CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 0TUG

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAR	Γ I - TO BE COMI	PLETED BY 1	THE STAT	E SURVEY AGENCY	Facility ID: 00376	
MEDICARE/MEDICAID PROVIDER NO. (L1) 245422 STATE VENDOR OR MEDICAID NO. (L2) 695342500	3. NAME AND ADDRESS OF FACILITY (L3) ELIM HOME - MILACA (L4) 730 SECOND STREET SOUTHEAST, PC (L5) MILACA, MN			O BOX 157 (L6) 56353	4. TYPE OF ACTION: 7 (L8) 1. Initial 7 Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUP	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 03/02/2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds	B. Not in Comp	ce With quirements	n	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A*	6. Scope of Services Limit 7. Medical Director	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 86 (L37) (L38) (L39)	ICF	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE	SHOW LTC CANCELL	ATION DATE):				
17. SURVEYOR SIGNATURE	Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:	
Brenda Fischer, Unit Supervi	sor (03/02/2015	(L19)			
PART II - TO	BE COMPLETEI	D BY HCFA R	EGIONAI	OFFICE OR SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)		PLIANCE WITH O	CIVIL		ial Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 02/01/1987		4. LTC AGREEMI ENDING DAT		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	05-Fail to Meet Health/Safety	
(L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNATIV A. Suspension (L27) B. Rescind Su	of Admissions:	(L25) (L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active	
28. TERMINATION DATE: 29 (L28)	0. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539 3:	2. DETERMINATION C 02/26/2015	OF APPROVAL DA	(L33)	Posted 04/09/2015 Co		



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245422 April 7, 2015

Ms. Laura Broberg, Administrator Elim Home - Milaca 730 Second Street Southeast, P.O. Box 157 Milaca, Minnesota 56353

Dear Ms. Broberg:

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 the above facility is certified for or recommended for:

86 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 86 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 4, 2015

Ms. Laura Broberg, Administrator Elim Home - Milaca 730 Second Street Southeast, P.O. Box 157 Milaca, Minnesota 56353

RE: Project Number S5422025

Dear Ms. Broberg:

On January 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 8, 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 March 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 8, 2015, effective February 16, 2015 and therefore remedies outlined in our letter to you dated January 23, 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.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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 245422	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/2/2015
Name	of Facility		Street Address, City, State, Zip Code	
EL	IM HOME - MILACA		730 SECOND STREET SOUTHEAS MILACA, MN 56353	ST, PO BOX 157

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			Correction Completed 02/16/2015		ID Prefix			Correction Completed 02/16/2015		ID Prefix			Correction Completed 02/16/2015
ū	483.10(b)(5) - (10), 483.10(I	o)(1)		Reg. # LSC	483.20(g) - (j)				Reg. # LSC	483.20(k)(3)(ii)		_
LSC				-	LSC				<u> </u>	LSC			_
ID Prefix Reg. # LSC	-		Correction Completed 02/16/2015		ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 02/16/2015			F0318 483.25(e)(2)		Correction Completed 02/16/2015
ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 02/16/2015		ID Prefix Reg. # LSC	F0371 483.35(i)		Correction Completed 02/16/2015		Reg. #	F0441 483.65		Correction Completed 02/16/2015
ID Prefix Reg. # LSC					Reg.#								
ID Prefix Reg. # LSC			-		ID Prefix Reg. # LSC								
Reviewed By		Reviewed I	Зу	Da	te:	Signature of	f Surve	yor:	-			Date:	
State Agency	,	BF	/KJ	3,	/4/2015			10562				3/2/2	2015
Reviewed By CMS RO	· — [Reviewed I	Зу	Da	te:	Signature of	f Surve	yor:				Date:	
Followup to	Survey Comple			_			-				a Summary of to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 0TUG

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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B. ACCREDITATION STATUS:	(L9)		01 Hospital			` /	22 CLIA		
From (a) :	8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC		03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC			NG DATE: (L35)
18 SNF	From (a): To (b): 12.Total Facility Beds		A. In Compliar Program Re Compliance1. A X B. Not in Com	nce With equirements Based On: ecceptable POC	1	2. Technical3. 24 Hour F4. 7-Day RN5. Life Safet	Personnel RN N (Rural SNF)	6. Scope of Sc 7. Medical Di 8. Patient Roc 9. Beds/Roon	ervices Limit irector om Size
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE	18 SNF 18/19 SNF 86							(L15)	
Austin Fry, HFE NE II O2/23/2015 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) 22. ORIGINAL DATE 23. LTC AGREEMENT OF PARTICIPATION BEGINNING DATE (L24) 25. LTC EXTENSION DATE: (L27) 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L27) B. Rescind Suspension Date: (L28) (L28) (L29) Kate JohnsTon, Enforcement Specialist (L21) 21. I. Statement of Financial Solvency (HCFA-2572) 2. Ownership Control Interest Disclosure Simt (HCFA-1513) 3. Both of the Above: 21. I. Statement of Financial Solvency (HCFA-2572) 2. Ownership Control Interest Disclosure Simt (HCFA-1513) 3. Both of the Above: 22. ORIGINAL DATE 23. LTC AGREEMENT OF PARTICIPATION OF AGRICIPATION OF Merger, Closure O2-Dissatisfaction W/ Reimbursement O4-Other Reason for Withdrawal O7-Provider Status Change O0-Active O4-Other Reason for Withdrawal O7-Provider Status Change O4-Other Reason for Withdrawal O4-Other Reason for Withdrawal O5-Pathor Active O6-Pathor Active O7-Provider Status Change O4-Other Reason for Withdrawal O4-Other Reason for Withdrawal O4-			SHOW LTC CANCELL						
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : —— 22. ORIGINAL DATE 23. LTC AGREEMENT 0F PARTICIPATION 0F PARTICIPATION 0F PARTICIPATION 0F DATE	17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY	AGENCY APF	PROVAL	Date:
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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1034

January 23, 2015

Ms. Laura Broberg, Administrator Elim Home - Milaca 730 Second Street Southeast, P.O. Box 157 Milaca, Minnesota 56353

RE: Project Number S5422025

Dear Ms. Broberg:

On January 8, 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>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;

Elim Home - Milaca January 23, 2015 Page 2

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7338

Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 17, 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 February 17, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Elim Home - Milaca January 23, 2015 Page 4

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 8, 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 July 8, 2015 (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:

Elim Home - Milaca January 23, 2015 Page 5

> Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245422	B. WING			01	/08/2015	
	ROVIDER OR SUPPLIER	·		73	REET ADDRESS, CITY, STATE, ZIP CODE 0 SECOND STREET SOUTHEAST, PO BOX 157 ILACA, MN 56353	915		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TIGITHE APPROPR DEFICIENCY) St. Cloud	3E	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000				
F 156 SS=E	as your allegation of Department's accept bottom of the first pay be used as verification. Upon receipt of an accept it of your facility that substantial comp has been attained in verification. 483.10(b)(5) - (10), 4 RIGHTS, RULES, SE	ance. Your signature at the ge of the CMS-2567 form will on of compliance. Exceptable POC an on-site will be conducted to validate diance with the regulations accordance with your 83.10(b)(1) NOTICE OF ERVICES, CHARGES	F	156	The facility informed residents (R36, R67, R103) of failure to provible them with the advanced beneficia.	ide		
ABORATORY	understands of his or regulations governing responsibilities during facility must also provo notice (if any) of the Standard prior to or upon resident's stay. Receany amendments to inviting. The facility must inform entitled to Medicaid by of admission to the noresident becomes eliptems and services the facility services under which the resident mother items and services the amount of charges the services the amount of charges.	guage that the resident her rights and all rules and gresident conduct and gresident conduct and gresident conduct and gresident etal in the facility. The vide the resident with the State developed under et. Such notification must be a admission and during the sipt of such information, and et, must be acknowledged in etal each resident who is benefits, in writing, at the time eursing facility or, when the gible for Medicaid of the at are included in nursing er the State plan and for any not be charged; those ces that the facility offers ident may be charged, and es for those services; and	og fly Jazli	K dur	notice on 2/5/15. R11 has expired. 2. The facility's business office an social services will inform all residents who receive Medicare F A of their potential for liability SNFABN (CMS) residents both orally and in writing	d eart 0-10055 g at the edicare kly for then	(X6) DATE	
ABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATURE			Administrator	2/	(X6) DATE 3/2015	

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.

