, he leaves the let's the pysician. HVD stated he mory" of the incident with R5 could recall, thought he the clinic on 11/8/19, and R5's party was not there so he but did not remain with him. d since the incident with R5, contacted by the nursing e situation or revise any are residents are met by family eft unsupervised at the clinic. 5 p.m. registered nurse unit as interviewed. RN-B as always able to attend residents; however, added "a y do go alone." RN-B voiced er(s) typically waited for the nic to her understanding, and e checked in to the clinic resident' safety and care the clinic's responsibility and nes. RN-B stated there were the locked memory care unit e" to send alone to voiced while the HUC and her sidents and appointments, al system to decide who needs no doesn't for appointments. not our policy to make sure em." RN-B then reviewed R5's 19. RN-B explained R5 had d self-propel in his wheelchair.				
nosota D	for people to take h	become confused and search him to various places. RN-B sident who probably should				

Minnesc	ota Department of He	alth				APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00375	B. WING		C 07/20/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HC		701 FIRS	T STREET			
		PRINCET	ON, MN 5537	71		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
	him at off campus a likely not give the p on his condition(s). much, if any, inform living (ADL) assista interventions (i.e. to were sent with resid "We don't do a who RN-B recalled R5's stated the clinic had when he arrived an upset" and question When questioned of ensure a similar situ 11/8/19 did not reod "probably nothing;" have brought the cl attention so they co	b prevent falls or elopements) dents on appointments adding, de lot of that kind of stuff." 11/8/19 appointment and d contacted her via telephone d she remembered "being hing why R5 was at the clinic. on her follow-up actions to uation like R5's incident on ccur, RN-B stated she did however, in hindsight, should inic' concerns to someone's buld review their system for appointments and make sure				
	(DON) and RN-B w voiced the nursing I setup the appointm and she "cannot ve home contacts fam attending with the r assume they would occurring. RN-B an not reviewed their s sending residents to care is coordinated The DON voiced sh thing" and "had we on it and "maybe put A facility policy on s	p.m. the director of nursing ere interviewed. The DON home's responsibility was to ent and arrange transportation rify" if anyone from the nursing ily to ensure they will be esident or not. DON added, "I ," and she felt that was d the DON verified they had systems or procedures for o appointments and ensuring and supervision is provided. he "didn't know this was a known" she would have acted ut something in place."				
nnesota D	at appointments wa	is not provided.				
ATE FOR	M		6899 8	VDD11	If continuation	on sheet 18 c

STATEMEN	ta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00375	B. WING		07/20/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	'1		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 18	2 830			
	(MDS), dated 10/28 and long-term mem severely impaired of decision making. The demonstrated beha scratching self, pub during the review pro- Assessment (CAA) symptoms were list completed. R1's care plan, last received mood stat targeted behaviors restlessness, disrot statements. A serie which included usin less than two report daily. The care plan	ange Minimum Data Set 3/19, identified R1 had short arry impairment along with cognitive skills for daily he MDS identified R1 avioral symptoms (i.e. hitting or vic sexual acts, screaming) eriod; and the Care Area for cognition and behavioral ed as being triggered to be revised 5/5/20, identified R1 bilizing medication(s) and listed which included anger, bing in public and repeated as of goals were listed for R1 og less medications and having ts of anxious verbalizations a listed several interventions to ed goals which included				
	documenting the re intervening as need reassurance to her	sident's behaviors and mood, led, and providing 1:1 visits or when distressed.				
	was being reviewed status assessment. registered nurse un identified, "Behavio	, dated 10/28/19, identified R1 d for a significant change in A note was completed by it manager (RN)-B which r: per the Target behavior reported on 1 day. Verbally				
	exhibiting anxiety w with redirection and not being effective. X 5 days with readi	as reported on 5 evenings l offering a snack or activity Inability to sleep was reported ng material, TV, and snacks Delusional comments				
	reported daily with r	redirection and 1-1 visits no t seeking reported on 2 days				

STATEME	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00375	B. WING			20/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ELIM HC	ME		T STREET FON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 19	2 830			
	with redirection and	1-1 not being effective."				
	and identified the for a verbal altercation 11/27/19, R1 was ro "aggressive towar Resident has increa- thoughts, and cursi administered, which Further, on 12/7/19 other resident' room her coloring box on R1 was recorded as	rds other residents this shift. ase [sic] anxiety, grand ng. PRN [as needed] n was somewhat effective." , R1 was attempted to go into ns and when re-directed threw the floor and became upset. s expiring on 1/16/20.				
