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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GF97

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00051

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245437**

2.STATE VENDOR OR MEDICAID NO.
(L2) **816740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME - WATERTOWN**
(L4) **409 JEFFERSON AVENUE SOUTHWEST**
(L5) **WATERTOWN, MN** (L6) **55388**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/04/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Gayle Lantto, Unit Supervisor — 10/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 10/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/14/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245437

October 8, 2015

Mr. Jason Nelson, Administrator
Elim Home - Watertown
409 Jefferson Avenue Southwest
Watertown, Minnesota 55388

Dear Mr. Nelson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 18, 2015 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

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

Electronically delivered
October 8, 2015

Mr. Jason Nelson, Administrator
Elim Home - Watertown
409 Jefferson Avenue Southwest
Watertown, Minnesota 55388

RE: Project Number S5437023

Dear Mr. Nelson:

On August 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 23, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 4, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 8, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 18, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 23, 2015, effective August 18, 2015 and therefore remedies outlined in our letter to you dated August 4, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245437	A. Building B. Wing	9/4/2015

Name of Facility	Street Address, City, State, Zip Code
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST WATERTOWN, MN 55388

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **08/18/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/14/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/14/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/14/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **08/14/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GL/mm	**Date:** 10/08/2015	**Signature of Surveyor:** 15507	**Date:** 09/04/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/23/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245437	01 - MAIN BUILDING 01	9/8/2015

Name of Facility	Street Address, City, State, Zip Code
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST WATERTOWN, MN 55388

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	07/23/2015	ID Prefix Reg. # NFPA 101 LSC K0050	07/24/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GS/mm	Date: 10/08/2015	Signature of Surveyor: 34764	Date: 09/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/22/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GF97

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00051

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245437**

2.STATE VENDOR OR MEDICAID NO.
(L2) **816740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME - WATERTOWN**
(L4) **409 JEFFERSON AVENUE SOUTHWEST, BOX 638**
(L5) **WATERTOWN, MN** (L6) **55388**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/23/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Shawn M. Soucek, HPR SWS — 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 4, 2015

Mr. Jason Nelson, Administrator
Elim Home - Watertown
409 Jefferson Avenue Southwest, Box 638
Watertown, Minnesota 55388

RE: Project Number S5437023

Dear Mr. Nelson:

On July 23, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 1, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 1, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure the bathroom mirrors were at an appropriate height to accommodate needs for 9 of 12 residents (R25, R11, R40, R50, R16, R14, R68, R15, R63) reviewed for residents that utilized a wheelchair. Findings include: R25's room was observed on 7/21/15, at 2:23	F 246	F246-E This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.	8/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/13/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - WATERTOWN	409 JEFFERSON AVENUE SOUTHWEST, BOX 638 WATERTOWN, MN 55388

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F 246	Continued From page 1 p.m. The observation noted R25's mirror in her bathroom was mounted to the wall at a height which did not allow her to view herself while sitting in a wheelchair as it was difficult to stand. R25 accessed her bathroom by wheelchair. R25 was admitted with a diagnosis that included Parkinson's, dementia, morbid obesity, and abnormal gait. The Minimum Data Set (MDS) dated 7/8/15, indicated R25 required extensive assist with transfers and mobility, the resident was extensive assist with one person physical assist for personal hygiene. The care plan dated 7/21/15, directed staff to provide set up and physical assistance of one staff for personal hygiene. R11's room was observed on 7/21/15, at 2:23 p.m. The observation noted R11's mirror in her bathroom was mounted to the wall at a height which did not allow her to view herself while sitting in a wheelchair. R11 was admitted with a diagnosis that included renal failure, dysphagia, congestive heart failure and fatigue. The MDS dated 5/9/15, indicated R11 required extensive assist with transfers and mobility. The resident needs supervision and one person physical assist for personal hygiene. The care plan dated 5/19/15, directed staff to provide physical assist of one staff for personal hygiene. On 7/21/15, at 2:23 p.m. both residents stated they cannot use the mirror at the height it was now. On 7/23/15, at 9:13 a.m. interview with nursing assistant (NA)-A, stated residents R11 and R25	F 246	It is the policy of Elim Home Watertown that bathroom mirrors are accessible for residents that are in wheelchairs. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Bathroom mirrors will be lowered and cantered to accommodate these affected residents in wheelchairs. 2.Actions taken to identify other potential residents having similar occurrences: All bathroom mirrors were evaluated for residents in wheelchairs potentially not being able to see themselves. 3.Measures put in place to ensure deficient practice does not recur: All bathroom mirrors in the facility will be lowered and will be cantered towards the resident to insure that they are able to see themselves in the mirror. 4.Effective implementation of actions will be monitored by: After mirrors are adjusted, we will audit 20 residents in wheelchairs to ensure they can see themselves properly. This report will be submitted to the QAPI committee to insure the installation was appropriate. 5.Those responsible to maintain compliance will be: The Director of Environmental Services will insure that all mirrors are installed and cantered.	

