

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 17, 2020

Administrator Elim Home 701 First Street Princeton, MN 55371

RE: CCN: 245494

Cycle Start Date: July 20, 2020

Dear Administrator:

On August 6, 2020, we notified you a remedy was imposed. On September 8, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 25, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 20, 2020 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 6, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 20, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist Licensing and Certification

Minnosota Donartment of Ho

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

PRINTED: 10/05/2020 FORM APPROVED OMB NO. 0938-0391

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ABORATOR'	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

09/17/2020

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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 17, 2020

Administrator Elim Home 701 First Street Princeton, MN 55371

Re: Reinspection Results

Event ID: 8VDD12

Dear Administrator:

On September 8, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 8, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

PRINTED: 10/05/2020 FORM APPROVED

Minnesota Department of Health

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		PRINCET	ON, MN 553	71		_
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	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
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Minnesota D	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed 09/17/20

PRINTED: 10/05/2020 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COME	(X3) DATE SURVEY COMPLETED	
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Minnesota Department of Health

STATE FORM 8VDD12 If continuation sheet 2 of 2



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.

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.

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:

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.

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

PRINTED: 08/24/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		X3) DATE SUR\ COMPLETE	
		245494	B. WING _			C 07/20/20	20
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1 000	On 7/16/20 to 7/20 was completed at y the Minnesota Department of the Was found not to be Part 483, Requirem Facilities.	/20, an abbreviated survey rour facility by surveyors from artment of Health (MDH) to investigation(s). Elim Home e in compliance with 42 CFR nents for Long Term Care	1 0				
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	(IJ), and substanda when a credible allowed resident(s) and staft required parties, ac protection provided locked memory car	d in an immediate jeopardy and quality of care, at F600 egation of abuse voiced by ff had not been reported to the sted upon, investigated and to resident(s) at risk in the e unit to ensure they remained					
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Electronically Signed 08/17/2020

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.

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	Exploitation The resident has th neglect, misapprop and exploitation as includes but is not I corporal punishmer	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.			
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	physical abuse, cor involuntary seclusic This REQUIREMEN by: Based on interview	NT is not met as evidenced vand document review, the		Regarding cited resident:	
	facility failed to ens	ure allegations of abuse were		Resident #10- Investigation into	

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F 600	appropriately report and agencies, invest protection provided abuse for 3 of 6 rest allegations were reconstituted an immorphism which had potential who resided on the memory unit at the continued to work of towards residents. The IJ began on 6/2 (trained medication with her hands grass voicing to the reside again. We're not do incident, no formal for TMA-A and no smonitoring of her carensure residents reapproximately 7/1/2 witnessed and reportegarding TMA-A wyelling and being "not acted upon, reportection plan(s) be all residents on the free of abuse by TM telephone), director registered nurse (R7/17/20, at 4:26 p.n. 7/18/20, at 5:25 p.s. successfully implement to the protection potential acted upon to the free of abuse by TM telephone), director registered nurse (R7/17/20, at 4:26 p.n. 7/18/20, at 5:25 p.s. successfully implement of the potential acceptance of the potential acceptance of the potential acceptance of the potential acceptance of the protection potential acceptance of the protection potential acceptance of the potential acceptance of the protection potential acceptance of the p	ded to the required person(s) stigated and adequate to ensure freedom from sidents (R9, R10, R11) whose viewed. These findings ediate jeopardy (IJ) situation to affect 16 of 16 residents Rum River Place secured time of the survey as TMA-A despite allegations of abuse 27/20, when an employee aide (TMA)-A) was witnessed sped around R9's wrists while ent, "You're not going to hit me bing this tonight!" Following the re-education was completed subsequent audits or are was implemented to emained free of abuse. On 20, a second incident was orted to the unit manager where she had been witnessed mean" to a different resident in care unit. This allegation was corted or investigated and to work unsupervised with no eing implemented to ensure locked unit remained safe and MA-A. The administrator (via of nursing (DON) and N)-A were notified of the IJ on the IJ was removed on	F6	600	findings initiated on 7/17/20. Staff involved in the reported in were suspended pending completion the investigation. TMA-A was terminated. RN-A was removed from leader position. Resident #9 and #11 assessed signs of psychosocial distress or fermo ongoing distress noted. Actions taken to identify other poter residents having similar occurrence residents having similar occurrence of the Root Cause Analysis of F600 and associated tags. Committee memberattendance: Administrator, DON, Dof Corporate Compliance, Director Operations, Clinical Directors of SN Services and Human Resources. Conducted interviews with those residents residing within the demendant who were able to verbalize cone. All cognitively intact residents interviewed regarding customer set experience and any concerns of abuse/neglect. Measures put in place to ensure depractice does not recur: Reviewed Vulnerable Adult police. Staff training on the revised VA with a focus on the requirement to witnessed or potential occurrences abuse or neglect. Weekly auditing throughout the building-2 audits per unit, per week weeks then 1 audit per unit per week weeks the set and the reported in the reported	on of rship for ar. with ntial es: perform ers in irector of IF e ntia unit icerns. rvice eficient icy. policy report of X 2	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ´COM	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 701 FIRST STREET PRINCETON, MN 55371		20/2020	
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F 600	Findings include: A submitted initial Sdated 6/27/20, idenabuse regarding Rsintended to produch handling." The reportive the locked memory "[R9] was attempting staff intervened and distracted and attergrabbed the reside to stay out here.' As [TMA-A] said, "We The report identifie and TMA-A was se investigation could. A corresponding ur Investigation (VOI) completed an investigation could. A corresponding ur Investigation (VOI) completed an investigation (VOI) completed an investigation (VOI) completed and verbal toileting, staff intervabout being distract [TMA-A]. [TMA-A] stated, 'you need to reported that [TMA tonight." The report notified of the incident pending further investigationed if she was nursing home, R9 was shrugged her shou	State agency (SA) report, tified an allegation of physical 9 which read, "Conduct e pain/injury or rough ort identified on 6/27/20, at nt happened in the hallway of care unit which included, ag to walk another resident d [R9] was upset about being 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 nt home until further	F 600	weeks which includes both re interview and staff care obser POC binder for questions and observations). Results will be and reviewed for necessary a • Results of these audits w reviewed until substantial com achieved and they will make t if further monitoring/audits are recommended.	vations (see d tabulated oction. ill be opliance is the decision		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 701 FIRST STREET PRINCETON, MN 55371		
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F 600	notified of the incide statements were list from multiple staff in assistant (NA)-A, Not recorded interview witnessed "with a goulling her aggress NA-A instructed TMTMA-A responded, her hands up in the immediately following seemed scared." Fix with an, "Investigation TMA-A had interce which " was interested" The on customer service communication. The submitted SA in dated 7/3/20, was recare plan was reviet the facility policy with followed," and no concident occurred. Investigation was obtained with a very with education on concorded with a very with education on 6/29/20 having verbally ack telephone call	r, physician and SA were all ent, and a series of witness sted which included statements members including nursing IA-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 for Summary," which outlined pted R9's attempt to strike her repreted as rough behavior on nother staff member who DON then re-educated TMA-A e and professional Investigation (5-Day Report), eviewed and identified R9's ewed and followed, along with nich was listed as, " hanges were made after the The facility's completed utlined which reflected the VOI and an additional form was nonstrated TMA-A had been bal disciplinary action along sustomer 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 60			

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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F 600	subsequent SA inv TMA-A had been for facility's abuse policy what constitutes also understanding behavior could increase respond. A provided residentified a total of Rum River Unit (locincluding R9, R10 at R9's annual Minima 4/8/20, identified Rimpairment; however or physical behavior kicking). On 7/17/2 interviewed in her resure how long she and just replied, "No concerns with staff On 7/17/20, at 10:5-A was interviewed with TMA-A on the stayed late to help explained R9 was a wandered into a spetheir bathroom and however, at approximate shad come out witnessed TMA-A's "squeezing" around struggle to free her shaking and pulling immediately told TI	ence in the completed VOI or estigation demonstrating ormally re-educated on the cies and procedures including buse or any education on avioral symptoms of residents se the risk of abuse and how to the listing, dated 7/16/20, 16 residents resided on the cked memory care unit)	F 60			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(E SURVEY PLETED
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F 600	wrists, so NA-A qui hands into a reside and TMA-A who ret then released R9's done" as she walke proceeded to help fopposite end of the immediately followin voiced she thought her. NA-A complete reported the allegat supervisor who sub DON. NA-A voiced complete her shift to involving R9 as she expressed significate subsequently return unit on an unsupervisor following TMA-A's rincident had happe potentially abused reknew R11 had expressed to at another resident just a few days after 6/27/20. NA-A state and R11 did report registered nurse unadded she was conthey even looked in she had known TM times with residents however, had never abusive with residents of the continue to potential to the potential to potential	ckly tossed the linens in her nt room and returned to R9 mained in the hallway. TMA-A wrists and yelled, "I'm so d away from R9. NA-A R9 to use a bathroom on the unit and R9 was upseting the incident, R9 even TMA-A had left bruising on a R9's cares and then ion and incident to the working sequently reported it to the TMA-A was not allowed to the night of the incident was sent home; however, and concern as TMA-A had need to work on the dementia vised basis. NA-A expressed eturn to work, a second need where TMA-A had residents. NA-A stated she	F 61				

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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F 600	work, as of that day unsupervised basis [shift]." R11's quarterly MD R11 had severe codemonstrated no do When interviewed astated she had lived approximately four her diabetes manay no concerns about however, expresse female staff membrical in a wheelchair. R1 as "grabbing her arher arms and wrists described TMA-A; I people [residents] to cognitive impairments she had observed the assomething she fright." R11 express about the incident; remember who, but to them as someon screams at people. On 7/17/20, at 1:47 and verified R11 has approximately "two TMA-A had "grabbed described R11's retained the remaining that approximately "two TMA-A was "yelling her arm and pulled".	(7/17/20), on an for "eight hours of the night of reight in the night		00		

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F 600	it [the incident]," as reporting it and "aln between words." HI fearful of retaliation she "[didn't] want he HMK-A verified the reported to her by Fmanager (RN-B); he specific follow-up withere had already be reported" pertaining time frame." Furthenever personally wiphysically abusive the witnessed her to be before and seem "a providing direction of the nursing home in worked during the codescribed 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 grabbed around her wrists, he grabbed her an TMA-A stated she as specifics from the elements."	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 a little frustrated" while	F6				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED C	
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(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	DON had also discacts, including place the incident on 6/27 abuse and would not denied any further memory care unit a work alone on the rovernight shift. TM, of being placed on cares or monitoring adding she had just was scheduled to with the work alone on the registered nurse (Fronthe overnight shift). TMA-RN-D acknowledge incident involving Froccurred in the passiviness it or recall shad not been instrumonitoring or observed and the properties of the survey adding, "Most days". On 7/17/20, at 2:33 interviewed and exadministrator was a time of the survey. Understanding of the and R9 on 6/27/20, trying to walk anoth TMA-A attempted to	e mannerisms and TMA-A added she thought the ussed with her the various sing hands on a resident like 7/20 outlined, could constitute ot be acceptable. TMA-A incidents with residents on the and voiced she continued to memory care unit on the A-A stated she was not aware any formal buddy-systems for g of the care she provided, t worked last on 7/15/20, and work again in the coming days. 20	F 60				