		R1's subsequent Target Behavior Monitoring flowsheets, dated 11/2019 to 1/2020, identified the following:				
	seeking with each of interventions compli- taking off the unit, h interventions were n recorded as, "Unch of crying and/or were interventions compli- and offering snacks time these interventions behavior was record 10 episodes of verta- recorded with each	1 had five episodes of exit of the episodes having leted, including coloring or nowever, each time these recorded the behavior was anged." R1 had six episodes eping recorded with leted, including reassurance s or activities, however, each tions were recorded the ded as, "Unchanged." R1 had bal complaints of anxiety of the episodes having leted. However, again, all of				
	these recorded epis recorded as, "Unch interventions. R1 ha sleep recorded, eac which included mas snacks; however, a	sodes had the behaviors				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00375	B. WING		07/20/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 20	2 830			
	delusional commen being completed, in visits, however eac were recorded the l "Unchanged." December 2019: R seeking with each of interventions complet taking R1 off the ur episodes was recor- being effective. The behavior as, "Uncha- of crying and/or we interventions complet and offering snacks interventions were us was recorded as, "U episodes of verbal with each of the epi- completed. However episodes had the b "Unchanged," desp seven episodes of i each of the episode completed which in and snacks; however the interventions. F delusional commen being completed, in visits, however eac were recorded the l "Unchanged."	urther, R1 had 22 episodes of its recorded with interventions including redirection and 1:1 h time these interventions behavior was recorded as, 1 had eight episodes of exit of the episodes having leted, including coloring or hit, however, only one of the reded as these interventions to other episodes recorded the anged." R1 had one episode eping recorded with leted, including reassurance s or activities, however, these not effective and the behavior Jnchanged." R1 had four complaints of anxiety recorded isodes having interventions er, again, all of these recorded ehaviors recorded as, ite the interventions. R1 had nability to sleep recorded with es having interventions cluded massage, warm packs er, again, all of these episodes for as, "Unchanged," despite urther, R1 had 14 episodes of ths recorded with interventions having redirection and 1:1 h time these interventions behavior was recorded as,				
	and verified she res	sided on the Rum River Unit re unit). R1 was able to				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00375	B. WING		07/20/2020	
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LIM HO	ME		T STREET ON, MN 5537	'1		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		VMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	OMPLE ⁻ DATE
2 830	Continued From pa	ge 21	2 830			
	attempted to use, of the unit. NA-D reca behaviors and woul "kicking, pounding expressed R1 was not, the staff would helped "most of the any demonstrated B reported to the nurs behaviors had gotte the months leading 2020.	heelchair and often used, or ther resident' bathrooms on lled R1 had exit seeking Id often go around the unit on doors and swearing." NA-D re-directable at times, and if give her medications which time." Further, NA-D stated behaviors from R1 were se(s) and added she felt R1's en "maybe slightly worse" in up to her death in January				
	evidence R1 had be reassessed and ne reduce R1's identifi behaviors, and imp recorded in the pro- Further, the medica a CAA had been co and behavioral sym	d was reviewed and lacked een comprehensively w interventions developed to ed behaviors despite the lemented interventions, being gress note(s) as not effective. al record lacked any evidence ompleted for R5's cognition uptoms despite being triggered OS (See F636 for additional				
	and verified she wa the last months of the RN-B explained wh behavior(s), the state behavior and try to "things they like." The meetings which hell they had not had a other things took pro- typically accomplished assessment by disc	cussing them "informally." On n. a subsequent interview was				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00375	B. WING		07/20/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ELIM HO	ME		T STREET ON, MN 5537	'1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE