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F 246	Continued From page 2 needed assistance with activities of daily living (ADLS), they do some tasks such as washing their face, however dependent on staff for the majority of their cares. NA-A was unsure if the residents use the mirrors in the bathrooms as staff assist with cares. R40's room was observed on 7/21/15, at 11:10 a.m. The observation noted R40's mirror in her bathroom was mounted to the wall at a height which did not allow her to view herself while sitting in a wheelchair. R40 accessed her bathroom by wheelchair. The MDS dated 6/4/15, indicated R40 and required staff assistance to stand due to weakness and balance impairment. The MDS further indicated she was nonambulatory and utilized a wheelchair for mobility. On 7/22/15, at 11:12 a.m R40's husband (F)-1 stated R40 did not have a mirror she could access, which would have included a hand-held mirror. He further stated, "It would be nice for her to have that opportunity." R50's room was observed on 7/21/15, at 2:27 p.m. The observation noted R50's bathroom mirror was too high above the sink for R50 to use while in her wheel chair. R50's annual MDS dated 5/1/15, indicated she required extensive assistance of two person physical assist with dressing, limited assistance of one person physical assist with personal hygiene and utilized a wheelchair for mobility. During interview on 7/23/15, at 9:57 a.m. NA-H stated R50 would not go into the bathroom because she's "claustrophobic", instead she	F 246	Completion date for certification purposes only is: August 18, 2015	

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F 246	Continued From page 3 utilized a bedside commode. However, NA-H stated even if R50 would use the bathroom, she would not be able to see in the mirror as the mirror was "are too high." R16's room was observed on 7/21/15, at 2:31 p.m. The observation noted R16's bathroom mirror was too high above the sink for R16 to use while in her wheel chair. R16's quarterly MDS dated 7/9/15, indicated she required an extensive assistance with one person physical assist with personal hygiene, extensive assistance with two person physical assist with dressing and utilized a wheelchair for mobility. R14's room was observed on 7/21/15, at 2:36 p.m. The observation noted R14's bathroom mirror was too high above the sink for R14 to use while in her wheel chair. R14's quarterly MDS dated 6/25/15, indicated that R14 required an extensive assistance with one person physical assist with personal hygiene, extensive assistance of one person physical assist with dressing and utilized a wheelchair for mobility. During interview on 7/23/15, at 9:42 a.m. NA-G stated R14 liked to use the mirror when doing her hair. NA-G stated R14 used a "stand lift" to stand R14 in the bathroom to that she can see the mirror, because the mirror is "too high." R68's room was observed on 7/20/15, at 10:40 a.m. The observation noted R68's bathroom mirror was too high above the sink for R68 to use	F 246		

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F 246	Continued From page 4 while in his wheel chair. R68 was interviewed and stated, "Sometimes I brush my teeth in the bathroom." R68's quarterly MDS dated 6/16/15, indicated that R68 required assistance with personal hygiene, dressing, toileting and utilized a wheelchair for mobility. R15's room was observed on 7/20/15, at 10:44 a.m. The observation noted R15's bathroom mirror was too high above the sink for R15 to use while in his wheel chair. R15 stated,"Sometimes I brush my teeth in the bathroom." R15 was interviewed and stated she utilized the sink in the bathroom. R15's quarterly MDS dated 6/2/15, indicated that R15 required assistance with personal hygiene, dressing, toileting and utilized a wheelchair for mobility. R63's room was observed on 7/20/15, at 11:17 a.m. The observation noted R63's bathroom mirror was too high above the sink for R63 to use while in his wheel chair. R63's annual MDS dated 7/2/15, indicated that R15 required assistance with personal hygiene, dressing, toileting and utilized a wheelchair for mobility. On 7/22/15, at 8:02 a.m. the social worker was interviewed and she stated there had been no concerns or grievances filed regarding the mirrors in the residents' bathrooms being too high.	F 246		