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F 600	NA-A had walked of the incident and obwrists" and so she in TMA-A was sent how was filed to the SA. unsure of the exact TMA-A's hands and around R9's wrists on the wrists or a constitute abuse do is grabbed and how situation was at the they interviewed Thincident as part of the TMA-A felt her action DON verbalized she be perceived as abconversation" with customer service as 6/27/20; however, sher any formal Reliatraining) courses or or dementia-related DON verified TMA-on an unsupervised monitoring of her caimplemented. RN-E "being scared" immon 6/27/20. As part attempted to intervilocked memory car cognitively respond stated R11 did not about TMA-A; howefollowing their discustions.	ge 11 brevent her from striking out. but of a room in the middle of served the "grabbing of the reported it to the supervisor, ome, and the incident report. The DON stated she was manner or specifics regarding dithe subsequent grip she had (i.e. open hand pushing down losed fist around the wrists) as in it at the time with the staff of voiced such actions could epending on how the resident of aggressive the overall moment. The DON explained of MA-A regarding the 6/27/20, their overall investigation, and ons were not abusive. The set told TMA-A her actions could usive and then had a "lengthy TMA-A on professionalism and as a result of the incident on the did not complete or assign as (computerized healthcare in abuse, vulnerable adult (VA) dispolicies and procedures. The A returned to work on 7/1/20, disposition being completed or are bein	F6	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245494	B. WING			C 07/20/2020
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F 600	of abuse involving (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 sa personal note-pareported to her. An taken notes was promoted to her. An taken notes was promoted in the sentences "Always pulling [R1" "Just happened a complete sentences" "She's mean," "She's nice to me," "Yells-too aggression" "[R11] pulled [HMK agressively [sic]." The interview continuould not consider historian (despite hinterview as part of added things R11 his seemed to "always questioned how the handled and investion timmediately repadministrator or DC and the service of the second services and	TMA-A and a different resident she felt the initial discussion the 6/27/20, incident as ead in R11's mind preport the second allegation by of paranoia. RN-B stated aspecifics of the second and R11 had shared with her; he had taken notes about it on discussion was undated, untitled copy of the bounded. The notes identified the top along with various which included:	F 6			

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F 600	RN-B stated she p TMA-A's cares, no re-education with Tallegation and verification and verification with The second with the resident pounit. The DON states the second she with the secon	laced no formal monitoring of r did she complete any TMA-A as part of the second fied, as of 7/17/20, TMA-A unsupervised on the night shift opulation on the Rum River ted this was "the first time I amond event [allegation]" and did the administrator been told we reported it as an allegation stigated it as such in eir abuse prevention policy. If expressed that, to their cility's administrator had no second allegation being to 7/16/20, identified all idents (FRI) to the State of lacked evidence R11's expertaining to TMA-A was	F 60			
	TMA-A was hired at A course named, "was listed as being second course with which was not com Date' of 7/31/20. TTMA-A's transcript documentation der formally re-educate nor subsequent str from cognitively imallegation of abuse	g on 7/3/20. Further, there				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	l` ′coı			E SURVEY PLETED
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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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPR	BE	(X5) COMPLETION DATE
F 600	"Alzheimer's Diseas 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 the the apeutic approach of the end been placed or her return to work to the end gage in poter towards them desp abuse being reported. A provided Schedulidentified TMA-A had 7:15 a.m. on the fol 7/7/20, 7/10/20, 7/1 Further, the scheduled for 7/20/20, 7/21/20, 7/20/20, 7/20/20, 7/21/20, 7/20	se and Related Disorders: ent," which had listed 'due 0; however, the classes were no completion date was n, there was no evidence survey demonstrating TMA-A n any formal monitoring upon o ensure she completed ches for the residents and did ntially 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. le outlined TMA-A continued the same shift hours on	F 6	00			

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F 600	prohibition plan aloubehaviors (i.e. rouglanguage) and additime displays suspet the supervisor must appropriate action. Protection During Indirected to provide resident(s) upon ideactions which include removing the reside perpetrator (AP) can Further, the policy of suspected or allege promptly and thorouncluded collecting physical examination of abuse and intervistaff members. The the results of the inincident on a facility. The IJ which begar 7/18/20, at 5:25 p.n successfully implement included removing reporting and begin allegation in accordant educating staff process to ensure a residents were reposed. On 7/18/20, frointerview(s) were controlled.	nd the facility' abuse ng with identify inappropriate h handling, derogatory ed, "If a staff member at any ect 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 riews with other residents and e policy directed to document vestigation and log the v Event Summary. n on 6/27/20, was removed on n. when the facility nented a removal plan which the AP from resident care, ming the investigation of R11's lance with their facility's policy, members on the reporting all allegations made by orted to the administrator and om 4:14 p.m. to 5:13 p.m. completed with direct care and to ensure these items had	F 60			
F 609 SS=D	Reporting of Allege	d Violations	F 60	9		8/25/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	СОМ	E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 701 FIRST STREET PRINCETON, MN 55371			
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F 609		onse to allegations of abuse,	F 609				
	must: §483.12(c)(1) Ensuinvolving abuse, ne	n, or mistreatment, the facility are that all alleged violations glect, exploitation or					
	source and misapp are reported immed hours after the alled that cause the alled serious bodily injury the events that cau abuse and do not re the administrator of officials (including to and adult protective provides for jurisdice	ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other the State Survey Agency e services where state law ction in long-term care ance with State law through ures.					
	designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct	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					
	Based on interview facility failed to ens physical abuse was and State agency (v and document review, the ure an allegation of potential reported to the administrator SA) within two hours, as residents (R11) whose viewed.		Regarding cited resident: Review of resident #11 updates made to reflect reand history of reporting incon behalf of other residents Initiated an investigation resident #10. Resident assort	sident status idents to staff s. on regarding essed for signs		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		E SURVEY PLETED
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PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETION DATE
F 609	Continued From p	page 17	F 60	9		
				 Staff involved in the repo 		
		DS, dated 6/15/20, identified		suspended pending completi	on of the	
		ognitive impairment; however,		investigation.		
		delusions or hallucinations.		RN-A was removed from	leadership	
		on 7/17/20, at 11:25 a.m. R11		position.	: 4 :	
		ed at the nursing home for ryears as she needed help with		TMA-A terminated from h	ner position.	
		agement. R11 stated she had		Actions taken to identify othe	r notential	
		t the way staff treated her;		residents having similar occu		
		ed she had recently seen a		QAPI committee convene		
		ber (TMA-A) abusing a resident		Root Cause Analysis of F609		
	in a wheelchair. R	11 described TMA-A's actions		associated tags. Committee	members in	
		and pushing her" while holding		attendance: Administrator, D		
		ts up to the surveyor. R11		of Corporate Compliance, Di		
		as "loud" while she helped		Operations, Clinical Directors		
		I she, herself, had never had an ; however, added "the other		services and Human Resource	ces.	
		they're not talking [due to		 Staff retraining on the Vu 	Inerable	
		ent]." R11 reiterated the incident		Adult policy.		
		between a resident and TMA-A		Staff interviews/audits ini	tiated on	
		felt was "not nice" and "not sed she told a staff member		7/17/20 on Vulnerable Adult		
		; however, was not able to		policy/reporting.Conducted memory care	resident	
		ut added she reported TMA-A		interviews. Exceptions where		
		ne who was "mean" and		were unable to engage in inte		
	screams at people	э.		process documented.		
				All other residents intervi	ewed	
		7 p.m. HMK-A was interviewed		regarding safety, security, an	d customer	
		nad reported a concern to her		service.		
		o weeks ago" which alleged				
		ped another resident." HMK-A		Measures put in place to ens	ure aeticient	
		eported concern to her as		practice does not recur:Vulnerable Adult policy re	aviewed	
	,	d her." HMK-A stated she told		· Vullierable Addit policy fe	FVICWEU.	
		to go and report the incident to		Staff training on the revis	ed VA policy	
		and described R11 as "upset by		with a focus on the requirement		
		s she was talking very fast while		witnessed or potential occurr		
		lmost manic and not breathing		abuse or neglect.		
		HMK-A explained R11 was		Conduct vulnerable adult	reporting	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	GCON		E SURVEY PLETED	
		245494	B. WING			C 20/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 609	fearful of retaliation she "[didn't] want he HMK-A verified the reported to her by finanager (RN-B); his specific follow-up with the had already be reported pertaining time frame." A provided Vulnera Log, dated 10/17/19 facility reported included agency. The listing allegation of abuse voiced to RN-B had R11's medical recomplication and beer and/or SA since be RN-B On 7/17/20, at 2:33 nursing (DON) were the facility' administivacation at the time explained she had different allegation; following their discumproached her and fabuse involving the different resident. Frecall specifics of the and R11 had share she had taken note note-pad when the An undated, untitled provided. The notes	ge 18 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 een "a different incident g to TMA-A around the "same ble Adult Report / Tracking 9 to 7/16/20, identified all dents (FRI) to the State lacked evidence R11's pertaining to TMA-A she been reported. Further, rd lacked any evidence the reported to the administrator ing voiced to HMK-A and p.m. RN-B and the director of e interviewed and expressed trator was off campus on of the survey. RN-B interviewed R11 as part of a however, within a couple days assion, R11 and HMK-A d reported a second allegation he same staff member and a RN-B stated she could not he second allegation HMK-A d with her; however, recalled s about it on a personal allegation was reported to her. d copy of the taken notes was es identified TMA-A's name at arrious one-line sentences	F 609	interviews with a minimum of 9 active staff. • Staff to complete Abuse/Ne Relias training. • Audit all VA reports submit 7/20/20 to ensure submission is accordance with the VA policy state/federal requirements. Effective implementation of act monitored by: • QAPI committee will review results until substantial complia achieved and a decision is made regarding a time-period for furth auditing/ monitoring.	eglect ted after n and ions will be v audit ance is de		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		MPLETED
		245494	B. WING		07	C 7/ 20/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 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 APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	Continued From pa	age 19	F 6	09		
	"Always pulling [R1	0] - come here,"				
	"Just happened a d	couple 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, be reported in the passis of truth." Who allegation was hand stated she did not it allegation to the addidn't feel it was cre [R11], that's why." first time I am hear [allegation]" and voadministrator been reported it as an all accordance with the RN-B and the DON knowledge, the face	ould not consider R11 to be a put added things R11 had t seemed to "always [have] a en questioned how the second dled and investigated, RN-B ammediately report the lministrator or DON as she edible as "it's coming from The DON stated this was "the ing of the second event inced, had she and the told of it, she would have legation of abuse in 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	able Adult - MN policy, revised all staff members must report ed abuse immediately and istrator is responsible for the the policy." The policy outlined ght to be free from verbal and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		245494	B. WING		C 07/20/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371	0.1.20.20
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 610 SS=E	were considered vudirected, "Each em suspected/alleged vimmediately, but no allegation is made, allegation involve a injury," and, "The immediately." Investigate/Prevent CFR(s): 483.12(c)(i) §483.12(c) (i) In response lect, exploitation must: §483.12(c)(2) Have violations are thoro §483.12(c)(3) Prevent consideration investigation is in properties accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMENT by: Based on interview facility failed to ensiphysical abuse and investigated and accordance accordance accordance accordance accordance accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMENT by: Based on interview facility failed to ensiphysical abuse and investigated and accordance accordance accordance accordance accordance accordance with St Survey Agency, with incident, and if the appropriate correct this REQUIREMENT by: Based on interview facility failed to ensiphysical abuse and investigated and accordance accordance accordance accordance accordance accordance with St Survey Agency, with incident, and if the appropriate correct this REQUIREMENT by: Based on interview facility failed to ensiphysical abuse and investigated and accordance with St Survey Agency with incident, and if the same correct this REQUIREMENT by:	all residents of the facility ilnerable adults. The policy ployee is responsible to report violations of mistreatment a later than 2 hours after the if the events that cause the buse or result in serious bodily a Administrator will be notified if (Correct Alleged Violation 2)-(4) anse to allegations of abuse, an, or mistreatment, the facility investigated. The evidence that all alleged ughly investigated. The entity of the facility investigated in the form of the facility investigated.	F 609		dent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245494	B. WING			2 0/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 0112	20/2020	
				701 FIRST STREET			
ELIM HOME			I	PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
F 610	Continued From page 21		F 610				
	to reside on the Ru care unit).	m River Unit (locked memory		 TMA-A terminated (#11). RN-A removed from leadershi position (#11). 	р		
	Findings include:			, , ,			
	identified a total of Rum River Unit (local including R11. R11's quarterly MD R11 had severe condemonstrated no downward when interviewed a stated she had lived approximately four her diabetes manage had recently seen a (TMA-A) abusing a "grabbing her and p TMA-A as "loud" who inced she, herself TMA-A; however, a [residents] they're residents]	Islisting, dated 7/16/20, 16 residents resided on the sked memory care unit) 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 expressed she a female staff member resident in a wheelchair by bushing her." R11 described hile she helped people and had never had an issue with dded "the other people and talking [due to cognitive exists at the incident she had		Actions taken to identify other poteresidents having similar occurrence. The QAPI committee convenered conduct Root Cause Analysis of Flassociated tags. Committee members in attendance Administrator, DON, Director of Compliance, Director of Operation Clinical Directors of SNF services Human Resources. Staff provided with the Vulnera Adult policy and staff interviews in on Vulnerable Adult policy/reportine. Audited vulnerable adult report OHFC allegation. Updated log tembased off audit findings. Ensure monitoring system is infor any staff with allegations upon returning to work (see measure puplace – internal investigation work	es: d to 610 and e: proporate s, and able tiated g. t log for plate n place ut in		
	observed between something she felt. R11 expressed she incident; however, who, but added she someone who was people. On 7/17/20, at 1:47 and verified R11 ha approximately "two TMA-A had "grabbe	reiterated the incident she had a resident and TMA-A as was "not nice" and "not right." a told a staff member about the was not able to remember a reported TMA-A to them as "mean" and screams at p.m. HMK-A was interviewed and reported a concern to her weeks ago" which alleged another resident." HMK-A		template). Measures put in place to ensure d practice does not recur: Vulnerable Adult policy review 07/17/20. Staff retrained on updated policy value work sheet up with area to include report related up action. Conduct vulnerable adult report interviews with a threshold of 90%	ed on cy. odated follow rting		
		ported concern to her as at this other resident and took		active staff.Staff will complete the 2020			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BOILDING			С	
		245494	B. WING			07/2	20/2020
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIM UC	ME			70	01 FIRST STREET		
ELIM HC	/IVIE			Ρ	RINCETON, MN 55371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) COMPLETION DATE	
F 610	her arm and pulled R11 they needed to the unit manager arit [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 Fmanager (RN-B); h specific follow-up withere had already breported" pertaining time frame." Furthen ever personally wiphysically abusive twitnessed her become and seem "aproviding direction of the facility' administration at the time explained she had different allegation; following their discusporached her and fabuse involving the different resident. Frecall specifics of the and R11 had share she had taken note note-pad when the An undated, untitled provided. The notes	her." HMK-A stated she told of go and report the incident to and described R11 as "upset by she was talking very fast while most 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 lowever, 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 itnessed TMA-A to be to a resident; however, had ome impatient with residents a little frustrated" while	F6	510	In person and by Zoom VA Regardering available to all staff througe external presenter. Effective implementation and conting compliance of corrective actions with monitored on an ongoing basis at quarterly QAPI meetings: Review current resident interview and staff care audits to determine compliance. Determine necessary action for further auditing/monitoring.	nued ill be ews	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			C (X3) DATE SURVEY		
245494 B. WING				07/20/2020			
NAME OF PROVIDER OR SUPPLIER ELIM HOME SUMMARY STATEMENT OF DESIGNATES			•	7	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 PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 610	Continued From pa	ge 23	F 6	310			
	"Always pulling [R1	0] - come here,"					
	"Just happened a c	ouple of days ago,"					
	"She's mean,"						
	"She's nice to me,"						
	"Yells-too aggressive. Threatens them," and,						
	"[R11] pulled [HMK agressively [sic]."	-A's] arm to demo - quite					
	credible historian, be reported in the passibasis of truth." Whe allegation was hand stated she did not it allegation to the addidn't feel it was crewas "the first time I event [allegation]" administrator been investigated it as an accordance with the RN-B and the DON knowledge, the facility was allegated.	buld not consider R11 to be a put added things R11 had a 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 a allegation of abuse in eir abuse prevention policy. expressed that, to their lity' administrator had no econd allegation being					
	Log, dated 10/17/19 facility reported inciagency. The listing allegation of abuse voiced to RN-B had	ble Adult Report / Tracking to 7/16/20, identified all dents (FRI) to the State lacked evidence R11's pertaining to TMA-A she been reported or er, no documented evidence					