If continuation sheet Page 1 of 39

Facility ID: 00376

February 20, 2015

Attention: Brenda Fisher, Unit Supervisor

Milaca Elim Care & Rehab Center POC 2567

Addendum to F278

- (2) All MDS's will have an evaluation of voiding pattern analysis completed from this point forward. Audits will be conducted by verifying correct coding with direct care staff and current care plan.
- (6) Correction will be monitored by DON and RN Staff nurse.

Addendum to F282

(2) All other residents at risk for impaired skin integrity with a Braden score of less than 19 will have a skin assessment completed and care plan will reflect plan of care. All residents will have a skin risk observation completed on admission, Quarterly, Annually, and with significant change. A licenses nurse will perform a skin assessment weekly on each resident and document any skin conditions with measurements, descriptions, and interventions will be implemented care plan will be updated.

Addendum to F 309

(2) All other residents will be monitored for proper positioning in wheelchair as applicable. Referrals will be made to OT for proper positioning devices to ensure maximum health and comfort. Residents will be evaluated by signs and symptoms of pain verbal and non-verbal

All other residents will be monitored for pain using verbal and non-verbal scales. Non-pharmacological will be attempted first to relieve pain. If pain has not subsided, pharmacological measures will then be implemented.

Addendum to F 314

See F282 for additions.

Addendum to F318

All other resident with current ROM programs in place will be evaluated to prevent further decline in ROM. Referrals will be made to OT for proper Interventions. Care plan will reflect plan care.

Addendum to F441

A new infection control policy has been reviewed and update with trend analysis tool to identify initial date of symptoms and what the symptoms are, resident initials, unit, admitted with or acquired, and date of resolution of symptoms.

Correction will be monitored by our Medical Director monthly at our QA meetings.

Brenda, I hope you find this to be a clearer picture of our plan of correction here at Milaca Elim. If you have any further questions or concerns please do not hesitate to call or email me.

Hama Broberg, Administrator. 2/20/15

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		E SURVEY MPLETED
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F 156	inform each resident the items and service (i)(A) and (B) of this so the resident's stay, or facility and of charge including any charge under Medicare or by The facility must furn legal rights which inco A description of the resident's stablishing eligible the right to request a 1924(c) which determinent the cost of the medical care in his ordinate toward the cost of the medical care in his ordinate toward the cost of the medical care in his ordinate toward the cost of the medical care in his ordinate toward the cost of the medical care in his ordinate toward the cost of the medical care in his ordinate toward the cost of the medical care in his ordinate toward the cost of the medical care in his ordinate toward the cost of the medical care in his ordinate toward the state licombudsman program advocacy network, a unit; and a statemen complaint with the Stagency concerning resident to the cost of the state of the s	when changes are made to as specified in paragraphs (5) section. If meach resident before, or ion, and periodically during a services available in the services available in the services not covered to the facility's per diem rate. Is a written description of ludes: Inanner of protecting personal light (c) of this section; Requirements and procedures solility for Medicaid, including in assessment under section innes the extent of a couple's less at the time of a dattributes to the community share of resources which diavailable for payment to institutionalized spouse's reprocess of spending gibility levels. Addresses, and telephone ent State client advocacy State survey and certification ensure office, the State	F 15	4. Completion Date: 2/16/15 5. Correction will be monitore by the Director of Social Services and Administrator. 6.Issues detected in audits w reported to QA committee for improvement suggestions.	ill be	

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	Continued From page facility, and non-compliance facility must information, and physician responsible. The facility must promovitten information, an applicants for admissinformation about how Medicare and Medicare and Medicare receive refunds for production of the such benefits. This REQUIREMENT by: Based on interview and facility failed to provide Nursing Facility Advance (SNFABN) upon term skilled services, to 5 R103, R10 and R67)	be 2 bliance with the advance of the way of contacting the efor his or her care. Ininently display in the facility and provide to residents and	F 15	DEFICIENCY)	PPROPRIATE	DATE
	services on 7/26/201 facility. R36's repres Care & Rehab Cente Non-Coverage form Medicaid Services (C via telephone. The fand/or her legal repre (CMS)-10055 to information of the services of	from Medicare Part A 3, and remained in the entative was given the Elim r, Notice of Medicare [Centers for Medicare and EMS)-10123] on 7/24/2014 acility did not provide R36 esentative with a SNFABN m her of potential liability for seven though they remained				

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F 156	in the facility. R11 was discharged services on 1/7/2015. R11's representative Elim Care & Rehab Control R11 and/with a SNFABN (CMS potential liability for not provide R11 and/with a SNFABN (CMS potential liability for not hough they remained R103 was discharged services on 10/29/20 facility. R103 was given a Rehab Center Non-Coverage form of did not provide R103 representative with a inform her of potential services on 12/19/20 facility. R10 was given a R10 was discharged services on 12/19/20 facility. R10 was given a R10 was discharged services on 12/10/20 facility. R10 was given with a inform her of potential services even though R67 was discharged services on 12/10/20 facility. R67 was given was given was given as given was given was given as given and the facility. R67 was given was given as given as given was given as giv	from Medicare Part A and remained in the facility. was given and signed the center, Notice of Medicare on 1/5/2015. The facility did or his legal representative S)-10055 to inform him of on-covered services even d in the facility. If from Medicare Part A 14, and remained in the ven and signed the Elim r, Notice of Medicare on 10/27/2014. The facility and/or her legal SNFABN (CMS)-10055 to all liability for non-covered they remained in the facility. If from Medicare Part A 14, and remained in the en and signed the Elim Care ice of Medicare on 12/17/2014. The facility and/or her legal SNFABN (CMS)-10055 to all liability for non-covered they remained in the facility and/or her legal SNFABN (CMS)-10055 to all liability for non-covered they remained in the facility. If they remained in the facility remained in the facility of they remained in the facility.	F	156		