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F 246	Continued From page 5 On 7/23/15, at 8:15 a.m. during the environmental tour the maintenance director and housekeeping director verified resident vanity mirrors do not accommodate the residents in wheelchairs as the bottom of the mirror was 48 inches from the floor. The maintenance director stated the mirrors have always been at that height and not adjustable. During interview with NA-F on 7/23/15, at 9:11 a.m. NA-F stated,"The mirrors in the residents' bathrooms are a little high." NA-F also stated residents in wheelchairs could not see into the mirrors as they were too high for residents seated in a wheelchair, the residents would have to be standing in order to look into the mirror.	F 246		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 resident (R45) in the sample who required daily skin monitoring. Findings include: During an observation of R45 on 7/20/15, at 11:40 a.m. the following skin conditions were noted; a dark purple bruise on left hand, a dark purple bruise on left arm, a dark purple bruise on the	F 282	F282-D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to	8/14/15

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F 282	Continued From page 6 right hand, and a skin tear to the right wrist/upper back of hand with a scant dried blood. R45 was interviewed at that time and stated he had a very thin skin and even if "I push down with my finger it will turn purple." When asked about the skin tear to his wrist, R45 stated he was not sure what had happened. During follow-up observations of R45 on 7/21/15, at 6:17 p.m. and 7:10 p.m. and on 7/22/15, at 8:19 a.m. and 11:50 a.m. the skin tear was noted to be open with scant dried blood during both observations. Review of Progress Notes indicated R45 had a bath on 7/20/15, at 1:00 p.m. and had a fall on 7/19/15, at 10:50 a.m. None of the reports indicated R45 has a skin tear. During medical record review on 7/21/15, no documentation was evident to indicate R45 had a skin tear to the right wrist or even any treatment was being provided. R45's care plan dated 7/21/15, identified the skin problem "potential for bruising d/t [due to] anticoagulant and ASA [aspirin]". The approaches included, "Nursing---Conduct a systematic skin inspection weekly on bath day. Observe skin daily with routine cares. Assess for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible." R45's plan of care was not followed as the skin was not monitored with daily routine cares. During interview on 7/21/15, at 7:11 p.m. nursing assistant (NA)-B stated R45 needed help with activities of daily living (ADLs), "always has bruises and skin tears", and they are supposed to report nurse with new skin conditions. NA-B confirmed she had seen the skin tear but thought	F 282	provide services in accordance with a resident¿s written plan of care that require daily skin monitoring. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The affected resident had a complete skin assessment and interventions were put in place to address the affected area. 2.Actions taken to identify other potential residents having similar occurrences: Other residents that potentially may be affected will be identified by a systematic skin inspection weekly on bath day and with daily routine skin observations. Skin care and interventions will be provided to those residents that may be affected. 3.Measures put in place to ensure deficient practice does not recur: All Nursing staff will be re-educated with the importance of following the skin care protocols that are in place immediately after staff reports a skin concern. 4.Effective implementation of actions will be monitored by: The Clinical Coordinator will perform random audits on 2 baths per week for one month to ensure any skin concerns are noted and provide on the spot education to any staff that did not note and provide such skin concerns. The Director of Nursing or designee will perform monthly audits for five months after the initial month, and will report their	