\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245494	B. WING			07/20/2020	
NAME OF PROVIDER OR SUPPLIER ELIM HOME				701	REET ADDRESS, CITY, STATE, ZIP CODE FIRST STREET INCETON, MN 55371	1 011	2012020
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610	Continued From page 24 was provided during the survey demonstrating it		F 6	10			
	had been investigated.						
	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 least state of the state of	ng Home Incident Reporting - mmary 33157, printed 7/16/20, n had submitted a report to the pon 11/14/19, involving R6. The illegation of, "Emotional or il described an incident where ad a nursing assistant (NA) sferring R6 inappropriately nce with her care plan. The NA owever, it was alleged the NA is room at a later date and ot. I might be losing my job nis caused R6 to become					
	Investigation (VOI) incident involving the identified R6 was inconcern for "possible because she had to [the NA] always traillift by herself." The administrator and Sallegation. A section provided which inclustaff member and the labeled, "Investigation with a plan with	indated Verification of form identified the 11/14/19 in NA and R6. The report interviewed and expressed ly 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 in 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					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245494	B. WING		07	C / 20/2020
NAME OF I	PROVIDER OR SUPPLIER	ξ		STREET ADDRESS, CITY, STATE, ZIP O 701 FIRST STREET PRINCETON, MN 55371		72072020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	·		(X5) COMPLETION DATE
F 610	determine potentia aside from R6; no steps taken demo would be monitore were implementin harm or injury to read the incidence in the aside from R6; no steps taken demo would be monitore were implementin determine potentia aside from R6; no steps taken demo would be monitore were implementin harm or injury to resident interviewed recalled the incidence in the incidence in the nursing incident, staff had people to transfer On 7/17/20, at 10 (DON) was interviewed in the incorresponding VC residents had been placed under any	al other allegations of neglect or did it list any procedures or instrating the NA identified ed or audited to ensure they g care plans correctly to prevent esidents. Investigation (5-Day), dated d the investigation was SA which outlined the facility' gation along with the identical sted on the VOI Form. This gation lacked any evidence erviews were completed to help al other allegations of neglect or did it list any procedures or instrating the NA identified ed or audited to ensure they g care plans correctly to prevent esidents. Immum Data Set (MDS), dated R6 had intact cognition and assistance for transfers. I on 7/16/20, at 3:07 p.m. R6 ent from 11/14/19, and denied arful of injury while being cared home. R6 stated since the consistently been using two	F6	510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, a Boile			С	
		245494	B. WING_		07	7/20/2020	
NAME OF I	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP CO 701 FIRST STREET PRINCETON, MN 55371	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610	plans were being would speak to th A subsequent interior on 7/17/20, at 12: investigation(s) ty interviews to help allegation and see identified. The DC are done using an completed "Custo of three other resiof their investigati However, all of the 11/22/19 (four day completed and su stated she was "n after the investigal identified had alre the DON verified I present for transfe in-effect at the tim The NA was re-eddocumented evided demonstrating an audits had been of to ensure care plate. The facility' Vulne 10/31/19, identifies suspected or allegadded, "The admi implementation of all reports of susp be " promptly a which included coincident, a physica for signs of abuse residents and staff	followed. The DON voiced she e unit manager and follow-up. erview was held with the DON 35 p.m. and she voiced pically included other resident determine the scope of the e if additional allegations are No expressed these interviews a audit tool, and provided some mer Service Audits" for a total dents which were used as part on in to R6's allegation. esee provided audits were dated ys after the investigation was bmitted to the SA). The DON ot aware" why they were done tion was completed and the NA ady returned to work. Further, R6 was to have two people ers per her care plan which was ne of the incident on 11/14/19. ducated; however, there was no ence she could find y subsequent monitoring or completed of the NA's care since ans were being followed. rable Adult - MN policy, revised d all staff members must report ged abuse immediately and nistrator is responsible for the f the policy." The policy directed exected or alleged abuse would and thoroughly investigated," lecting data around the all examination of the resident(s) and interviews with other of members. The policy directed, sults of the investigation." and	F 6	10			

AND DIAN OF CODDECTION IN IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	COM	COMPLETED	
		245494	B. WING _			C 20/2020
NAME OF F	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 610	Continued From pa	_	F 61	0		
		a facility Event Summary. sessments & Timing 1)(2)(i)(iii)	F 63	96		8/25/20
	a comprehensive, a	nduct initially and periodically accurate, standardized sment of each resident's				
	§483.20(b)(1) Res A facility must make assessment of a re goals, life history ar resident assessme by CMS. The asse the following: (i) Identification and (ii) Customary routi (iii) Cognitive patter (iv) Communication	sident's needs, strengths, and preferences, using the nt instrument (RAI) specified ssment must include at least demographic information ne.				
	(v) Vision. (vi) Mood and beha (vii) Psychological v (viii) Physical functi (ix) Continence. (x) Disease diagnos (xi) Dental and nutr (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications. (xv) Special treatmo (xvi) Discharge plan (xvii) Documentation regarding the additional continuous	evior patterns. Well-being. oning and structural problems. sis and health conditions. itional status. s. ents and procedures. nning. on of summary information ional assessment performed riggered by the completion of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245494	B. WING			C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 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	RECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 636	(xviii) Documentation assessment. The sinclude direct observation with the resident, a licensed and nonlice members on all shifts \$483.20(b)(2) When timeframes prescrit chapter, a facility meassessment of a restimeframes specific through (iii) of this sprescribed in §413 apply to CAHs. (i) Within 14 calend excluding readmissing significant change mental condition. (I "readmission" meas following a temporary or therapeutic leaves (iii) Not less than or This REQUIREME by: Based on interview facility failed to ensure a compression of the status Minimum Dato ensure a compression.	on of participation in assessment process must rvation and communication s well as communication with censed direct care staff ifts. In required. Subject to the bed in §413.343(b) of this nust conduct a comprehensive esident in accordance with the ed in paragraphs (b)(2)(i) section. The timeframes .343(b) of this chapter do not dar days after admission, sions in which there is no in the resident's physical or For purposes of this section, ns a return to the facility ary absence for hospitalization	F 630	Regarding cited resident: Resident #1 was deceased parts and the residents having similar occurs. Weekly audits of CAA's nurse completion x 4 weeks. Perform audit of all Adm Significant Change, and ann	er potential urrences: to verify MDS ission, ual MDS's	
	Long-Term Care Fallinstrument (RAI) 3.	edicare & Medicaid (CMS) acility Resident Assessment 0 User's Manual, dated the RAI helps nursing home		completed since 7/20/20 to 6 completion of CAA's Measures put in place to enspractice does not recur:		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245494	B. WING				20/2020
NAME OF F	PROVIDER OR SUPPLIER			70	TREET ADDRESS, CITY, STATE, ZIP CODE 01 FIRST STREET RINCETON, MN 55371	1 017	
(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 APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 636	staff gather informal ensure care plans a The manual outline Assessment (CAA) the RAI consisted concludes the MDS, the the the thickness of the CAAs were required comprehensive assessment and the thickness of the CAAs were required comprehensive assessment along with included depression along with medications, and disymptoms not directly depression along with medications, and disymptoms not directly depression along with included, "O2. Cand, "O3. Behavioral triggered CAA(s) to with included, "O2. Cand, "O3. Behavioral triggered CAA(s) have and behavioral symptoms of the CAA(s) which assessment along the CAA(s) which assessment along the CAA(s) which assessment along the CAA(s) which and behavioral symptoms of the CAA(s) which assessment along the CAA(s) which assessment along the CAA(s) which assessment along the CAA(s) which and behavioral symptoms are planted."	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 ares. The manual identified d to be completed for OBRA aresments (i.e. admission, change in status, or significant are comprehensive). Inge in status MDS, dated R1 had anxiety disorder and with both short and long-term at. The MDS identified R1 in-anxiety and anti-depressant are monstrated other behavioral atted at others (i.e. hitting or allic sexual acts, disruptive s during the look-back period. Allicition V of the MDS, the be completed were identified Cognitive Loss/Dementia," all Symptoms." Both of these and dictation present which	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	