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F 156	inform her of potentia		F 15	56		
	registered nurse (RN) whose skilled service the facility's liability not to that service ending resident's PT/OT (phy therapy) was ending, resident remained in resident, or the representation of the "Elim Care & Reh Medicare non-Coveration".	rsical or occupational for example, and the the facility, "I would give that sentative, the liability notice." form given to residents was ab Center, Notice of tige" form, or CMS-10123.				
	the director of nursing aware of which liabilit receiving, but said "I of been giving the corre would have to look at	n 1/8/2015 at 10:30 a.m., g (DON) stated she was not y notice form residents were understand we have not ct one." The DON said they the process and make a I think this would be an easy prected."				
F 278 SS=D	stated the facility did related to resident lial they follow the federa 483.20(g) - (j) ASSES ACCURACY/COORE		F 27	78		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G	(X3) DATE COMI	E SURVEY PLETED
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F 278	resident's status. A registered nurse meach assessment with participation of health. A registered nurse meassessment is completed in individual who cassessment must signed that portion of the assumation of th	ust conduct or coordinate in the appropriate in professionals. ust sign and certify that the eted. completes a portion of the in and certify the accuracy of sessment. Medicaid, an individual who by certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who by causes another individual individ	F 27	1. Resident (R16) had an ME modification completed 2/2/1 urinary status. Staff will ensu documentation of continence resident's (R16) MDS by folloquarterly report. Resident (R16) will have an evaluation voiding patterns to assess continence status. 2. All other residents in facilithave an evaluation of voiding analysis completed with each from this point forward.	5 to correct re proper status in owing of ty will g pattern	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282 SS=D	10/17/14, included the continent of urine. He note dated 10/22/14,always incontinent. When interviewed on MDS coordinator (RN been coded as alway always continent of u nurses working on the in the computer that t unless you check everrors. "RN-B did ndirect care staff in coauto-fill property of the system. The Resident Assess dated 12/2014, include assessment of urinar medical record for blarecords of flow sheet progress notes, phys exams. "Ask dire work with the resident incontinence episode 483.20(k)(3)(ii) SERV PERSONS/PER CAFT The services provided must be provided by accordance with each care.	e resident was completely bewever, R16 's progress "Quarterly MDS completed of bowel and bladder " 1/8/15, at 9:23 a.m. the 1/8-B stated R16 should have so incontinent of urine versus rine. RN-B stated the elfloor fill out assessments ransfer into the MDS and, "bry answer, there could be not review records or talk with ding, but relied on the elfacilities medical record ment Instrument Manual ded instructions for y incontinence, "Review the adder or incontinence so, nursing assessments and ician history, and physical ct care staff who routinely ton all shifts about so." VICES BY QUALIFIED RE PLAN d or arranged by the facility	F 278	by verifying incontinence status with direct care staff. Staff will be educated on the importance or proper documentation or incontinence status. 4. Audits will be conducted by vericorrect coding with direct care staff weekly for one month, then monthly months, then quarterly until consist compliance is achieved. 5. Completion Date: 2/16/15 6. Correction will be monitored by and MDS Coordinator 7. Issues detected in audits will be reported to QA committee for improvement suggestions	h e of of fying f y x3 tent
	1 -	n, interview, and document		<u> </u>	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 282	review, the facility interventions to predevelopment, prev falls out of a chair reviewed for care previewed Alzheimer's diseas assistance for all A of range of motion and was at risk for had any falls since R16's care plan da for falls r/t [related hallucinations, delumech [mechanical] cognitive impairment needed] pain mederisk. Use of broda chair] d/t [due to] legistory] of fall out instructed from the to, "May remove Hift] sling when in we sliding down in whomat] in w/c [wheel sliding in chair."	failed to follow care plan event pressure ulcer ent skin irritation, and prevent for 1 of 10 residents (R16) clan implementation. Inimum Data Set dated, severe cognitive impairment, se, required total staff (IDL's, had functional limitations (ROM) of upper extremities, pressure ulcers. R16 had not the prior assessment. Inted 10/22/14, included, "At risk to] falls/crawls out of bed, usions, limited mobility, needs as set for transfers, severe ent, scheduled and PRN [as is [medication]. Fall risk, high [brand name reclining wheel eans forward, comfort and HX of wheel chair." Staff were in "Impaired Mobility" care plan over [brand name mechanical wheel chair d/t scooting and eel chair. Dycem [non skid chair] to keep resident from	F 2	6/6	mprehensive skin ed 2/2/15. was updated. will be monitored velopment. ned and in their skin ted on proper s, which is equal to not per ed weekly for one ly x3 months the stent compliance 2/16/2015 monitored by DON s. audits will be nittee for	ne en is	
	included, "At risk fo	re plan dated 10/22/14, or skin breakdown R/T limited ere directed to turn and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 282	use "peri wipes" (pon her skin. R16's nursing assi included, to reposi and "Must have dy R16 was observed at 7:14 p.m. the ba approximately 45 of the chair so that he front of the chair, a Activity aide (AA)-7:15 p.m., but did	hours while awake and not to bre-packaged cleansing wipes) stant care sheet dated 1/7/15, tion every 2 hours while awake, from mats in geri chair." If on in a Broda chair on 1/5/15, ack of the chair was reclined degrees. R16 had slid down in the buttocks was toward the and was lying almost flat. A stopped and talked to R16 at not assist her up into the chair.	F 28	12			
	chair and pulled he without assisting he p.m. NA-H and NA mechanical lift. It did not have any control of the second seco	ng assistant (NA)-G took R16's er backwards down the hall her up into the chair. At 7:25 hal assisted R16 to bed using a was noted R16's Broda chair lycem in it. If for morning cares on 1/7/15, NA-A and NA-B. NA-A used cleansing cream to wash cks. R16 was assisted in the 5 a.m. without any dycem in the che lift sling. R16 was then room until 8:50 a.m. at which light to the dining room. R16 ning room until 9:25 a.m. where to the day room again. R16 ay room until 9:39 a.m. at which light to the chapel. At 10:57 hin brought to the beauty shop					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	IPLE CONSTRUCTION NG	COMPLETED
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F 282	where she remained was brought to the activity. R16 slept until 11:51 a.m. at the dining room. R room until 12:48 p. brought to her room without being reposassisted R16 into be under the sling or continent of a small her buttocks and p NA-B with peri-wip repositioned R16 a gotten up in the changened between activities of the down to get her off. When interviewed MDS coordinator (out in a rash from this is why they we RN-B stated R16 shouts every 2 horeakdown. RN-B worksheet and staindicate the peri-well R16. The nurse air rather than the car R16 was observed a.m. with the direct (RN)-A, and NA-B. R16 had been reporning. NA-B stated R16 had been reporning.	age 9 ad until 11:33 a.m. when she nurse 's station for a reading in the chair during the activity, which time she was brought to tate remained in the dining m. at which time she was m, 4 hours and 23 minutes sitioned. NA-A and NA-B bed, there was still no dycem on top of it. R16 was hall amount of loose stool on heri-area which was removed by hes. NA-A stated they had not hat any time since she had hair at 8:25 this morning, 4 hetes ago. NA-A stated R16 had here has hall had broken here were unable to catch here here. Normally they would lay here here buttocks every 2 hours. Horn 1/8/15, at 9:23 a.m. the here peri wipes back in 2011 and here not to be used for peri-care. Hours to prevent skin reviewed the nurse aide heted the worksheet failed to hipes should not be used for here des would refer to this sheet, he plan for routine care. If or pericare on 1/8/15, at 9:42 hor of nursing, registered nurse here director of nursing stated here on 1/7/15 in the here ated R16 had not actually been hall had not actually been hall had not actually been hall boosted up in the chair, this	F2	282	