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F 282	Continued From page 7 "someone had reported already" since "it didn't look fresh." During interview on 7/22/15, at 8:01 a.m. NA-G stated R45 required extensive assist with "everything", used a sit-to-stand mechanical lift and always has bruises. NA-G stated she did not know anything about the skin tear as R45 was "already up when I got here." She stated that any new skin condition is supposed to be reported to the nurse "right away." During interview on 7/22/15, at 11:59 a.m. licensed practical nurse (LPN)-B stated R45 bumped himself on walls as he wheeled himself. LPN-B stated they monitor skin weekly on bath day and that the wound coordinator assesses and tracks wounds. LPN-B confirmed she had seen R45 with a skin tear and "thought it has been taken care of." LPN-B confirmed there was no documentation R45's skin tear nor was R45 receiving any treatment or monitoring to the skin tear. During interview on 7/23/15, at 11:07 a.m. director of nursing (DON) stated her expectation was that her staff should follow the care plan and provide services per the care plan. DON verified if staff had followed the care plan and did daily skin observation and monitoring, the skin tear would not have been gone unnoticed. An Injury Documentation policy dated 7/14, directed that skin will be inspected daily with cares done by the nursing assistant. If any skin concerns are identified, they are to be reported immediately to the designated nurse. The policy further directed that the 'Skin Injury Event Form' should be open and completed by the licensed	F 282	findings to the next two quarterly QAPI meetings. 5.Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible for maintaining compliance for daily skin monitoring. Completion date for certification purposes only is: August 14, 2015	

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F 282	Continued From page 8 nurse immediately upon identification of a skin injury (that is NOT a pressure ulcer).	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services related to monitoring and treatment of a skin tear for 1 of 1 resident (R45) in the sample identified as having skin conditions. Findings include: R45 was observed on 7/20/15, at 11:40 a.m. and the following skin conditions were identified. A dark purple bruise on left hand, a dark purple bruise on left arm, a dark purple bruise on the right hand, and a skin tear to the right wrist/upper back of hand with a scant amount of dried blood. R45 was interviewed on 7/20/15, at 2:41 p.m. and stated he had very thin skin and even if "I push down with my finger it will turn purple." When asked about the skin tear to his wrist, R45 stated that he was not sure what had happened. During follow-up observations of R45 on 7/21/15,	F 309	F309 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to provide necessary care and services related to monitoring and treatment of skin tears for residents having skin conditions. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The affected resident had a complete skin	8/14/15

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F 309	Continued From page 9 at 6:17 p.m. and 7:10 p.m. and on 7/22/15, at 8:19 a.m. and 11:50 a.m. the skin tear was noted to be open during all observations. R45's quarterly Minimum Data Set (MDS) dated 7/9/15, indicated R45 required extensive assistance with two person physical assist with bed mobility, transfer and toilet use. R45 required extensive assistance with one person physical assist with dressing, locomotion on unit and personal hygiene. In addition, the MDS did not identify R45 as having a skin tear. Review of Progress Notes indicated R45 had a bath on 7/20/15, at 1:00 p.m. and had a fall on 7/19/15, at 10:50 a.m. None of the reports indicated that R45 had a skin tear. R45's care plan dated 7/21/15, identified the skin problem "potential for bruising d/t [due to] anticoagulant and ASA [aspirin]." The approaches included, "Nursing---Conduct a systematic skin inspection weekly on bath day. Observe skin daily with routine cares. Assess for presence of risk factors. Treat, reduce, and eliminate risk factors to extent possible." During medical record review on 7/22/15, documentation indicated R45 had bruises to his right and left hands. However, no documentation was evident to indicate R45 had a skin tear to the right wrist or even if any treatment was being provided. Nursing assistant (NA)-B was interviewed on 7/21/15, at 7:11 p.m. and stated R45 needed help with activities of daily living (ADLs), "always has bruises and skin tears", and that they are supposed to report nurse with new skin conditions. NA-B confirmed she had seen the skin tear but thought "someone had reported	F 309	assessment and interventions were put in place to address the affected area appropriately. 2.Actions taken to identify other potential residents having similar occurrences: Other residents that potentially may be affected will be identified by a systematic skin inspection weekly on bath day and with daily routine skin observations. Skin care and interventions will be provided to those residents that may be affected. Treatment to any affected areas will be completed based on the interventions put in place after the skin inspection or during daily observations. 3.Measures put in place to ensure deficient practice does not recur: All Nursing staff will be re-educated with the importance of following the skin care protocols that are in place immediately after staff reports a skin concern so that any skin tears can be addressed immediately. 4.Effective implementation of actions will be monitored by: The Clinical Coordinator will perform random audits on 2 baths per week for one month to ensure any skin concerns are noted and provide on the spot treatment to the resident and education to any staff that did not note and provide such skin concerns. The Director of Nursing or designee will perform monthly audits of skin treatments for five months after the initial month, and will report their findings to the next two quarterly QAPI	