STATEMENT OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245494	B. WING _			C / 20/2020
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371	1 017	20/2020
(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 CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
ch cc VV re w 10 m th ex w C no sh be for exp and si w th A re F 684 SS=D SQ and fact the state of the state	When interviewed of egistered nurse (R) who completed and 0/28/19. RN-C standard record and ne triggered CAA(s) explained the facility as responsible to example the sends e-mails the completed, howe officed they were not explained the facility rocesses or done are completed befounce R1's MDS was important to enter the example to example the completed befounce R1's MDS was important to enter the example the example to a facility policy on the example to all the exam	chem identifying them as on 7/20/20, at 10:28 a.m. N)-C verified she was the RN signed R1's MDS dated ted she had reviewed R1's was unable to find evidence by had been completed. RN-C y' social services department complete those assigned he had "once in awhile" of 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 are the MDS' are submitted as completed, and added it sure CAAs are being done as whole assessment." CAA(s) completion was received.	F 63			8/25/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		E SURVEY PLETED
		245494	B. WING _			C 20/2020
NAME OF F	PROVIDER OR SUPPLIER	- L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		20/2020
				701 FIRST STREET		
ELIM HO	ME			PRINCETON, MN 55371		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From p	age 31	F 68	34		
	Based on intervie	w and document review, the		Regarding cited resident:		
		sure care was appropriately		 Resident #5 expired. 		
		n outside hematology clinic to				
		delayed treatment for 1 of 1		Actions taken to identify other	er potential	
		iewed with cognitive impairment		residents having similar occ		
		to a medical appointment		 Develop and implement 		
		sing confusion on the reason(s)		regarding residents who req		
		tment to be provided.		appointments.	•	
				 Assess all residents to d 	determine the	
	Findings include:			appointments.		
				 Update resident care plant 	ans to reflect	
		Point Intake Form, dated		assessment outcomes.		
		d a concern received by the				
		regarding R5. The report		Measures put in place to en	sure deficient	
		een brought to an off campus		practice does not recur:		
		ent with no supervision and was		 Audit 50% of outside ap 		
		why he was there to the staff or		each week for 4 weeks to er		
		king, " how much the vet bill		residents escort needs were	e met Discuss	
		R5 had a listed guardian who		at weekly IDT meeting	5.500/ 5	
		facility' staff he was unable to		Perform quarterly audits		
		ment, so he was waiting to hear		outside appointments therea		
		cheduled. The report outlined,		Retrain staff on escort p	olicy changes	
		any decision maker available		as they occur.		
		ever, other labs weren't a		Monitoring over time:		
	possibility as [R5]	was unable to give consent."		Review/monitor POC ap	pointment	
	P5's admission Mi	inimum Data Set (MDS), dated		audits and implementation of		
		R5 had severe cognitive		for compliance and baseline		
		al medical diagnoses including		audits.	, for fatare	
		artery disease (CAD) and heart		 Monitor the effective and 	d consistent	
		corded episodes of shortness		implementation of the policy		
		uring the review period.		through quarterly audit revie		
	2. 2. 3. 3. 1 (3.3.) di	and remain portion.		 Identify opportunities for 		
	R5's Referral Form	n, dated 11/7/19, identified R5		improvement and make	F. 55550	
		nt at 3:00 p.m. that day with a		recommendations regarding	audit process	
		ous at the clinic. A section		and frequency of audits once		
		otes/Reason For Referral," was		compliance is achieved for t		
		not list any reasons for the		consecutive audits.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONST	COM	(X3) DATE SURVEY COMPLETED		
		245494	B. WING			1	C / 20/2020
NAME OF I	PROVIDER OR SUPPLIER			701 FIRS	ADDRESS, CITY, STATE, ZIP CODE ST STREET STON, MN 55371		20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI ROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 684	visit to the physicial however, merely lis unit coordinator (HI manager (RN)-B's number. The physic 11/7/19 and provide "Labs," and, "T Bordiagnosed with a B pancytopenia (low oblood cells: red blood platelets). R5's corresponding note, dated 11/8/19 for an episodic care as the main concer "came to follow up [R5] today. Spoke yout what and why lawas at the appointr was there, [R5] did with. Has known Paper orders. Nursing oncologist office or about the results ar information came for The note identified sitting out in the correspond to simple coloss, staff anticipate note listed several diuretic medication reeducation of antip R5's progress note recorded entries: Onursing home. R5 with place or time up the coloss of the place or time up the place or time up the coloss.	n or notes to be addressed; ted the nursing home' health JC) and registered nurse unit name(s) and a telephone cian signed the note on ed dictation which read, ne Marrow Biopsy." R5 was	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED			
		245494	B. WING			C / 20/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 701 FIRST STREET PRINCETON, MN 55371	· · · · · · · · · · · · · · · · · · ·	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	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. R5's medical record evidence the facility outside hematology information or guida prevent delays in trappointment on 11/known cognitive im no evidence in the infamily had been corat the appointment communication and the facility's behalf. During interview on nursing assistant (Noresiding on the Runcare unit) and descensily re-directable, resident on the unit bring the resident at the tothe van driver and there typically was another to appoin added, "That's a good the same state of the van driver was a good to appoin added, "That's a good transport of the van driver was a good to appoin added, "That's a good transport of the van driver and there typically was a good transport of the van driver and there typically was a good transport of the van driver and there typically was a good transport of the van driver and there typically was a good transport of the van driver and there typically was a good transport of the van driver and there typically was a good transport of the van driver and there are typically was a good transport of the van driver and the van driver and there are typically was a good transport of the van driver and t	which the note outlined, " ntia." On 11/8/19, the of reported a critical lab value and hemoglobin. The physician e. There were no recorded in the appointment R5 had with ic on 11/8/19; and R5 expired of was reviewed and lacked of had sent or provided the originic 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 ntact and agreed to meet R5 to help facilitate a treatment with the clinic on 17/16/20, at 11:22 a.m. IA)-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 and a prepared envelope down d send them. NA-A stated not a staff member or family pring 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	F 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		(X3) DATE SURVEY COMPLETED			
		245494	B. WING				C 20/2020
NAME OF I	PROVIDER OR SUPPLIER			701	EET ADDRESS, CITY, STATE, ZIP CODE FIRST STREET NCETON, MN 55371	<u> </u>	20/2020
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F 684	When interviewed of licensed practical in process for getting. Unit to their appoint sometimes the fam they go to off camp. "HandiVan" service LPN-A verified staff attend appointment residents and state home should be coappointment to ensithere; however, LP. "[didn't] know if their voiced she could "vin the past where a appointment and dithere when they arnot recall any revisicompleted since the expressed it was in was with residents advocate for them a is provided to the poon 7/16/20, at 11:4 interviewed and verappointments for the Rum River Unit. HU [a resident's] cognitiset-up appointment someone meets the she did not make the not need to be accounted to the pointment of the stated she typically resident's appointment of the stated she typically resident's a	on 7/16/20, at 11:31 a.m. urse (LPN)-A explained the residents on the Rum River tments. LPN-A stated illy will take them, otherwise us appointments using a which the HUC will arrange. If members do not routinely as with cognitively impaired do 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 donot know why they were rived. LPN-A stated she could ons or re-education being at incident; however, apportant to ensure someone at their appointments to and ensure accurate reporting hysicians.	F 6	84			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	()	COMF	SURVEY
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 701 FIRST STREET PRINCETON, MN 55371	DE	0172	072020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 684	re-education comple on the unit adding sincident where R5 happointment unsup someone should be supervised." When interviewed a HandiVan driver (Hup from the nursing an envelope which desk at the clinic or service was basical and someone from checks them in. How meet residents fron clinic; however, it w [percent]" of the timhair memory" of the what he could recal at the clinic on 11/8 responsible party whim inside, but did the HVD stated since the never been contact discuss the situation ensure residents ar when left unsupervition of 7/16/20, at 1:25 manager (RN)-B was explained family was appointments with residents at the clinic added once they're	e had not been any revisions or eted with her since R5 resided the was unaware of an and 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 the provides to the reception hospital. He expressed his ly a "desk to desk" service, the clinic takes over after he VD voiced family, at times, will in the nursing home at the as only "maybe 60/40 e. HVD stated he recalled "a e 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 no revise any procedures to e met by family or kept safe	F 6	84			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245494	B. WING			C / 20/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 701 FIRST STREET PRINCETON, MN 55371	•	20/2020
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684	planning becomes not the nursing hor some residents on she "would hesitate appointments, and do speak about resthere was no forma supervision and wh RN-B added, "It's not somebody's with the RN-B then reviewer RN-B explained Roself-propel in his ware a resident who profor a staff member pappointments as he physician accurate condition(s). RN-B appointment and significant accurate condition(s).	the clinic's responsibility and mes. RN-B stated there were the locked memory care unit et 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 nem." Id R5's incident from 11/8/19. If had dementia and could heelchair. RN-B stated R5 was bably should have had family present with him at off campus et would likely not give the information on his recalled R5's 11/8/19 tated the clinic had contacted when he arrived and she "being upset" and questioning clinic. RN-B stated clinic's ing adequate information or there the resident is unable to ary input for the physician had nowever, RN-B felt it was "very stioned on her follow-up actions situation like R5's incident on occur, RN-B stated she did however, in hindsight, should linic' concerns to someone's ould review their system for		34		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION (COMPLETED	
		245494	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 DEFICIENC)	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)	BE COMPLÉTION
F 689 SS=D	and she "cannot vehome contacts fam attending with the rassume they would occurring. The DOI with R5 on 11/8/19 miscommunication and R5's family as part" and arranged RN-B and the DON their systems or proto appointments an and needed inform. The DON voiced shing" and "had we on it and "maybe poutside providers where of Accident Hard CFR(s): 483.25(d) (1) The as free of accident supervision and as accidents. This REQUIREMED by: Based on interview facility failed to ensappropriate supervite risk of accidents.	rify" if anyone from the nursing ily to ensure they will be esident or not. DON added, "I I," and she felt that was N stated she felt the incident happened due to between the physician office the nursing home "did our the transportation for R5. I verified they had not reviewed ocedures for sending residents densuring care is coordinated ation relayed to the providers. The "didn't know this was a known" she would have acted at something in place." Coordination of care with the vas not provided. Exactly Supervision/Devices 1)(2) This. The sident environment remains hazards as is possible; and The resident receives adequate sistance devices to prevent Nor is not met as evidenced of and document review, the cure precautions and sision was provided to reduce the or injuries for 1 of 1 residents had severe cognitive	F 68		s:

STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	243434	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	07/2	20/2020
ELIM HC				701 FIRST STREET PRINCETON, MN 55371			
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F 689	appointment off car Findings include: A Common Entry P 11/10/19, identified State agency (SA) outlined R5 had be medical appointme unable to explain w physician even ask 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 red with transfers. Furth sustained a fall with months. R5's undated 48 Ho identified R5 was o experienced halluci dictation present re there, Has convers. Further, the care pl of frequent falls and R5's Referral Form had an appointmen physician off campulabeled, "Nurse Not provided which did	Point Intake Form, dated a concern received by the regarding R5. The report en brought to an off campus nt with no supervision and was thy 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 gR5 to the appointment with all be unsafe. Inimum Data Set (MDS), dated R5 had severe cognitive quired extensive assistance her, the MDS identified R5 had in a fracture within the past six our Initial Plan of Care rientated to self and inations with handwritten rading, "Thinks something is ations no one there [sic]." an identified R5 had a history	F	689	regarding residents who require es appointments. Assess all residents to determi potential need for escort to appoint. Update resident care plans to rassessment outcomes. Measures put in place to assess de practice: Audit 50% of outside appointmeach week for 4 weeks to ensure the residents escort needs were met. It 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: Monitoring over time: Monitoring over time: Monitoring over time: Identify opportunities for process improvement and make recommendations for process chart. Determine the need for ongoing based on consistent compliance with policy.	ne the ments. eflect eficient ents ne Discuss 6 of ellow es and ene effect enge. g audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG) COM	(X3) DATE SURVEY COMPLETED C		
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	however, merely lis unit coordinator (HU manager (RN)-B's number. The physic 11/7/19 and provide "Labs," and, "T Bordiagnosed with a B pancytopenia (low blood cells: red blood platelets). There wincluding level of as for R5, to ensure he campus at the apportant of the place or time up SLUMs test (cognit R5. He scored 8/30 to the place or time up SLUMs test (cognit R5. He scored 8	ted the nursing home' health JC) and registered nurse unit name(s) and a telephone cian signed the note on ed dictation which read, he Marrow Biopsy." R5 was 12 deficiency and counts for all three types of od cells, white blood cells, and as no recorded directions, esistance and any precautions are remained safe while off bintment. J Fairview Geriatric Services of identified R5 had been seen a visit with pancytopenia listed in. 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	F 6	89			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION ING		COM	E SURVEY PLETED
		245494	B. WING				C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 701 FIRST STREET PRINCETON, MN 55371	DDE .	0171	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(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, the facility had commur needed levels of as precautions to ensure of accidents if he not the restroom, or attunsupervised. When interviewed on unsupervised. The resident and the resident and the van driver and the van driver and the van driver and the van driver and the van adding, "I don't she was not sure was were sent to appoin added, "That's a go	d reported a critical lab value of hemoglobin. The physician e. There were no recorded in the appointment R5 had with ic on 11/8/19; and R5 expired in the appointment R5 had with ic on 11/8/19; and R5 expired in the appointment R5 had with ic on 11/8/19; and R5 expired in the appointment on the appointment on the initial appointment in the ini	F 6	,			
	home and she could at the appointment	often verbalize he wanted to go d see R5 becoming confused and "wondering why he isn't g to go home" then trying to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245494	B. WING		07	C / 20/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 701 FIRST STREET PRINCETON, MN 55371		120/2020
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F 689	On 7/16/20, at 11:4 interviewed and ver appointments for the Rum River Unit. Hua residents cognition set-up appointment someone meets the she did not make the not need to be accepted that was the unit may stated she typically resident's appointment in saved or placed in HUC-A stated there re-education comple on the unit adding sincident where R5 happointment unsup someone should be supervised." When interviewed thandiVan driver (Hup from the nursing an envelope which desk at the clinic or service was basical and someone from checks them in. However, it we [percent]" of the time remain with the percent and if no family is president see the phercealled "a hair meet residents meet the phercealled and some meets and it is percently in the percent of the time remain with the percent of the phercealled and the pherceall	5 a.m. HUC-A was	F 6	89		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	(SURVEY PLETED
		245494	B. WING			07/2	20/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	0112	.0/2020
ELIM HO	ME			701 FIRST STREET			
ELIM HO	IVIE			PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	son or responsible	ge 42 the clinic on 11/8/19, and R5's party was not there so he but did not remain with him.	F 6	89			
	Further, HVD stated he had never been home to discuss the procedures to ensu	d since the incident with R5, contacted by the nursing e situation or revise any re residents are met by family eft unsupervised at the clinic.					
	On 7/16/20, at 1:25 manager (RN)-B was explained family was appointments with a lot of the times they the HandiVan drive residents at the clin added once they're appointments, the replanning becomes not the nursing hon some residents on she "would hesitate appointments, and do speak about resthere was no format supervision and whe RN-B added, "It's necessary with the incident from 11/8/2 dementia and could	p.m. registered nurse unit as interviewed. RN-B is always able to attend residents; however, added "a of do go alone." RN-B voiced r(s) typically waited for the ic to her understanding, and checked in to the clinic esident' safety and care the clinic's responsibility and nes. RN-B stated there were the locked memory care unit " to send alone to voiced while the HUC and her idents and appointments, I system to decide who needs o doesn't for appointments. ot our policy to make sure em." RN-B then reviewed R5's 19. RN-B explained R5 had It self-propel in his wheelchair.					
	someone who did be for people to take he stated R5 was a resolved have had family or him at off campus a likely not give the p on his condition(s).	es, she recalled R5 as become confused and search im to various places. RN-B sident who probably should a staff member present with appointments as he would hysician accurate information RN-B stated she didn't think nation on activities of daily					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	` '	E SURVEY IPLETED
		245494	B. WING			C 20/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371	1 077	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	living (ADL) assista interventions (i.e. to were sent with residual were sent with residual when he arrived an "being upset" and or clinic. When question to ensure a similar 11/8/19 did not reoduprobably nothing;" have brought the clattention so they consending people to a they're supervised at they're supervised at (DON) and RN-B work work to ensure a similar 11/8/19 did not reoduprobably nothing;" have brought the clattention so they consending people to a they're supervised at they're supervised the nursing setup the appointment of the pool occurring. RN-B and they would occurring. RN-B and they would occurring. RN-B and they would occurring they would occurring they would occurring they would occurring. RN-B and they would occurring they would occurred they would occurring they would occurred they would occu	nce or supervision 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 them questioning why R5 was at the pned 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 appointments and make sure	F 68	9		
	at appointments wa Treatment/Service CFR(s): 483.40(b)(s not provided. for Dementia	F 74	4		8/25/20

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		045404					
		245494	B. WING			07/2	20/2020
ELIM HC	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 744	§483.40(b)(3) A residiagnosed with den appropriate treatmer maintain his or her mental, and psychothis REQUIREMEI by: Based on interview facility failed to comdevelop intervention promote well-being reviewed who displicated delusional behavior addressed. Findings include: R1's significant characteristic in making. The decision making. The decision making. The demonstrated behavior as severely impaired of decision making. The demonstrated behavior as severely impaired of decision making. The demonstrated behavior as severely impaired of decision making. The demonstrated behavior as severely impaired of decision making. The demonstrated behavior as severely impaired of decision making. The review phasessment (CAA) symptoms were list completed. R1's care plan, last received mood stattargeted behaviors restlessness, disrois statements. A series which included using less than two report daily. The care plan meet the established the series which included using less than two report daily. The care plan meet the established the series with the care plan meet the established the series with the care plan meet the established the series with the series with the series with the series with the established the series with the series wit	sident who displays or is nentia, receives the ent and services to attain or highest practicable physical,	F 7	744	Regarding cited resident: Resident # 1 expired 1/16/20 Actions taken to identify other poter residents having similar occurrence Review and update the Behavid Health policy. Re-initiate dementia unit behave meetings. Review all residents over the nequarter to coincide with scheduled conferences. Measures put in place to assess depractice: Audit 100% of behavioral care over the next quarter to assess for intervention effectiveness. Conduct quarterly audits of 100 behavioral care plans. Retrain staff on policy changes they occur Monitoring over time: Conduct review of quarterly behavioral care plan audit results to identify deficient areas of practice. Determine opportunities for profimprovement.	es: oral rioral ext care eficient plans 0% of as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
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(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 744	intervening as neer reassurance to her R1's progress note was being reviewe status assessment registered nurse unidentified, "Behavior charting crying was exhibiting anxiety with redirection and not being effective. X 5 days with read not being effective reported daily with being effective. Ex with redirection and R1's subsequent p and identified the fra verbal altercation 11/27/19, R1 was remarked with redirection and Resident has increated thoughts, and curs administered, which Further, on 12/7/19 other resident' room her coloring box or R1 was recorded at R1's subsequent T flowsheets, dated the following: November 2019: Reseeking with each interventions compared to the seeking with each interventions.	ded, and providing 1:1 visits or when distressed. e, dated 10/28/19, identified R1 d for a significant change in at A note was completed by hit manager (RN)-B which or: per the Target behavior is reported on 1 day. Verbally was reported on 5 evenings d offering a snack or activity. Inability to sleep was reported ing material, TV, and snacks. Delusional comments redirection and 1-1 visits not it seeking reported on 2 days d 1-1 not being effective." rogress note(s) were reviewed ollowing: On 11/17/19, R1 had a with another resident.	F 744				

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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(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)	I SHOULD BE	(X5) COMPLETION DATE	
F 744	recorded as, "Unch of crying and/or we interventions comp and offering snacks time these interventions comp these recorded with each interventions comp these recorded as, "Unch interventions. R1 has sleep recorded, each which included mas snacks; however, a recorded the behave the interventions. Findelusional commer being completed, in visits, however each were recorded the "Unchanged."	recorded the behavior was langed." R1 had six episodes eping recorded with leted, including reassurance 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 sodes had the behaviors langed," despite the ad 13 episodes of inability to ch having interventions listed sage, warm packs and lagain, all of these episodes wior as, "Unchanged," despite further, R1 had 22 episodes of ints recorded with interventions including redirection and 1:1 th time these interventions behavior was recorded as,	F 74	14			
	interventions comp taking R1 off the ur episodes was recor- being effective. The behavior as, "Unch of crying and/or we interventions comp and offering snacks interventions were was recorded as, "I episodes of verbal with each of the ep	leted, including coloring or nit, however, only one of the rded as these interventions e 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 Unchanged." R1 had four complaints of anxiety recorded isodes having interventions er, again, all of these recorded					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED C		
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(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 744	"Unchanged," desp seven episodes of each of the episode completed which in and snacks; however recorded the behavithe interventions. Feelusional commer being completed, in visits, however each were recorded the "Unchanged." When interviewed nursing assistant (I and verified she result (I and verified she verified	repeated as, pite the interventions. R1 had inability to sleep recorded with the shaving interventions reluded massage, warm packs are, again, all of these episodes are, again, all of these episodes are, again, all of these episodes of the recorded with interventions reluding redirection and 1:1 the time these interventions behavior was recorded as, and and the recorded as, and the resident bathrooms on alled R1 had exit seeking and often used, or other resident bathrooms on alled R1 had exit seeking and often go around the unit on doors and swearing." NA-D re-directable at times, and if give her medications which are time." Further, NA-D stated behaviors from R1 were se(s) and added she felt R1's en "maybe slightly worse" in a up to her death in January and was reviewed and lacked een comprehensively the interventions developed to be deen to death in January and the record lacked any evidence and record lacked any evidence and record lacked any evidence.	F 74	4			