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
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F 282 F 309 SS=D	RN-A stated R16 sho hours and peri-wipes stated R16 should ha mechanical lift sling a was not present at th A policy was requeste facility. 483.25 PROVIDE CA HIGHEST WELL BEI Each resident must re provide the necessar or maintain the highe mental, and psychosol	ed pressure on her buttocks. uld be repositioned every 2 were not to be used. RN-A ve dycem under the is well as on top, but this is time either. ed but not provided by the IRE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical,		1. Resident (R16) care plupdated by staff for whee positioning and the Dycereplaced to prevent slippi Resident (R73) care plan updated to add a back pi with anti-thrust cushion to proper positioning in chai	lan was elchair m was ing in chair. I was llow along o ensure	
	by: Based on observation review, the facility fair chair positioning for 2 R73) who were review addition, the facility far management to allow of motion (PROM) arresidents (R16) review Findings include: Wheel Chair Position R16 's quarterly Minim 10/17/14, included see	or comfort with passive range and the defendence of the defendence		Resident (R16) was screen occupational therapy on bilateral hand contracture received new orders for smedication on 1/9/15.	1/8/15 for es. Resident	ain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 1 MILACA, MN 56353			
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F 309	MDS included R16 w staff for all activities of R16 's Impaired Mobi 10/22/14, included, "[mechanical lift sling] [due to] scooting and Dycem in w/c [wheel sliding in chair." R16 's At Risk for Fal included, "Broda chair licluded, "Broda chair." R16's nurse sincluded, "Must have R16 was observed in 7:14 p.m. the back of approximately 45 deg the chair so that her befont of the seat and short At 7:16 p.m. nursing wheel chair and pulle hall, without assisting At 7:25 p.m. NA-H arbed, utilizing a mechait was noted, there we the mechanical lift slim. R16 was observed or 8:28 a.m. for morning assisted R16 into the mechanical lift at 8:24 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling, no sling was left under Fall in the mechanical lift at 8:25 under the lift sling in the mechanical lift at 8:25 under the lift sling in the mechanical lift at 8:25 under the lift sling in the mechanical lift at 8:25 under the lift sling in the mechanical lift at 8:25 under the lift sling in the mechanical lift at 8:25 under the lift sling in the mechanical lift at 8:25 under the lift sling in the mechanical lift at 8:25 under the lift sling in the mechanical lift at 8:25 under	as totally dependent upon if daily living (ADL's) lity care plan dated May remove Hoyer sling when in wheel chair d/t sliding down in wheel chair. chiar] to keep resident from Is care plan dated 10/22/14, ir [a large reclining wheeledskid mat) mats in geri aide worksheet dated 1/7/15, dycem mats in geri chair." a Broda chair on 1/5/15, at the chair was reclined grees. R16 had slid down in buttocks was towards the she was lying almost flat. It topped and talked to R16 at assist to sit back into chair. assistant (NA)-G took R16 's do her backwards down the R16 to sit upright in chair. In anical lift. Once lying down, as no dycem under R16 or ang. In 1/7/14, from 8:13 a.m. until process. NA-A and NA-B Broda chair with a sa.m. There was no dycem or on top of the sling, the	F 3		 All other residents will be monit to ensure proper wheele positioning and will be referred therapy if needed. Staff will be re-educated on monito for signs and symptoms of pain, we and nonverbal, during completion restorative programs. Audits conducted weekly for one month, then monthly x3 months, the quarterly from then on to ensure p compliance with wheelchair position and pain management. Completion date: 2/16/15 Correction will be monitored by and Nurse Unit Managers Issues detected in audits will be reported to QA committee for improvement suggestions 	chair that to oring erbal of enen roper oning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245422	B. WING			01/08/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 730 SECOND STREET SOUTHEAST, F MILACA, MN 56353			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	down in her Broda was at the front of the left arm rest. No resident, and she was mechanical lift sling. R16 was observed registered nurse (Foursing had assisted into bed. There was without the was a stated there should mechanical lift sling from sliding down in had been placed a chair. RN-A verification in her chair. R73's quarterly Min 10/1/14, included rowith diagnoses of muscular coordina (painful swelling of R73 required extert to or from bed, challo also identified R73 knee, ankle, foot) in R73's Mobility care the following intervariansfers, physical mobility, and occuranti-thrust cushion promote R73 to sit R73 was observed.	s in the day room, and had slid chair to where her buttocks the seat, her head was lying on to Dycem was noted under was sitting on a blue	F 30				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245422	B. WING _			01/08/2015		
	ROVIDER OR SUPPLIER			730 \$	EET ADDRESS, CITY, STATE, ZIP CODE SECOND STREET SOUTHEAST, PO BOX 157 ACA, MN 56353			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 309	back of his wheelchal touching the back of was in the hallway sli and was not sitting in On 1/8/15, at 8:49 a.r. dining room eating broom not back in his wheelposition, sliding down During interview on 1 stated that R73 often wheelchair throughout When interviewed on stated it is hard to getwheelchair because in During interview with therapist assistant (Ca.m. COTA-B stated to contracted knees and his wheelchair. We held foot pedals to keep held an anti-thrust cushion promote an upright sides down in his chacked to position himself sides down in his chacked to his wheelchair and is for his wheelchair.	