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F 309	Continued From page 10 already" since "it didn't look fresh." Nursing assistant (NA)-G was interviewed on 7/22/15, at 8:01 a.m. stated R45 required extensive assist with "everything," used a sit-to-stand mechanical lift and always had bruises. NA-G stated that she did not know anything about the skin tear as R45 was "already up when I got here." She stated that any new skin condition is supposed to be reported to the nurse "right away." Licensed practical nurse (LPN)-B was interviewed on 7/22/15, at 11:59 a.m. and stated R45 bumped himself on walls as he wheeled himself. LPN-B stated they monitor the skin weekly on bath day and that the wound coordinator assesses and tracks wounds. LPN-B confirmed that she had seen R45 with a skin tear and "thought it has been taken care of." LPN-B confirmed there was no documentation on R45's skin tear nor did R45 receive any treatment or monitoring to the skin tear. The director of nursing (DON) was interviewed on 7/22/15, at 1:07 p.m. stated all skin tears are documented and monitored and "treatment" provided accordingly until resolved. DON stated she did not know anything about R45's skin tear, but will look at it and get back to the surveyor. At 1:12 p.m. DON stated she had talked to R45 who stated to her that he had bumped his hand on wheelchair "a while ago." DON verified the skin tear should have been reported to the nurse and documented. DON also verified there was no treatment being provided for the skin tear nor was there any monitoring. Following another interview on 7/23/15, at 11:07	F 309	meetings. 5.Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible for maintaining compliance in monitoring for residents with skin conditions. Completion date for certification purposes only is: August 14, 2015	

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F 309	Continued From page 11 a.m. DON stated that her expectations is that nursing assistants reports promptly to the nurse any new skin condition, and that nurses are to document, provide appropriate treatment as needed and monitor until healed. DON stated that she would have expected R45's skin tear to be noted and documented by now. An Injury Documentation policy dated 7/14, directed that skin would be inspected daily with cares done by the nursing assistant. If any skin concerns are identified, they are to be reported immediately to the designated nurse. The policy further directed that the 'Skin Injury Event Form' should be open and completed by the licensed nurse immediately upon identification of a skin injury (that is NOT a pressure ulcer).	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident's assistance device safely for 1 of 1 resident (R65) reviewed for accidents. Findings include:	F 323	F323-D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of	8/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245437	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 12 R65's grab bars were observed on 7/20/15, at 10:46 a.m. The grab bars were attached to the bed and were very loose. The grab bars swayed back and forth at least one and a half inches to two inches when the bars were touched. In addition, the top end of the mattress was slid towards the top of the bed and there was approximately five inches of bare space of metal bed spring at the foot of the bed. Also, R65's grab bar was approximately seven to eight inches from the edge of the mattress. --At 2:03 p.m. maintenance came to R65's room and verified R65's grab bar was loose and had movement of approximately one and a half inches to two inches. Maintenance measured the mattress to grab bar at four and a half inches. Maintenance stated [R65's] grab bar is flexed out." Maintenance also stated, "I will go and get a wrench and try to tighten it." Surveyor observed maintenance tighten up R65's grab bar and re-measured from R65's mattress to R65's grab bar and it measured two and three-quarter inches. Maintenance stated no staff had notified him of R65's loose grab bar on her bed. Maintenance and surveyor went and looked in the basket for maintenance fix it slips for the staff to complete at the nurses station and there was no slip written up to repair R65's grab bar. Maintenance further stated he had not known of R65's loose grab bar and also that he did not have any grab bar audits nor had he checked residents' grab bars for tightness. R65's quarterly Minimum Data Set (MDS) dated 7/14/15, indicated R65 had a diagnosis of dementia and had severely impaired cognitive skills in decision making. The MDS also indicated R65 needed one staff extensive assist with transfers and that R65 when moving from seated	F 323	Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to maintain residents¿ assistive devices so that they remain safe. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The assistive device of the cited resident was tightened and adjusted to the specific parameters prior to exit of the surveyors. 2.Actions taken to identify other potential residents having similar occurrences: All residents with grab bars were examined to ensure that they were in proper working order and were tightened and adjusted as necessary to ensure that the resident¿s environment remains as free of accident hazards as possible. 3.Measures put in place to ensure deficient practice does not recur: The Environmental Services department will do monthly checks and potential adjusts as needed to all grab bars to ensure safety for all residents using that assistive device. 4.Effective implementation of actions will be monitored by: The Director of Nursing or designee will audit monthly for six months to ensure the grab bar checks are being performed, with those findings reported to the QAPI	