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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F 744	Continued From pa	ge 48	F 7	44			
	and behavioral sym on the 10/28/19 ME information). On 7/16/20, at 2:01 and verified she wa the last months of h	mpleted for R5's cognition ptoms despite being triggered DS (See F636 for additional p.m. RN-B was interviewed s R1's care manager during her life at the nursing home.					
	behavior (s), the sta behavior and try to "things they like." T meetings which hel	en a resident displays ff attempt to observe the intervene by coming up with he unit used to have behavior ped in this process, however,					
	other things took pr typically accomplish assessment by disc	cussing them "informally." On					
	held with RN-B. The reviewed at the beh which RN-B could f	n. a subsequent interview was e last time R1 had been lavior meetings, at least to ind evidence supporting, was					
	implement a "calmi however, RN-B voic the care plan and s	decided at the meeting to ng activities" intervention, ced it had never been added to hould have been. Further, medical record and verified					
	there was no comp completed regardin implemented interv effective and R1 co behaviors, and reite	rehensive assessment g R1's behaviors, despite the entions being listed as not ntinuing to have the same erated the system in place for s was the monthly meetings					
	dated 5/31/19, iden encompasses a resmental well-being.	ral Health Services policy, tified behavioral health sident's whole emotional and The facility was to use " a essment process for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245494	B. WING ₋			C / 20/2020
NAME OF F	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 CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 744	psychosocial status person-centered ca obtaining information family and/or the re cognition or mood a	essing a resident's mental and a sand providing are." This assessment included on from medical records, esident on usual patterns of and behavior; and, using the ent Instrument (RAI) process and CAA(s).	F 7			8/25/20
SS=F	S483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infect	1)(2)(4)(e)(f) Control Stablish and maintain an and control program e a safe, sanitary and ament and to help prevent the cansmission of communicable tions.	. 0			0/20/20
	program. The facility must es and control prograr a minimum, the foll	•				
	infections and com- residents, staff, vol- individuals providin- arrangement based	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				
	procedures for the but are not limited t	en standards, policies, and program, which must include, o: reillance designed to identify				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245494	B. WING		07	C / 20/2020
NAME OF PROVIDER OR SUPPLIER ELIM HOME				STREET ADDRESS, CITY, STATE, ZIP COI 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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	possible communic infections before the persons in the facil (ii) When and to who communicable discreported; (iii) Standard and to to be followed to provide (iv) When and how resident; including (A) The type and dopending upon the involved, and (B) A requirement of least restrictive postic cumstances. (v) The circumstances. (v) The circumstances. (vi) The circumstances (vi) The hand hygie by staff involved in §483.80(a)(4) A syidentified under the corrective actions to \$483.80(e) Linens. Personnel must had transport linens so infection. §483.80(f) Annual The facility will con IPCP and update to this REQUIREME by:	cable diseases or ney can spread to other ity; nom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility oyees with a communicable skin lesions from direct ints or their food, if direct if the disease; and ne procedures to be followed direct resident contact. stem for recording incidents a facility's IPCP and the taken by the facility.	F 8	Regarding cited resident:		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
	A. BOILDING			С			
		245494	B. WING _			20/2020	
NAME OF I	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COL	•		
ELIM HO	ME			701 FIRST STREET			
LLIW 110	WIL			PRINCETON, MN 55371			
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F 880	review the facility of were being activel verifying temperat screening process potential transmiss (COVID-19), in ac Disease Control (Opotential to affect residing in the facing survey. Findings Include: A Centers for Med COVID-19 Long-T dated 4/2/20, iden implemented to retransmission in a lincluded, " ever reason entering a (including resident healthcare worker asked about COV also have their temperature of their temperature with another employees self sc their temperature with another employees in the process of the p	failed to ensure all employees by screened (other employees are readings during the solor for the prevention and solor of corona virus cordance with the Centers for CDC) guidelines. This had the all 92 residents currently lity at the time of the COVID-19 lity at the time of the COVID-19 ong-term care Facility Guidance, tified procedures to be duce the risk of COVID-19 ong-term care setting. This by individual regardless of long-term care facility states, staff, visitors, outside states, vendors, etc.) should be lid-19 symptoms and they must imperature checked." Proximately 8:55 a.m. survey ity through the main doors. At staff observed three facility reening with no verification of or COVID screening questions by ee before entering the facility ree being present at the the time (employee was	F 88	 Screen all residents for signs/symptoms of COVID-19 to include temperature and sy screen. Upon initiation of procresident baseline was 100% n signs/symptoms. Actions taken to identify other residents having similar occur Staff training on COVID-1 policy. Root Cause Analysis Place more comprehensivat screening area, notifying stascreening requirements. Assign staff to screening sbeginning of each shift. During the receptionist will screen or, nursing staff to screen staff/ouessential workers/visitors who building. Measures put in place to ensupractice does not recur: Conduct observation audiscreening station 4x/week for 2x/week for 1 week and biweet thereafter, until 100% compliant achieved. Review audit findings and screening process, if necessate Effective implementation of acmonitored by: Review audit results to deneed for further auditing/mon 	mptom ess, egative for potential rences: 9 Screening re signage aff of station at the g off times, staff will call itside enter the re deficient its of the 1 week, skly ince is alter ry. stions will be termine the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245494	B. WING				C 20/2020
NAME OF PROVIDER OR SUPPLIER ELIM HOME				701	REET ADDRESS, CITY, STATE, ZIP CODE I FIRST STREET RINCETON, MN 55371	1 0111	
(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	someone there to no screening." DA-A so anyone "needing to stated again she set temperature and do symptoms section of the work of the wor	make sure you are doing the stated she did not know of check my temperature". DA-A eff-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 ays to be someone around to ening process. DON ening process consisted of s about symptoms and taking stated temperature ing "someone else" look at the fy result. DON stated there helping employees screen to be at the screening area to ening to verify information. It is not aware of employees not ares. DON further explained en educated on the screening ided showing another temperature results. ID-19 Phase 2-All SNFs and "healthcare workers will m screening form, including ature checkedthese forms a facility designee prior to	F8	880	Other recommendations		



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. § 144.653 and/or 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, Enforcement Specialist Licensing and Certification

Minnesota Department of Health

P.O. Box 64970 Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

alison Helm

Email: alison.helm@state.mn.us

PRINTED: 08/24/2020 FORM APPROVED

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		00375	B. WING			0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HC	DME	701 FIRST PRINCETO	STREET ON, MN 553	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency for the manner of the Minnesota Deputer of the Minnesota Deputer of the Minnesota Deputer of the Minnesota Deputer of the Minnesota Opposition of the number and MN Ruwhen a rule contain comply with any of lack of compliance. The result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	by surveyors from the Health (MDH) to delicensure in conjuctinvestigation(s) for H5494044C, H5494	20, a survey was conducted he Minnesota Department of stermine compliance for state				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 08/17/20

STATE FORM 6899 If continuation sheet 1 of 26 8VDD11

TITLE

(X6) DATE

AND DIAN OF CORRECTION INDENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00375	B. WING		C 07/20/2020	
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ELIM HO	ME	701 FIRST PRINCETO	T STREET ON, MN 553	71		
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2 000	Continued From pa	ge 1	2 000			
	H5494050C.					
	issued. Please indic correction that you and identify the date Minnesota Departmenthe State Licensing federal software. To assigned to Minnesota Nursing Homes. The appears in the far leading Tag." The state stallisted in the "Summa column and replace the correction order the findings which a statute after the stalling as evidence by." For are the Suggested Time period for Correction for Correc	owing correction orders are cate your electronic plan of have reviewed these order, e when they will be corrected. The ent of Health is documenting and correction Orders using ag numbers have been ota state statutes/rules for the assigned tag number eff column entitled "ID Prefix attute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of the state tement, "This Rule is not met ollowing the surveyors findings method of Correction and trection.				
	receipt of State lice the Minnesota Department of Hear you electronically. Is necessary for State enter the word "corrected. You must then State licensure processors and the state licensure processors and the state licensure processors.	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 ectronically submitting to the				

Minnesota Department of Health

STATE FORM 8VDD11 If continuation sheet 2 of 26

	AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` ′	E CONSTRUCTION	COMPLETED	
			B. WING			
		00375	B. WINO		07/2	0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HC	ME		T STREET ON, MN 553	71		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREMI CORRECTION FOI	RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF				
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment		2 540			8/25/20
	conduct a compreh- resident's needs, w capability to perforn significant impairme nursing assessmen Minnesota Statutes 15, may be used as resident assessmer comprehensive resi used to develop, re- comprehensive plan 4658.0405. Subp. 2. Informa comprehensive resi include at least the A. medically de medical history; B. medical statu C. physical and D. sensory and E. nutritional statu F. special treatu	on;				

Minnesota Department of Health

STATE FORM 8VDD11 If continuation sheet 3 of 26

AND DIAN OF CORRECTION IDENTIFICATION NUMBER					X3) DATE SURVEY COMPLETED	
					С	
		00375	B. WING		07/2	0/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ELIM HO	ME	701 FIRST				
			ON, MN 553			
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 3	2 540			
	K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.					
	by: Based on interview	and document review, the ure triggered Care Area		Corrected		
	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 informatics.	as) on a significant change in ta Set (MDS) were completed whensive 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.				
	Assessment (CAA) the RAI consisted of includes the MDS, includes t	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 essments (i.e. admission, change in status, or significant comprehensive). In the comprehensive of the				
	scratching self, pub sounds) 1 to 3 time	lic sexual acts, disruptive s during the look-back period. ion V of the MDS, the				

Minnesota Department of Health

STATE FORM 8VDD11 If continuation sheet 4 of 26

Minnesc	<u>ita Department of He</u>	ealth				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		I COMP	LETED
						;
		00375	B. WING		07/20/2020	
			DDEGG OFFI	TATE TIP 0005		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ELIM HO	ME		T STREET			
		PRINCET	ON, MN 553	71		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG	TREGOE TOTAL OTTE		IAG	DEFICIENCY)	1407112	
0.540	0 " 15		0.540			
2 540	Continued From pa		2 540			
		be completed were identified				
		Cognitive Loss/Dementia,"				
		al Symptoms." Both of these				
		ad dictation present which				
	read, "See CAA sur					
		d was reviewed and lacked				
		red CAA(s) for R1's cognition				
		ptoms had been completed.				
		Summary listing, printed				
		red colored "!" next to each				
		n had triggered for the with a corresponding green				
		under the column titled,				
		ever, despite both the cognition				
		ptoms CAA(s) being identified				
		was no green colored				
		them identifying them as				
	completed.	, 0				
	When interviewed of	on 7/20/20, at 10:28 a.m.				
	registered nurse (R	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"				
		ot 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				
		sure CAAs are being done as				
		whole assessment."				
		CAA(s) completion was				
		r, noné was received.				
		HOD OF CORRECTION: The				

STATE FORM 6899 If continuation sheet 5 of 26 8VDD11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00375	B. WING			0/2020
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	1 0172	
ELIM HC	DME	701 FIRST PRINCETO	T 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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 540	director of nursing (review applicable po Care Area Assessn inserivce staff and a	ge 5 DON), or designee, could olices and procedures on nent (CAA) completion; then audit to ensure compliance. R CORRECTION: Twenty-one	2 540			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing card custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	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	2 830			8/25/20
	by: Based on interview facility failed to ensi coordinated with an reduce the risk of d residents (R5) revie and who was sent t unsupervised causi and course of treati ensure precautions was provided to red injuries for 1 of 1 re	and document review, the ure care was appropriately outside hematology clinic to elayed treatment for 1 of 1 ewed with cognitive impairment 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 sidents (R5) reviewed who e impairment and was sent to		Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7110121	VOI CONNECTION	OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING:				
		00375	B. WING			2 0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIM H	OME		T STREET ON, MN 553	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 CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	a medical appointm and failed to comp develop interventio promote well-being reviewed who displ delusional behavior addressed. Findings include: Coordination of car A Common Entry P 11/10/19, identified State agency (SA) outlined R5 had be medical appointme unable to explain w physician even ask would cost him." R5 had expressed to fa attend the appointn if it had been re-scl "Due to not having and with him, howe possibility as [R5] w R5's admission Mir 11/5/19, identified F impairment, several anemia, coronary a failure; and had recof breath (SOB) du R5's Referral Form had an appointment physician off campilabeled, "Nurse Noprovided which did visit to the physician	nent 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	2 830			

Minnesota Department of Health

STATE FORM 8VDD11 If continuation sheet 7 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.1.2.1.2.1			A. BUILDING:			
		00375	B. WING		07/2	: :0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HO	ELIM HOME 701 FIRS			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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	unit coordinator (HI manager (RN)-B's number. The physic 11/7/19 and provide "Labs," and, "T Bordiagnosed with a B pancytopenia (low oblood cells: red blood ce	JC) and registered nurse unit name(s) and a telephone cian signed the note on ed dictation which read, ne Marrow Biopsy." R5 was	2 830			