and (NA)-B. After the vere not positioned into the ir, his lumbar area was not the chair. At 8:22 a.m. R73 ding down in his wheelchair, an upright position. m. R73 was observed in the eakfast. R73's hips were chair and was in a reclining in his wheelchair. ////15, at 7:45 a.m. NA-D slides down in his it the day. 1/7/15, at 8:25 a.m. R73 to comfortable in my my knees bother him. certified occupational OTA)-B on 1/8/15, at 10:00 the resident had very I he often sits sideways in lave placed a cushion on his is feet in place and are using in on his wheelchair seat to	F	309				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245422	B. WING_			01/	08/2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	wheelchair with his hi back of the wheelchair often slides down in hanti-thrust cushion, w wheelchair. COTA-B in an upright position reposition R73 in his vibe touching the back in an upright position. R73 was observed in therapy assistant (PT a.m. (30 minutes afte COTA-B and NA-D) in his wheelchair. When interviewed (P' a.m. PTA-D stated R7 wheelchair. PTA-D s pillow/support would be prevent him from slidit PTA-D asked R73 to wheelchair with his arreposition himself. A discussion was held pillow/cushion for R73 with COTA-B and PTA both agreed that a babeneficial for R73 to grow in his wheelchawork, then occupation ordering a new wheel prevent him from slidit	r3 was sliding down in his ps were not touching the ir. COTA-B stated R73 its chair and she added an hich was currently in R73's agreed R73 was not sitting and found NA-D to help wheelchair so his hips would of his wheelchair and sitting his wheelchair with physical rA)-D on 1/8/15, at 10:43 r being repositioned by R73 was again sliding down TA)-D on 1/8/15, at 10:43 r3 was sliding down in his uggested a back be beneficial for R73 to help ing down in his wheelchair. push himself back into his rms, but R73 was unable to d in regards to a back 3 on 1/8/15, at 11:03 a.m. A-D. COTA-B and PTA-D inck pillow/support would be prevent him from sliding iir. If the support did not	F	309			
	PAIN						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245422	B. WING _			01/08/2015	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	R16's quarterly Minir 10/17/14, included set Alzheimer's disease, from staff for all activ had functional limitat (ROM) of both upper have any pain. R16's Pain care plan "At Risk For Alteratio hand contractures, Staff were directed, of skin palm protectors further contractures. staff rub lotion on he warmth of a blanket also helps to relieve R16's progress note "Pain; no pain indica assessment period." R16 was observed for at 8:13 a.m. with nu NA-B. NA-B placed toothette (a small sp attempted to shove ir out, "Ouch, there are me and you are doin hands are so tight, e and clean them, she NA-B stated they are	num Data Set (MDS) dated evere cognitive impairment, required total assistance ities of daily living (ADL's), ions of range of motion extremities, and did not dated 12/18/12, included, in in Comfort RT [related to] IX [history] of pain in hands." dated 12/18/12, to "Sheep to both hands to prevent Resident also enjoys having rhands, very lightly. The over the resident's hands pain." dated 10/22/14, included, tors reported in this or morning cares on 1/7/15, rsing assistant (NA)-A and some cleansing cream on a onge on a stick) and tinto R16's fists, R16 cried to bad reindeer that try to hurt g that." NA-B stated R16's very time they try to open "fights," she has pain. a able to, "pry" them open	F3				
	bath day, "but barely	get her fingernails cut on ," it hurts her too much. nave wash cloths placed in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245422	B. WING _		0	1/08/2015
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 730 SECOND STREET SOUTHEAST, PC MILACA, MN 56353		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	are done." NA-A sta hands are touched, R16 was observed f a.m. NA-A and NA-E	gets them out as soon as we ated R16 hates it when her it hurts. For cares on 1/7/15, at 12:48 B assisted R16 into bed.	F3	309		
	asked about PROM to do it either with m but only if R16 is sle PROM on R16's has because, "she does she has pain, she of the wash cloth in me gets really agitated attempted to open F "owe, stop hurting nattempted with R16" out. NA-A and NA-I this to the nurses ar	for R16. NA-A stated they try for R16. They are unable to do for R16. They are unable to the R16. They are unable to they have reported and the nurses know she has at washing R16's hands and				
	Screen form dated	ng Referral For Therapy 7/7/09 indicated R16 was ger separators. Therapy then ctor," for left hand.				
	1	on 1/7/15, at 1:36 p.m. RN-A aware R16 was having any I to her hands.				
	When interviewed coccupational therap	on 1/8/15, certified ist (COTA)-A stated six				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245422	B. WING			01/	08/2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	she did not have any aware R16 was resis should only attempt v R16 had a behavior p	e 17 looked at R16's hands and contractures. She was tive to PROM and staff when the resident is sleeping. It is sleeping to the n't feel it was pain related.	F	309			
	stated R16 gets sche times a day at 8:00 a p.m. This would not were attempting to w bedtime cares, or PR made to offer pain me hand care or PROM.	1/8/15, at 9:16 a.m. RN-A duled pain medication three .m., 2:00 p.m. and 10:00 coincide with when staff ash hands for morning and OM. No attempts had been edication prior to attempting No non-pharmacological irm towels to hands prior to l.					
	stated she was in change nursing program. Sh	e evaluates the residents t aware R16 was having pain					
	hands to determine if 2011, on 1/8/15, at 1/ R16 cried out, "It hur attempt at PROM wa stated, "She is having for contracture at this would contact the nu pain medication with	perform PROM on R16's more contracted than in 0:25 a.m. During the attempt is so bad, I can't do it." The sidiscontinued. COTA-A gipain, we can't assess her point." RN-A stated she rise practitioner to coordinate PROM and hand care, as rm towels to hands prior to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245422	B. WING _		01/08/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 730 SECOND STREET SOUTHEAST, MILACA, MN 56353	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETION DATE
F 309	Continued From page		F3	009	
F 314 SS=D	facility. 483.25(c) TREATM PREVENT/HEAL Pl Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores reces services to promote prevent new sores for	rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and healing, prevent infection and	F3	Resident had a completed 2 Resident's care plan was All other residents will pressure ulcer development will be turned and reposit their skin assessment. Staff will be educated off-loading techniques, wone minute per patient per second sec	violated. be monitored for ent. Residents ioned based on enterprise on proper which is equal to
	review, the facility fa assistance with repulcer development of reviewed for pressure. Findings include: R16 's quarterly Min 10/17/14, included of disease. R16 had s was totally dependent issues, and was at development. R16 's Pressure Uld (CAA) dated 7/30/1 risk for skin breakdo	ion, interview, and document ailed to provide timely ositioning to prevent pressure for 1 of 2 residents (R16) are ulcer risk. Inimum Data Set (MDS) dated a diagnosis of Alzheimer 's evere cognitive impairment, ent upon staff for all mobility risk for pressure ulcer Der Care Area Assessment 4, included, "Resident is at own. Resident requires total ff for toileting. Resident is		turn/reposition. 4. Audits conducted of month, then monthly of quarterly until consistent achieved. 5. Completion date: 2/16 6. Correction will be more and Nurse Unit Managers 7. Issues detected in audition reported to QA committee improvement suggestion.	3 months then tompliance is 6/15 sitored by DON dits will be e for