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F 323	Continued From page 13 to standing was not steady, and was only able to stabilize with human assistance. The MDS further indicated R65's walking was not steady, but R65 was able to stabilize without human assistance. On 7/21/15, at 6:05 p.m. R65 was observed walking around her room without her wheeled walker. R65 when asked stated that she held onto the grab bar to get in and out of bed. R65 stated she got out of bed all by herself, unless somebody is here to help. R65 then demonstrated to surveyor how she puts her hand on the grab bar. R65 then took her wheeled walker and walked out of her room down the hall. --At 6:10 p.m. nursing assistant (NA)-B stated R65 is stand by assist for transfer and stated R65 is weaker and needed supervision of walking prn (as needed) depending on the day. NA-B also stated R65 was considered a fall risk had fallen recently from self transferring in her room at night. --At 6:29 p.m. NA-C stated R65 needed one staff assist to transfer, that R65 just needed a little of assistance and that R65 walked alone. NA-C also stated that R65 should have supervision walking, but could not keep R65 seated, that she was just too busy and that R65 was a fall risk and had taken a tumble today. --At 6:47 p.m. licensed practical nurse (LPN)-A stated that R65 likes to move around, get up and walk around and is unsteady when walking. LPN-A also stated that R65 had fallen in her room today, that R65 had been toileted by staff and then R65 sometimes wants to just sit in her room and that staff had left her and resident had lost her balance in her room. LPN-A further stated R65 is unsteady on her feet and R65 gets up out of chairs whenever she wants and just fall so quickly that everyone keeps an eye on her.	F 323	committee. 5.Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible for maintaining compliance in grab bar safety. Completion date for certification purposes only is: August 14, 2015	

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F 323	Continued From page 14 --7:16 p.m. NA-D stated R65 had fallen and thought R65 had a problem with her blood pressures and that R65 was so unsteady. NA-D also stated that R65 had said she gets dizzy. NA-D further stated R65 used her grab bar to get out of bed. On 7/23/15, at 8:25 a.m. NA-E stated R65 is supervised and that it was really hard to keep an eye on her and that all staff helped watch her. --At 9:14 a.m. registered nurse (RN)-A stated R65 was a fall risk and that she had completed R65's grab bar assessment on 7/13/15. RN-A also stated that the assessment involved asking the NAs if the resident used the grab bar and stated that R65 did use her grab bar to get out of bed. RN-A further stated that the grab bar assessment did not include checking the grab bar for tightness and that she had not known that R65's grab bar was observed loose on 7/20/15. RN-A further stated that R65 was on the falling star program as she had had more than two falls. -- At 10:00 a.m. the director of nursing was interviewed and she stated residents' grab bars were not checked for tightness as the grab bars are bolted onto the bed and could not get loose. On 7/23/15, a policy on grab bars was requested but not provided by the facility.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		8/14/15

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F 356	Continued From page 15 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nursing hours posting reflected current hours worked. This had the potential to affect all 34 residents who resided in the facility and family/visitors who wished to view the information. Findings include: On 7/20/15, at 9:51 a.m. during the initial tour of the facility, a Nurse Staffing form was observed on an 8 x 11 sheet of paper on a bulletin board in	F 356	F356-C This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown to	