Minnesota Department of Health

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:			
		00375	B. WING		07/2	0/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HO	ME	701 FIRST	STREET			
	/WIL	PRINCETO	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 SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	for R5's platelets ar was notified of thes progress notes fron the hematology clin on 12/24/19.	nd hemoglobin. The physician e. There were no recorded in the appointment R5 had with ic on 11/8/19; and R5 expired				
	R5's medical record was reviewed and lacked evidence the facility had sent or provided the outside hematology clinic with adequate information or guidance to facilitate care and prevent delays in treatment pertaining to R5's appointment on 11/8/19; despite R5 having known cognitive impairment. Further, there was no evidence in the record demonstrating R5's family had been contact and agreed to meet R5 at the appointment to help facilitate communication and treatment with the clinic on the facility's behalf.					
	During interview on 7/16/20, at 11:22 a.m. nursing assistant (NA)-A stated she recalled R5 residing on the Rum River Unit (locked memory care unit) and described him as forgetful, but easily re-directable. NA-A explained when a resident on the unit has an appointment, the staff bring the resident and a prepared envelope down to the van driver and send them. NA-A stated there typically was not a staff member or family present when they bring the resident down to the van adding, "I don't believe so." NA-A expressed she was not sure why residents from the unit were sent to appointments unsupervised and added, "That's a good question." Further, NA-A stated HUC-A makes appointments for the residents on the Rum River Unit.					
	licensed practical n process for getting	on 7/16/20, at 11:31 a.m. urse (LPN)-A explained the residents on the Rum River ments. LPN-A stated				

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STATE FORM 8VDD11 If continuation sheet 9 of 26

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
		00375	B. WING		07/2	0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EL IM LIC		701 FIRST	STREET			
ELIM HC	VIVI E	PRINCET	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	they go to off camp "HandiVan" service LPN-A verified staff attend appointment residents and state home should be co appointment to ensithere; however, LP "[didn't] know if that voiced she could "vin the past where a appointment and dithere when they are not recall any revisic completed since the expressed it was in was with residents advocate for them a is provided to the p	ily will take them, otherwise us appointments using a which the HUC will arrange. If members do not routinely is with cognitively impaired do someone from the nursing ntacting family prior to the ure someone is going to be N-A acknowledged she to actually happens." LPN-A reguely remember" an episode resident had been sent to an donot know why they were rived. LPN-A stated she could ons or re-education being at incident; however, apportant to ensure someone at their appointments to and ensure accurate reporting hysicians.				
	Rum River Unit. HU [a resident's] cognitiset-up appointment someone meets the she did not make the not need to be accepted that was the unit mistated she typically resident's appointmenting someone of saved or placed in HUC-A stated there re-education complion the unit adding sincident where R5 II	rified she made the se residents residing on the JC-A explained "depending on tivity" they will call family and its with them to ensure the at the site. HUC-A voiced the decision on who did or did ompanied to appointments, as anager' responsibility. HUC-A makes a note on the then the card regarding if family is for not, however, these are not the medical record. Further, the had not been any revisions or letted with her since R5 resided the was unaware of an anad been sent to a medical ervised. HUC-A voiced				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00375	B. WING			C 2 <mark>0/2020</mark>
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ELIM HC	OME	701 FIRST	「STREET ON, MN 553	71		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	someone should be supervised."	e present "so they are				
	HandiVan driver (H up from the nursing an envelope which desk at the clinic or service was basical and someone from checks them in. Ho 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 whim inside, but did in HVD stated since the never been contact discuss the situation.	on 7/16/20, at 12:09 p.m. the VD) stated he picks residents in home and typically is given the provides to the reception in hospital. He expressed his lay a "desk to desk" service, the clinic takes over after he VD voiced family, at times, will in the nursing home at the vas only "maybe 60/40 in the hours are incident with R5 and, from all, thought he dropped him off vas not there so he brought not remain with him. Further, the incident with R5, he had all by the nursing home to mor revise any procedures to the met by family or kept safe ised at the clinic.				
	manager (RN)-B wa explained family wa appointments with I lot of the times they the HandiVan drive residents at the clin added once they're appointments, the r planning becomes not the nursing hon some residents on she "would hesitate appointments, and	as interviewed. RN-B as always able to attend residents; however, added "a o do go alone." RN-B voiced r(s) typically waited for the nic to her understanding, and 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 to send alone to voiced while the HUC and her idents and appointments,				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDFLAN	TO CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING:			
		00375	B. WING		07/2	0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FLIM HOME		701 FIRST PRINCETO	T 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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	there was no forma supervision and wh RN-B added, "It's n somebody's with the RN-B then reviewed RN-B explained R5 self-propel in his what a resident who protor a staff member pappointments as he physician accurate condition(s). RN-B appointment and sther via telephone where we will be the recessary input happened before; have brought the clattention so they consure a similar 11/8/19 did not receive to ensure a sim	I system to decide who needs o doesn't for appointments. ot our policy to make sure em." I R5's incident from 11/8/19. had dementia and could neelchair. RN-B stated R5 was pably should have had family present with him at off campus would likely not give the information on his recalled R5's 11/8/19 ated the clinic had contacted then he arrived and she gupset" and questioning why resident is unable to provide a for the physician had however, RN-B felt it was "very tioned on her follow-up actions situation like R5's incident on cour, RN-B stated she did however, in hindsight, should inic' concerns to someone's fould review their system for appointments. p.m. the director of nursing ere interviewed. The DON mome'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 stated she felt the incident	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			_	
		00375	B. WING			C 20/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ELIM HO	DME	701 FIRST PRINCET	T 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 830	and R5's family as part" and arranged RN-B and the DON their systems or proto appointments an and needed informathe DON voiced shing" and "had we on it and "maybe providers whing" and "had we on it and "maybe providers who accidents A Common Entry P 11/10/19, identified State agency (SA) outlined R5 had be medical appointme unable to explain with physician even ask would cost him." R5 had expressed to fa attend the appointmif it had been re-schooncern as sending nobody present councern as sending nobody present councern and recount transfers. Furtly sustained a fall with months. R5's undated 48 Household R5 was one experienced hallucidictation present reconcern resent reconcern resent reconcern resent reconcern as a fall with months.	the nursing home "did our the transportation for R5. verified they had not reviewed ocedures for sending residents densuring care is coordinated ation relayed to the providers. The "didn't know this was a known" she would have acted at something in place." Toordination of care with the regarding R5. The report the prought to an off campus and with the was there to the staff or ing, " how much the vet bill of had a listed guardian who accility' staff he was unable to the eduled. The report outlined of R5 to the appointment with	2 830				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00375	B. WING		C 07/20/2020		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	0112	.0/2020	
		701 FIRST		TATE, ZII OODE			
ELIM HO	PME	PRINCETO	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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 13	2 830				
	Further, the care ploof frequent falls and	an identified R5 had a history d wandering.					
	had an appointmen physician off campulabeled, "Nurse Not provided which did visit to the physician however, merely lis unit coordinator (Humanager (RN)-B's in number. The physic 11/7/19 and provide "Labs," and, "T Bondiagnosed with a B pancytopenia (low oblood cells: red blood platelets). There wincluding level of as for R5, to ensure he campus at the appointed as the main concer "came to follow up to [R5] today. Spoke wout what and why lawas at the appointed with." The note ider wheelchair and sitti adding, "Will responsible memory loss, staneeds." The note lis which included diur	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 bintment. Fairview Geriatric Services i, identified R5 had been seen e visit with pancytopenia listed in. The note outlined R5, with labs that were done on with the nurse manager to find abs. [R5] saw [physician] and ment alone. Not clear why he not know and family did not go not in the commons area and to simple questions but with the faff anticipate much of his sted several orders for R5 etic medication, laboratory					
	his memory loss, st needs." The note lis which included diur	aff anticipate much of his sted several orders for R5					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		C		
		00375	B. WING		07/2	0/2020	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ELIM HC	ME	701 FIRST PRINCETO	SIKEEI DN, 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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From page 14		2 830				
	recorded entries: O nursing home. R5 with the place or time up SLUMs test (cognit R5. He scored 8/30 this indicates demellaboratory 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 on admission. On 11/7/19, a ion test) was administered to which the note outlined, " entia." On 11/8/19, the ind reported a critical lab value ind hemoglobin. The physician e. There were no recorded in the appointment R5 had with ic on 11/8/19; and R5 expired					
	R5's medical record was reviewed and lacked evidence the facility had arranged family or staff to accompany R5 to his medical appointment on 11/8/19, despite being identified with severe cognitive impairment and a history of wandering and falls. Further, the record lacked evidence the facility had communicated to the clinic staff on needed levels of assistance or any needed safety precautions to ensure R5 was kept safe and free of accidents if he needed to be transferred, use the restroom, or attempted to leave the clinic unsupervised.						
	nursing assistant (No residing on the Rundare unit) and descensily re-directable, resident on the unit bring the resident at to the van driver and there typically was a present when they wan 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					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7412 1 2741	or contraction	isertii istrieit itelusert	A. BUILDING:			
		00375	B. WING		07/2	20/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HO	ELIM HOME 701 FIRS PRINCET			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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	added, "That's a go stated R5 used to chome and she coul at the appointment home" and "wanting leave the clinic. On 7/16/20, at 11:4 interviewed and ver appointments for the Rum River Unit. Hua residents cognitions set-up appointments someone meets the she did not make the not need to be accounted that was the unit mustated she typically resident's appointment in stated she typically resident's appointment in the unit adding sincident where R5 happointment unsup someone should be supervised." When interviewed thandiVan driver (Hup from the nursing an envelope which desk at the clinic or service was basical and someone from checks them in. Hymeet residents from	ntments unsupervised and od question." Further, NA-A often verbalize he wanted to go d see R5 becoming confused and "wondering why he isn't g to go home" then trying to 5 a.m. HUC-A was	2 830			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					(
		00375	B. WING		07/2	0/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
E. 184 . 10		701 FIRS1	STREET			
ELIM HOME PRINCET			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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 16		2 830			
		e. HVD verified he does not son while they're at the clinic,				
	and if no family is p	resent, he leaves the let's the				
		ysician. HVD stated he nory" of the incident with R5				
		could recall, thought he				
		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					
		re residents are met by family				
		eft 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					
	lot of the times they	residents; however, added "a v do go alone." RN-B voiced				
		r(s) typically waited for the ic to her understanding, and				
		checked in to the clinic				
	appointments, the r	esident' safety and care				
		the clinic's responsibility and nes. RN-B stated there were				
		the locked memory care unit				
	she "would hesitate	" to send alone to				
		voiced while the HUC and her				
	•	idents and appointments, I system to decide who needs				
		o doesn't for appointments.				
	RN-B added, "It's n	ot our policy to make sure				
		em." RN-B then reviewed R5's				
		19. RN-B explained R5 hadI self-propel in his wheelchair.				
		es, she recalled R5 as				
	someone who did b	ecome confused and search				
		im to various places. RN-B sident who probably should				