AND DUAN OF CODDECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245422	B. WING		·	01	/08/2015
	ROVIDER OR SUPPLIER			73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 SECOND STREET SOUTHEAST, PO BOX 157 ILACA, MN 56353	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	always incontinent of incontinent of bladder void in the bedpan but need for toileting know impairment. Resident toileted every 2 hours [afternoons] and ever Resident has a hx [hit periarea. Staff applie every incontinent episintegrity. Resident all ulcer to coccyx." R16 's At risk for skin 10/22/14, directed stareposition] A2 [assist and 3 hours on nocs res [resident], use was R16's nurse aide wor included a need to reawake and every 3 hours and every charworksheet failed to in be used for R16. R16 was observed for at 8:13 a.m. with nurs NA-B. R16 was note on left hip (approximate and on coccyx (approximate and on coccyx (approximate and on coccyx area had a approximate and on coccyx area had a approximate and on coccyx area had a positive area on in the coff with pericare. NA cleansing cream to wo oxide cream. R16 was wheeled chair (a BrownA-A and NA-B utilizing the side of the	bowel and frequently T. Resident will seldomly It is unable to make her It wn d/t [due to] cognitive It is checked/changed or It is on days and pms It is on days and pms It is on days and pms It is on the self of the self of the self of the self It is on the self of the se	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		245422	B. WING _			01/08/2015	
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA				STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 314	R16 remained in the where she was brought female in the which time she was 10:57 a.m. R16 was room. At 10:58 a.m. beauty shop where when she was brought a reading activity. If the activity, until 11: brought to the dining dining room until 12 was brought to her hassisted R16 into be R16's left hip and a small amount of loo peri-area which was peri-wipes. Zinc oxi stated they had not since she had gotte hours and 23 minute R16 should be repound for activitie and to get her hair activities and the get her hair activities an	as brought to the dining room. de dining room until 9:25 a.m. aght to the day room again. de day room until 9:39 a.m. at brought to the chapel. At again brought to the day again brought to the day again brought to the she remained until 11:33 a.m. aght to the nurse 's station for all 6 slept in the chair during 51 a.m. at which time she was ag room. R16 remained in the as again brought to the she remained until 11:33 a.m. aght to the nurse 's station for all 6 slept in the chair during 51 a.m. at which time she agenome. R16 remained on be shown and NA-B and NA-B and The red area remained on be shown and NA-B and The red area remained on be shown and shown a	F3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245422	B. WING		01/08/2015		
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 314	rather than the care p R16 was observed fo a.m. with the director (RN)-A, and NA-B. T R16 had been reposit morning. NA-B stated repositioned, but only would not have reliev R16's left hip was pin pressed by RN-A. Th and the white area in than white, this area t by RN-A. When inter should be repositioned peri-wipes were not to A skin care/pressure but not provided by th 483.25(e)(2) INCREA IN RANGE OF MOTION Based on the compressident, the facility m with a limited range of	Ian for routine care. In pericare on 1/8/15, at 9:42 of nursing, registered nurse the director of nursing stated dioned on 1/7/15 in the did R16 had not actually been boosted up in the chair, this ted pressure on her buttocks. In the skin blanched when the coccyx area also was pink the center was more pink the center was more pink the oblanched when pressed viewed RN-A stated R16 did every 2 hours and to be used. In the facility. In the skin blanched the skin blanched when the coccyx area also was pink the center was more pink the canter was more pink to blanched when the canter was more the canter was more pink to blanched when the canter was more pink to blanched was pink the canter was more pink to blanched was pink the canter was more pink to blanched was pink the canter was more pink to blanched was pink the canter was more pink to blanched was pink the canter was more pink to	F 3-	14	or dent d pain ample		
	by: Based on observatio review, the facility fail			and will receive sufficient pain management techniques, non-pharmacological and pharmacological, before therapie			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245422	B. WING _		01/	/08/2015	
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353				
(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 X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 318	Findings include: R16's quarterly Minim 10/17/14, included se Alzheimer's disease, from staff for all activi had functional limitati (ROM) of both upper passive ROM 6 out o R16's Restorative Nu 7/30/14, included, "Docontractures, Severe R16's goal was, "To ropen hands to allow Staff were instructed, motion] to all extremitivice a day] daily The napping/sleeping per d/t [due to] resident be Resident has rolled uprevent further contractive Nursing: BID daily. Goal is to to open hands to allo and prevent further heffective." R16's Pain care plan "At Risk For Alteration hand contractures, H Staff were directed, coskin palm protectors further contractures. staff rub lotion on her	num Data Set (MDS) dated overe cognitive impairment, required total assistance ties of daily living (ADL's), ons of range of motion extremities and received a f the 7 assessment days. rsing Care Plan dated ones not walk, hand cognitive impairment." naintain ability for resident to staff to wash them well." "PROM [passive range of ties for 15 min [minutes]/BID ry ROM to hands when OT [occupational therapy] eing resistive at times. p wash cloths in hands to	F3	3. Staff will be re-educate importance of restorative the signs and symptoms nonverbal pain. 4. Audits conducted week month, then monthly x3 mquarterly from then on to compliance with pain mar restorative programs. 5. Completion Date: 2/16, 6. Correction will be moniand Nurse Unit Managers. 7. Issues detected in audit reported to QA committee improvement suggestions.	programs and of verbal and all of verbal all of verbal all of verbal and all of verbal and verbal and verbal all of verbal and v		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		245422	B. WING _			01/08/2015	
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX MILACA, MN 56353				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 318	also helps to relieve R16 was observed on her hands in fists. R16 was observed for at 8:13 a.m. with nur NA-B. NA-B placed toothette (a small spot attempted to shove if out, "ouch, there are me and you are doin hands are so tight, erand clean them, she NA-B stated they are with a lot of effort to go bath day, "but barely wash cloths placed in them out as soon as R16 hates it when he hurts. Morning cares a.m. and R16 was brawaiting breakfast. R16 was observed for a.m. NA-A and NA-B When cares were con asked about PROM to do it either with mobut only if R16 is sleen PROM on R16's han because, "she doesn's he has pain, she can the wash cloth in mon gets really agitated an attempted to open R "owe, stop hurting mattempted with R16's services."	or morning cares on 1/7/15, sing assistant (NA)-A and some cleansing cream on a onge on a stick) and into R16's fists, R16 cried bad reindeer that try to hurt g that." NA-B stated R16's very time they try to open "fights," she has pain. able to, "pry" them open get her fingernails cut on." R16 is supposed to have a her hands, but, "she gets we are done." NA-A stated or hands are touched, it is were completed at 8:25 ought to the day room or cares on 1/7/15, at 12:48 assisted R16 into bed. They are unable to do ds, for over 6 months, it let you get into her hands, it let you get into her hands, it open them, we can't get st of time, or once in, she and suddenly it is out." NA-A 16's left hand, R16 cried out,	F3	18			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245422	B. WING _			01/08/2015	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353				
(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 ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 318	this to the nurses and pain with attempts at attempting PROM. A Pro Rehab Nursing Screen form dated 6 hand middle finger w not indicate the other contracted. A Pro Rehab Nursing Screen form dated 7 having pain with fingissued, "palm protect no mention about the were contracted on the were contracted on the were contracted on the were contracted on the were day and evening. Staff were day and evening, to check skin each shift which hand or finger were no further there contractures. R16's Point of Care I revealed R16 was reminutes twice a day, which joints were be when interviewed or stated she was awar having trouble getting R16's hands, but did	d the nurses know she has washing R16's hands and Referral For Therapy (4/09, indicated R16's left as contracted. The form did fingers, or right hand were Referral For Therapy (7/09 indicated R16 was er separators. Therapy then tor," for left hand. There was eright hand or what fingers he left hand. Referral For Therapy (7/11 indicated R16 had an mand ROM while R16 is instructed to wash hands apply palm protectors, and to the form did not indicate to were contracted. There apy notes regarding hand History, Restorative Nursing ceiving PROM for 8-20 The report did not identify	F3	318			
	stated there would b	e no way to tell from the rif the PROM was being					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245422	B. WING			01/08/2015		