2 830	which RN-B could f in July 2019. They of implement a "calmi however, RN-B void the care plan and s RN-B reviewed the there was no comp completed regardin implemented interv effective and R1 co behaviors, and reite assessing behavior which had "fallen by A provided Behavior dated 5/31/19, iden encompasses a res mental well-being. comprehensive ass identifying and asse psychosocial status person-centered ca obtaining informatio family and/or the re cognition or mood a	havior meetings, at least to ind evidence supporting, was decided at the meeting to ng activities" intervention, ced it had never been added to hould have been. Further, medical record and verified rehensive assessment og R1's behaviors, despite the entions being listed as not ontinuing to have the same erated the system in place for 's was the monthly meetings y the wayside." oral Health Services policy, tified behavioral health sident's whole emotional and The facility was to use " a sessment process for essing a resident's mental and and providing ure." This assessment included on from medical records, esident on usual patterns of and behavior; and, using the ent Instrument (RAI) process				
	director of nursing (review applicable p inservice staff on id requirements, and t compliance with fac	then audit to ensure cility' policies regarding to n, outside clinic consultation				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00375				LE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED C 07/20/2020	
		00375	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ELIM HC	ME		ST STREET FON, MN 55:	371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
21375	Program Subpart 1. Infection home must establis	D Subp. 1 Infection Control; on control program. A nursing sh and maintain an infection signed to provide a safe and nt.	21375		8/25/20	
	by: Based on interview review the facility fa were being actively verifying temperatu screening process) potential transmissi (COVID-19), in acc Disease Control (C potential to affect a	ent is not met as evidenced , observation and document niled to ensure all employees screened (other employees re readings during the for the prevention and ion of corona virus ordance with the Centers for DC) guidelines. This had the II 92 residents currently ty at the time of the COVID-19		Corrected		
	COVID-19 Long-Te dated 4/2/20, identi implemented to red transmission in a lo included, " every reason entering a lo (including residents healthcare workers	care and Medicaid (CMS) frm Care Facility Guidance, fied procedures to be uce the risk of COVID-19 ing-term care setting. This individual regardless of ong-term care facility s, staff, visitors, outside , vendors, etc.) should be D-19 symptoms and they must perature checked."				
	team entered facilit	oximately 8:55 a.m. survey y through the main doors. At aff observed three facility				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
	00375		B. WING		07/	07/20/2020	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
ELIM HO	ME		T STREET TON, MN 5537	71			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	ge 24	21375				
	their temperature o with another employ despite an employe screening table at t screening survey st When interviewed o dietary aide (DA-A) she answered ques temperature. DA-A someone there to n screening." DA-A s anyone "needing to stated again she se temperature and do	eening with no verification of r COVID screening questions yee before entering the facility ee being present at the he time (employee was taff). on 7/17/20, at 11:49 a.m. stated when arriving to work stions and took her own a said, "There is always nake sure you are doing the stated she did not know of c check my temperature". DA-A elf-administered her own bocumented the results in the of the screening process.					
	director of nursing (table there was alw assist with the scree explained the scree answering question temperature. DON monitoring was hav temperature to verif was a schedule for and someone was assist with all scree DON stated she wa verifying temperatu employees had bee process which inclu	on 7/17/20, at 1:29 p.m. the (DON) stated at the screening rays to be someone around to ening process. DON ening process consisted of as about symptoms and taking stated temperature ring "someone else" look at the fy result. DON stated there helping employees screen to be at the screening area to ening to verify information. as not aware of employees not res. DON further explained en educated on the screening ided showing another temperature results.					
	all CO sites states, complete a sympton	ID-19 Phase 2-All SNFs and "healthcare workers will m screening form, including rature checkedthese forms					

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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IAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21375	Continued From page 25		21375			
	reporting to the resi SUGGESTED MET director of nursing (educate staff on ac then audit to ensure	HOD OF CORRECTION: The (DON), or designee, could tive screening for COVID-19;				
	epartment of Health					