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F 356	Continued From page 16 the front entrance of the facility. The posted nurse staffing information lacked the total number and the actual hours worked per shift by the licensed and unlicensed nursing staff directly responsible for resident care. Review of the Nurse Staffing forms, dated 7/14/15 to 7/20/15, noted the facility reported the number and shift the licensed and unlicensed staff were scheduled to work; however, they did not report the actual number of hours worked for both the licensed and unlicensed nursing staff. In addition, the facility did not post staffing information for any shift on 7/19/15. During an interview on 7/20/15, at 10:48 a.m. the director of nursing (DON) verified the information and stated she expected the staff posting would include actual hours each licensed and unlicensed staff was scheduled to work and that would be done on a daily basis. She explained that would be necessary to identify what staff was working at any given time. -At 10:53 a.m., the DON stated the facility did not have a policy regarding staff posting. During interview with DON on 7/23/15, at 9:47 a.m. DON stated the New West nurse on nights completed the daily staff information according to the staffing schedule and at midnight the New West night nurse checked the facility census and then hung the posting in the plastic cabinet on the wall. DON also stated sometimes to replace sick calls, licensed practical nurses (LPNs) would work for registered nurses and trained medication aides would replace LPNs. The DON further stated census did change at times during the day with admissions and discharges. In addition, the DON stated that no staff member updated the	F 356	post nursing hours reflecting the current nursing hours worked. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Nursing hours will be updated when necessary and posted daily so that residents and families/visitors will be able to view the information. 2.Actions taken to identify other potential residents having similar occurrences: Other residents will be able to view the nursing hours that are updated when necessary and posted daily in a conspicuous location. 3.Measures put in place to ensure deficient practice does not recur: The facility will post nursing staff hours and the actual nursing hours worked in a visible location in a main hallway in an easy to read format for families/visitors to see. Each Clinical coordinator/charge nurse on night shift will post the hours at the beginning of the morning, will review posting upon change of shift and update as needed. All nurses will be educated on how to fill out posting hours and updating the posting. 4. Effective implementation of actions will be monitored by: Monitoring will be done weekly for three months, and then bi-weekly for three months to assure the Nurse staffing information is posted correctly. The	

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F 356	Continued From page 17 posting once hung with any census or staffing changes. On 7/23/15, a policy for staff nursing posting was requested but not provided by the facility.	F 356	correction will be monitored by the DON to ensure compliance. 5. Those responsible to maintain compliance will be: The Director of nursing or designee is responsible for maintaining staffing hours are posted. Completion date for certification purposes only is: August 14, 2015	

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	245437	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/22/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 22, 2015. At the time of this survey, Elim Home Watertown was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/13/2015

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Elim Home Watertown is a one-story building with partial basement. The facility was constructed at three different times. The original building was constructed in 1964 and was determined to be of Type I(222) construction. In 1988, an addition was constructed to the north and was determined to be of Type II(111) construction. In 1998, an addition was constructed to the west and was determined to be of Type V (111) construction. The nursing home is separated from an apartment building by a complying two-hour fire wall assembly. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 51 beds and had a census of 34 at time of the survey. Because the original building and the two additions met the minimum construction types	K 000		

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K 000	Continued From page 2 allowed for existing buildings, the facility was surveyed as one building, and one (1) Form CMS 2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain one or more corridor doors in the means of egress in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.6.3. and Chapter 7, Section 7.2. In a fire emergency, this deficient practice could	K 018	K018-F This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that	7/23/15

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K 018	Continued From page 3 adversely affect any patients, staff or visitors within the affected smoke compartment. FINDINGS INCLUDE: On 07/22/2015 at 10:40 AM, observation revealed the corridor door to the Oxygen Storage Room did not positively latch into the door frame without force. This finding was verified with the Facility Maintenance Director (JS).	K 018	one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the intention of Elim Home Watertown to insure that all doors are not impeded from closing. The door to the Oxygen Storage Room was adjusted to correctly close and is no longer impeded from closing and latching into its frame. The Environmental Director will continue to insure doors are not impeded from fully closing. Completion date for certification purposes only is: July 23, 2015	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure fire drills were conducted	K 050	K050-F This Plan of Correction constitutes my	7/24/15

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K 050	Continued From page 4 once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 34 residents. Findings include: On facility tour between 08:00 AM and 11:30 AM on 07/22/2015, the review of the fire drills reports for 07/2014-07/2015, the following drills were missed: 1. 2nd quarter night shift 2. 3rd quarter night shift. 3. 4th quarter Evening and Night shift. These deficient practices were confirmed by the Facility Maintenance Director (JS) at the time of discovery.	K 050	written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Elim Home Watertown that fire drills will have varying times to insure staff reacts to fires in an appropriate manner to keep our residents, visitors and staff safe. To assure that this occurs, a schedule of fire drills for the year has been developed that varies the day of the month and the time of the day for fire drills. The Environmental Director is responsible for maintaining this schedule and insuring compliance with varying the times of those fire drills. Completion date for certification purposes only is: July 24, 2015	