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 318	When interviewed o occupational therap months ago she had she did not have an aware R16 was resishould only attempt R16 had a behavior resistiveness and did When interviewed of stated R16 gets schitimes a day at 8:00 p.m. This would now were attempting to we bedtime cares, or Promade to offer pain in hand care or PROM methods (such as we cares) had been tried. When interviewed of stated she was in clausing program. Since your program. Since you with PROM or hand evaluation she look. Restorative Nursing being completed. Finally was for them joints. RN-B stated hands for quite som 2011 she had devel her finger related to	hands or just her other joints. In 1/8/15, certified ist (COTA)-A stated six d looked at R16's hands and y contractures. She was stive to PROM and staff when the resident is sleeping. problem leading to the dn't feel it was pain related. In 1/8/15, at 9:16 a.m. RN-A leadled pain medication three a.m., 2:00 p.m. and 10:00 to coincide with when staff wash hands for morning and ROM. No attempts had been nedication prior to attempting l. No non-pharmacological warm towels to hands prior to add. In 1/8/15, at 9:23 a.m. RN-B harge of the restorative she evaluates the residents of aware R16 was having pain care. When she does her is at the Point of Care History, report. It looked like it was a RN-A stated there would be no report if the PROM was a shands or other joints. The to do bilateral upper extremity R16 has had contracted le time and back in May of oped pressure ulcers between the contractures. She did not actures were more contracted	F 3	18				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245422	B. WING _		01/08/2	015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BO MILACA, MN 56353	X 157	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) MPLETION DATE
F 318	COTA-A attempted to hands to determine if 2011, on 1/8/15, at 10 R16 cried out, "It hurt attempt at PROM wa stated, "She is having for contracture at this would contact the nur pain medication with well as see about wa attempts. Because of PROM, they were un a decline in ROM of the Even though the faciliplan that she experied identified hand pain washing hands, and ordered PROM, the francische production of R16's pain and/or off R16's hands from be 483.25(h) FREE OF HAZARDS/SUPERV. The facility must ensien vironment remains as is possible; and eadequate supervision prevent accidents.	perform PROM on R16's more contracted than in 0:25 a.m. During the attempt is so bad, I can't do it." The s discontinued. COTA-A g pain, we can't assess her point." RN-A stated she rese practitioner to coordinate PROM and hand care, as rm towels to hands prior to if R16's pain with attempt at able to determine if she had he hands. ity was aware from her care nced hand pain, staff with attempts at PROM and were unable to perform the acility failed to address er any alternatives to prevent coming more contracted. ACCIDENT ISION/DEVICES ure that the resident as free of accident hazards	F3		Illing out 5. aff traint cted 1/8/15 nts had	
	by: Based on observation	on, interview, and document led to comprehensively		diassessed positioning device		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245422	B. WING		01/08/2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	O BE COMPLETION
F 323	reduce the risk of injuresidents (R7) review hazards. Findings include: R7's quarterly Minimal 12/2/14, identified he memory problems, who for transfers and bed to buring observation of was in bed with his estable the low position (clost placed against the wipillows shoved under left side causing the one side at approximal When interviewed or registered nurse (RN a fall from his bed on found by staff lying of Subsequent observation, and of morning a.m., found R7 to be cushion wedge placed again causing the material of the province of	plement interventions to arry and falls for 1 of 3 and falls for 1 of 3 and falls for 2 of 3 and 5 and	F 324	3. Reoccurrence will be prevented by providing sufficie education for staff members. 4. Audits conducted weekly for month, then monthly x3 months quarterly from then on to ensure no positioning devices have been implemented without proper assessment. 5. Completion Date: 2/16/15 6. Correction will be monitored by and Nurse Unit Managers 7. Issues detected in audits will reported to QA committee for improvement suggestions	one then
	identified R7 was, " NAR Inursing assista	noted on floor at 0740 by			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245422	B. WING			01/	08/2015
	ROVIDER OR SUPPLIER			7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 SECOND STREET SOUTHEAST, PO BOX 157 IILACA, MN 56353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	pushed parcially [sp] on floor by res." The obtained minor injury care plan was being f R7's care plan, dated at risk of falling due to mobility, bowel and ble medication use, and a transfer out of bed un identified of, "Resider crawling out of bed or interventions of, "Free out of bed and bring to "Resident sleeps in low mat on floor near bed The care plan did not placing rolled pillows under R7's mattress to out of bed. R7's Nursing Observator 12/8/14, identified R7 admission, but was defor falls. The assessment reventions to be us falls, including the use cushion wedges being mattress to prevent house to keep R7 from floor, and had been in falls.	one mat, the other mat against door, wedge laying report identified R7 from the fall, however the ollowed. 12/23/14, identified R7 was a decreased physical adder incontinence, a history of attempting to assisted. A goal was at will not injure self when not mat", and indicated quent checks, if restless get	F	323			
	stated staff had been	using the pillows and wedge nattress for the past few					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245422	B. WING _			01/08/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 730 SECOND STREET SOUTHEAST, PO MILACA, MN 56353			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	months to keep his wasn't there, he wasn't the proper steps. Months to keep his wasn't the proper steps wasn't the wasn't the wasn't the proper steps. Months to keep his wasn't the proper steps. Months to keep his wasn't the wasn't the proper steps. Months to keep his wasn't the proper steps.	m from falling out of bed, "If it ould roll out onto the floor." n 1/7/15 at 12:15 p.m., licensed PN)-A stated in the past R7 thion for his positioning in bed, not be placed underneath his nim in bed. on 1/7/15 at 12:30 p.m., RN)-A stated she was unaware was and wedge cushions being mattress to prevent him from however would speak to the ewhy it was being done. It interview on 1/7/15 at 1:24 she was unable to determine staff to use the devices, but that orted he (R7) was trying to crawl mattress side one day and she was expected by the potential for increased ows and wedge cushion placed attress because he could fall vation. Using the devices in this appropriate and could be more	F 3.	23			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245422	B. WING		01/08/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 15 MILACA, MN 56353	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 COMPLETION	1
F 323 F 371 SS=E	authorities; and	CURE, ERVE - SANITARY sources approved or by by Federal, State or local stribute and serve food	F 3:		orne food s. The and	
	by: Based on observation review, the facility fails to an internal temperal least 15 seconds to prillness for 16 of 76 rest foods on a regular base. Findings include: During observation of at 11:23 a.m. cook (C precooked carrots from placed the carrots into approximately 50 second carrots out of the microus plate for resident contempt to take the teleptore serving the food asked C-A to check the carrots. C-A obtained	the main kitchen on 1/7/15,)-A removed a baggie of m the freezer. He then o the microwave for onds. After taking the rowave, they were placed on insumption. C-A made no imperature of the food indicate the surveyor		 All other residents who are identified of the potential for foodb illness will receive services that fo food safety policies and procedures All dietary staff were educated and trained on the proper procedures for reheating foods on 1/7/15 CDM or designee has develope auditing tool and started auditing service/reheating foods immediate and will continue to do so three tir per week for one month and then weekly for three months to ensure compliance or until considered response. 	d an neal ly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245422	B. WING	B. WING		01/08/2015	
	ROVIDER OR SUPPLIER			73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 SECOND STREET SOUTHEAST, PO BOX 157 IILACA, MN 56353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 371	placed the carrots ba approximately 50 sec carrots from the micro temperature again. I degrees F. C-A agair into the microwave fo The temperature was plate was then served C-A stated they do not the food they microwasteaming when it com "we do not temp [tem During interview on 1 stated they do not ha cooked in the microw items are precooked residents who do not meal. When interviewed on aide (DA)-B stated we in the microwave for a During observation or retrieved eight individ noodles from the free individual servings int placed these bags int taking the temperatur a.m. C-B grabbed the the steam table and p She then grabbed Alf refrigerator and place then proceeded to place on a plate without che ensure it was 165 degrees.	was not hot enough and ck into the microwave for onds. He then removed the owave and took the femperature was 120 in placed the carrots back in approximately 50 seconds. 170 degrees F and the distorated to a resident. In take the temperature of ave. Usually the food is the sout of the microwave, so perature] the food." 17/15, at 11:30 a.m. C-B ave any raw items that are ave. All the microwave and we reheat them for awant the main entree for the approximately 50 seconds. 17/15, at 11:37 a.m. dietary awarm the precooked food approximately 50 seconds. 17/15, at 11:38 a.m. DA-B and bags of frozen spaghetti are. She placed two on the microwave and then on the steam table without the of the noodles. At 11:39 appreheated noodles from but them into the microwave.	F	371	5.Completion Date: 2/16/15 6.Correction will be monitored by the Certified Dietary Manager or designate of the Cer	he inee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUII		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245422	B. WING _			01/08/2015	
	NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO MILACA, MN 56353			