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Minneso	ota Department of He	ealth				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	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	701 FIRST PRINCETO	T STREET ON, MN 553	71		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	him at off campus a	a staff member present with appointments as he would	2 830			
	on his condition(s). much, if any, inform living (ADL) assista					
	were sent with residuely "We don't do a who	o prevent falls or elopements) dents on appointments adding, ble lot of that kind of stuff."				
	stated the clinic had when he arrived and upset" and question	11/8/19 appointment and d contacted her via telephone d she remembered "being hing why R5 was at the clinic.				
	ensure a similar situ 11/8/19 did not reod	on her follow-up actions to uation like R5's incident on ccur, RN-B stated she did however, in hindsight, should				
	have brought the cli attention so they co	linic' concerns to someone's buld review their system for appointments and make sure				
	(DON) and RN-B w voiced the nursing h setup the appointment	p.m. the director of nursing vere interviewed. The DON home's responsibility was to lent and arrange transportation				
	home contacts fam attending with the re assume they would	erify" if anyone from the nursing hily to ensure they will be resident or not. DON added, "I I," and she felt that was and the DON verified they had				
	not reviewed their s sending residents to care is coordinated	systems or procedures for o appointments and ensuring and supervision is provided. The control of the control o				
	thing" and "had we on it and "maybe pu	known" she would have acted ut something in place."				
	A facility policy on s at appointments wa	supervision of residents while as not provided.				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00375			B. WING			C 20/2020
NAME OF PROVIDER OR SUPPLIER STREET AD 701 FIRST				TATE, ZIP CODE		
LLIIVITIC	/IVIL	PRINCETO	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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE 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 behas cratching self, public during the review processes ment (CAA) symptoms were list completed. R1's care plan, last	ange Minimum Data Set 8/19, identified R1 had short fory impairment along with cognitive skills for daily the MDS identified R1 avioral symptoms (i.e. hitting or olic sexual acts, screaming) eriod; and the Care Area for cognition and behavioral ed as being triggered to be				
	targeted behaviors restlessness, disrol statements. A serie which included usin less than two repor daily. The care plar meet the established documenting the re	pilizing medication(s) and listed which included anger, ping in public and repeated as of goals were listed for R1 ag less medications and having at sof anxious verbalizations a listed several interventions to ad goals which included asident's behaviors and mood, aled, and providing 1:1 visits or when distressed.				
	was being reviewed status assessment. registered nurse un identified, "Behavio charting crying was exhibiting anxiety with redirection and not being effective. X 5 days with readinot being effective. reported daily with its status assessment.	dated 10/28/19, identified R1 for a significant change in A note was completed by it manager (RN)-B which reported on 1 day. Verbally as reported on 5 evenings offering a snack or activity lnability to sleep was reported material, TV, and snacks Delusional comments redirection and 1-1 visits not seeking reported on 2 days				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
	A.		7. BOILDING.			С	
	00375 B. WING			1	0/2020		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ELIM HO	ME	701 FIRST		74			
PRINCETO			PROVIDER'S PLAN OF CORRECTION		(VE)		
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 19	2 830				
	with redirection and	1-1 not being effective."					
	R1's subsequent progress note(s) were reviewed and identified the following: On 11/17/19, R1 had a verbal altercation with another resident. On 11/27/19, R1 was recorded as being, "aggressive towards other residents this shift. Resident has increase [sic] anxiety, grand thoughts, and cursing. PRN [as needed] administered, which was somewhat effective." Further, on 12/7/19, R1 was attempted to go into other resident' rooms and when re-directed threw her coloring box on the floor and became upset. R1 was recorded as expiring on 1/16/20. R1's subsequent Target Behavior Monitoring flowsheets, dated 11/2019 to 1/2020, identified the following: November 2019: R1 had five episodes of exit seeking with each of the episodes having interventions completed, including coloring or taking off the unit, however, each time these 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						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
					С	
	00375 B. WING 07/20		0/2020			
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ELIM HC	ME	701 FIRST		71		
PRINCETO		ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
(X4) ID PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 20	2 830			
	the interventions. F delusional commer being completed, ir visits, however each were recorded the law "Unchanged." December 2019: R seeking with each of interventions comp taking R1 off the unepisodes was recorded swas recorded as, "Unchanged," depisodes of verball with each of the episodes had the bow "Unchanged," desp seven episodes of each of the episodes of t	urther, R1 had 22 episodes of ats recorded with interventions acluding redirection and 1:1 th time these interventions behavior was recorded as, 1 had eight episodes of exit of the episodes having leted, including coloring or ait, 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 to or activities, however, these anot effective and the behavior Unchanged." R1 had four complaints of anxiety recorded isodes having interventions er, again, all of these recorded ehaviors recorded as, ite the interventions. R1 had anability to sleep recorded with the shaving interventions cluded massage, warm packs er, again, all of these episodes are, again, all of these episodes of ats recorded with interventions and 1:1 th time these interventions behavior was recorded as,				
	nursing assistant (Nand verified she res	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				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
ANDILAN	EAN OF CONNECTION IDENTIFICATION NOWIDEN.		A. BUILDING:			
		00375	75 B. WING C			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HO	DME	701 FIRST PRINCET	T 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	self-propel in her wattempted to use, of the unit. NA-D recabehaviors and woul "kicking, pounding expressed R1 was not, the staff would helped "most of the any demonstrated by 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 identification behaviors, and imprecorded in the proper Further, the medical a CAA had been count and behavioral symon the 10/28/19 ME information). On 7/16/20, at 2:01 and verified she watthe last months of the RN-B explained who behavior (s), the stabehavior and try to "things they like." The meetings which held they had not had a other things took proposed to the property of the stabelavior and try to stabelavior and try to "things they like." The meetings which held they had not had a other things took property assessment by discapping the property of the stabelavior and try to "things took property assessment by discapping the property of the prope	heelchair and often used, or other resident' bathrooms on lled R1 had exit seeking ld 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 d was reviewed and lacked sen comprehensively winterventions developed to ed behaviors despite the lemented interventions, being gress note(s) as not effective. If record lacked any evidence ompleted for R5's cognition aptoms despite being triggered DS (See F636 for additional p.m. RN-B was interviewed as R1's care manager during her life at the nursing home. en a resident displays off attempt to observe the intervene by coming up with the unit used to have behavior ped in this process, however, meeting for "a few months" as itority. RN-B stated the facility	2 830			

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	00375		B. WING		07/2	0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ELIM HC	ME	701 FIRST		74		
(V4) ID	SLIMMA DV STA	TEMENT OF DEFICIENCIES	ON, MN 553	PROVIDER'S PLAN OF CORRECTION	- N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMON DELICITION OF THE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 22	2 830			
	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 identifying and assessing a resident's mental and psychosocial status and providing person-centered care." This assessment included obtaining information from medical records, family and/or the resident on usual patterns of cognition or mood and behavior; and, using the Resident Assessment Instrument (RAI) process including the MDS and CAA(s).					
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures, inservice staff on identified needs and requirements, and then audit to ensure compliance with facility' policies regarding to resident supervision, outside clinic consultation and dementia care.					
	(21) days	R CORRECTION: Twenty-one				

Minnesota Department of Health STATE FORM

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FLIM HOME			T STREET ON, MN 553	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21375	Program Subpart 1. Infection home must establist control program destantiary environments This MN Requirements Based on interview, review the facility fawere being actively verifying temperatures screening process) potential transmissi	ent is not met as evidenced , observation and document illed to ensure all employees screened (other employees re readings during the for the prevention and	21375	Corrected		8/25/20
	potential to affect a	DC) guidelines. This had the II 92 residents currently ty at the time of the COVID-19				
	A Centers for Medic COVID-19 Long-Tedated 4/2/20, identifing implemented to red transmission in a loincluded, " every reason entering a louincluding residents healthcare workers asked about COVID also have their tempon 7/17/20, at approximate the control of the coving and the coving also have the co	care and Medicaid (CMS) frm Care Facility Guidance, fied procedures to be uce the risk of COVID-19 ng-term care setting. This individual regardless of ong-term care facility s, staff, visitors, outside vendors, etc.) should be 0-19 symptoms and they must perature checked."				

Minnesota Department of Health STATE FORM

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 FIRST STREET PRINCETON, MN 55371 (X4) ID PREPIX (EACH DEPROCED WINSTE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21375 Continued From page 24 employees self screening with no verification of their temperature or COVID screening questions with another employee before entering the facility despite an employee before entering the screening survey staff). When interviewed on 7/17/20, at 11:49 a.m. dietary aide (DA-A) stated when arriving to work she answered questions and took her own temperature. DA-A sated spain she self-administered her own temperature and documented the results in the symptoms section of the screening process. When interviewed on 7/17/20, at 1:29 p.m. the director of nursing (DON) stated there was always to be someone around to assist with the screening process consisted of answering questions about symptoms and taking temperature. DON stated temperature monitoring was having "someone else" look at the temperature to verify result. DON stated there was a schedule for helping employees screen in state of the proposes screen was a schedule for helping employees screen in street and process consisted of answering questions about symptoms and taking temperature. DON stated there was a schedule for helping employees screen in state of the temperature was a schedule for helping employees screen in street and process consisted of answering questions about symptoms and taking temperature. DON stated there was a schedule for helping employees screen in street and process consisted of answering questions about symptoms and taking temperature. DON stated there was a schedule for helping employees screen in street and process consisted of answering questions about symptoms and taking temperature. DON stated there was a schedule for helping employees screen in street and process consisted of answering questions about symptoms and taking temperature. Don's taken the screening process consisted of answering qu	ANDFLAN	DENTIFICATION NOMBER.		A. BUILDING:		COMPLETED	
CALL			00375	B. WING			
CALID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21375 Continued From page 24 employees self screening with no verification of their temperature or COVID screening questions with another employee before entering the facility despite an employee before entering the facility despite an employee being present at the screening survey staff). When interviewed on 7/17/20, at 11:49 a.m. dietary aide (DA-A) stated when arriving to work she answered questions and took her own temperature. DA-A said, "There is always someone there to make sure you are doing the screening." DA-A stated she did not know of anyone "needing to check my temperature". DA-A stated again she self-administered her own temperature and documented the results in the symptoms section of the screening process. When interviewed on 7/17/20, at 1:29 p.m. the director of nursing (DON) stated at the screening table there was always to be someone around to assist with the screening process consisted of answering questions about symptoms and taking temperature. DON stated temperature monitoring was having "someone else" look at the temperature to verify result. DON stated there was a schedule for helping employees screen	ELIM HC	DME			71		
employees self screening with no verification of their temperature or COVID screening questions with another employee before entering the facility despite an employee being present at the screening table at the time (employee was screening survey staff). When interviewed on 7/17/20, at 11:49 a.m. dietary aide (DA-A) stated when arriving to work she answered questions and took her own temperature. DA-A said, "There is always someone there to make sure you are doing the screening." DA-A stated she did not know of anyone "needing to check my temperature". DA-A stated again she self-administered her own temperature and documented the results in the symptoms section of the screening process. When interviewed on 7/17/20, at 1:29 p.m. the director of nursing (DON) stated at the screening table there was always to be someone around to assist with the screening process. DON explained the screening process consisted of answering questions about symptoms and taking temperature. DON stated temperature monitoring was having "someone else" look at the temperature to verify result. DON stated there was a schedule for helping employees screen	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
assist with all screening to verify information. DON stated she was not aware of employees not verifying temperatures. DON further explained employees had been educated on the screening process which included showing another employee verifying temperature results. Policy entitled COVID-19 Phase 2-All SNFs and all CO sites states, "healthcare workers will complete a symptom screening form, including	21375	employees self screetheir temperature of with another employers screening table at the screening survey streening survey streening. DA-A someone there to make anyone "needing to stated again she settemperature and do symptoms section of the screening survey streening." DA-A sanyone "needing to stated again she settemperature and do symptoms section of the screening survey streening	eening with no verification of r COVID screening questions yee before entering the facility be 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 make sure you are doing the stated she did not know of a check my temperature". DA-A elf-administered her own ocumented the results in the control of the screening process. On 7/17/20, at 1:29 p.m. the (DON) stated at the screening arys to be someone around to be ening process. DON ening process consisted of a sabout symptoms and taking stated temperature and stated there helping employees screen to be at the screening area to the	21375	DELI KIENCI)		

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		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE COMPI	
					С	
00375 B. WING 07/20		0/2020				
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ELIM HO	ME	701 FIRST		71		
(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 APPROFIMENCY)	D BE	(X5) COMPLETE DATE
21375	will be reviewed by reporting to the resi SUGGESTED MET director of nursing (educate staff on action audit to ensure	a facility designee prior to ident care area". THOD OF CORRECTION: The (DON), or designee, could tive screening for COVID-19;	21375			

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