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F 371	spaghetti noodles in theated marinara sauce then poured the sauce temperature was take marinara sauce. Surtake the temperature and marinara sauce. degrees F. C-B place microwave for an addobtained the temperat degrees F. C-B put pmarinara sauce back for approximately 50 different thermometer of the spaghetti and rwas 180 degrees F. T sauce were served to During observation or began checking all fo precooked items that microwave prior to the residents. When interviewed on certified dietary mana operations (DO) states	m. C-B reheated precooked he microwave, and then be in the microwave. She en over the noodles. No en of the spaghetti and the veyor requested that C-B of the spaghetti noodles. The temperature was 120 ed the plate back into the litional 50 seconds. C-B ture again and it was 147 elate of spaghetti and into the microwave again seconds. C-B used a to obtain the temperature marinara sauce, temperature The spaghetti and marinara a resident. In 1/7/15, at 11:46 a.m. staff od temperatures of all were reheated in the em being served to the	F3				
	and look at changing also stated that when process of reheating would take the tempe Our system included took for specific items microwave to be at the	foods a few years ago, staff rature of reheated foods. that we knew how long it to be reheated in the e correct temperature (for approximately 50 seconds).					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245422	B. WING		01/08/2015		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 371	the microwave. The facility policy ent Service, dated 11/11/cooked food must be temperature of 165 d seconds. Reheated within 2 hours will be 483.65 INFECTION (SPREAD, LINENS) The facility must esta Infection Control Prosafe, sanitary and co to help prevent the dof disease and infect (a) Infection Control The facility must esta Program under which (1) Investigates, contin the facility; (2) Decides what proshould be applied to	itled Food Preparation and 13, included, "Previously reheated to an internal egrees for at least 15 foods that are not consumed discarded." CONTROL, PREVENT Ablish and maintain an gram designed to provide a mfortable environment and evelopment and transmission ion. Program ablish an Infection Control in it - crols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective	F 37	1. The facility will develop an effi and effective infection control pro detailing resident instances of in- building location of infection, and statistical analysis of incidence a prevalence identified in each uni the facility as a whole. 2. There will be a consistently maintained and thoroughly docu infection control program. Reside employees will benefit from a local log of infection trends within the unit and across facility. The facility will be able to recognize areas	egram fection, Ind t and mented ents and calized the		
	prevent the spread o isolate the resident. (2) The facility must processed communicable diseation direct contact will train the spread of the	on Control Program sident needs isolation to f infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if		in which infection is prevalent ar be able to take measures to pre the spread of infection to other u. 3. Audits conducted weekly for month, then monthly x3 months quarterly from then on to ensure proper c with infection control.	vent inits. one then		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245422	B. WING _		0	1/08/2015	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From page		F 4	41			
hands after each din hand washing is indi professional practice				4. Completion date: 2/16/2	2015	·	
	(c) Linens			5. Correction will be monit	ored by DON		
		le, store, process and to prevent the spread of		6. Issues detected in audi reported to QA committee improvement suggestions	for		
	by: Based on observation review, the facility fair control program to incompany analysis of collected						
	Findings include:						
	p.m. a sign was obse entrance door that ide residents with influen						
	infections: 1 eye, 5 re urinary (UTI), and 9 c identify the specific, " separated which infer admission, and acqui total of 19 infections to of the 19 residents has for the reporting period	dentified the following espiratory (URI), 1 skin, 3 eithers. The report did not other" infections, however citions were present upon red while at the facility, for a for the month. A total of 16 ad "one or more infections" od, 3 residents required ent had a repeat infection					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245422	B. WING_	B. WING		01/08/2015	
	NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP COD 730 SECOND STREET SOUTHEAST, PO MILACA, MN 56353			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 441	identify who these reverse located in the far "Was it necessary to Study Reports for the was identified by the were no case study reporting period. The facility had a data as Order Report by Comonth. These reports categories of antibiotion of the start date of the specific to antibiotics and the start date of the specific to antibiotics month, it identified all antibiotics, making it currently had an active Order Report by Categories of antibiotics month, it identified all antibiotics, making it currently had an active Order Report by Categories of these reports identification and listed medication received and these reports identification, symptomally infections, trending of analysis to determine spreading in the facility was required. A facility Infection Su 11/1/14 to 11/30/14, i infections: 1 gastroins UTI, and 1 other. The	s; however the report did not sident were or where they acility. The form identified, perform one or more Case a period reported on?" This facility as "yes" but there exports completed for this a collection report identified category form, for each a were divided into two ics and antifungals. In antibiotics Order Report de 47 residents had active ic, and listed their name, ation (antibiotic) received taking it. The report was not being started during that a current orders for difficult to determine who we infection. The antifungal eggry form identified 22	F	141			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245422	B. WING _		01	1/08/2015	
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	and acquired while at infections for that more residents experienced the reporting period, and 1 resident had a past 90 days; however which residents these "Was it necessary to Study Reports for the was identified by the were no case study reporting period. A facility antibiotic Onform, dated 11/1/14 to residents had active of listed their name, roo (antibiotic) received at The report was not specification, sympto infections, trending of analysis to determine spreading in the facility was required. A facility Infection Sur 10/1/14 to 10/31/14, infections: 1 GI, 3 ski report did not identify infections, however swere present upon at the facility, for a to 9 residents had expe	present upon admission, the facility, for a total of 12 onth. A total of 10 of the 12 d one or more infections for 1 resident required isolation, repeat infection from the per the report did not identify a were. The form identified, perform one or more Case period reported on?" This facility as "yes" but there exports completed for this der Report by Category of 11/30/14, identified 26 orders for an antibiotic, and m number, medication and the start date of taking it. Decific to antibiotics started eview. There were no tified for this time frame. The acked any organism ms identified with the fifthe collected data, or if infectious disease was try or if education to the staff dentified the following in 3 UTI, and 3 other. The the specific, "other" eparated which infections dmission, and acquired while tal of 10 infections. A total of rienced one or more	F	441			
		orting period, none required ents had a repeat infection					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245422	B. WING		01,	/08/2015	
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA				STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BO MILACA, MN 56353			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC 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 441	identify which residence to cation in the facilit necessary to per Reports for the peridentified by the facase study reports period. A facility antibiotic form, dated 11/1/14 residents had active listed their name, responsible for the report was not during the month in determine who had antifungal Order Residentified 24 residentified 24 residentified 24 residentified 24 residentified antifungal medicat number, medication taking it; however started that month organism identificate the infections, trenunallysis to determ spreading in the factor of nursing responsible for the program since Sep Summary Report winfections were according to each medication and the summary Report winfections were according to each medication and the summary Report winfections were according to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was based aspecific to each medication and the summary Report was period to the summary Report was based aspecific to each medication and the summary Report was period to the summa	ays; however the report did not dents these were or their lity. The form identified, "Was form one or more Case Study riod reported on?" This was cility as "yes" but there were no completed for this reporting Order Report by Category 4 to 11/30/14, identified 24 re orders for an antibiotic, and com number, medication d and the start date of taking it. It is specific to antibiotics started in review, making it difficult to d an active infection. The report by Category form and listed their name, room in received and start date for was not specific to antifungals. The reports lacked any ration, symptoms identified with ding of the collected data, or ine if infectious disease was cility or if education to the staff on 1/8/15 at 10:40 a.m., the (DON) stated she was facility infection control otember 8, 2014. The Infection was used to determine if quired in-house or not, but the con active orders, and not conth. Infections are also	F 44				
	specific to each moverbally tracked in						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245422	B. WING _			01/08/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO B MILACA, MN 56353	3OX 157		
(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 CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	in the computer, and infections in the build A subsequent intervie 1/8/15 at 1:20 p.m. recontrol program. The develops symptoms get started on antibio morning report, "Its justated she did not tradeveloped influenza, multiple residents we DON stated there was the collected data an current infection rate, contamination occurr though they recently influenza. A facility Infection Coindicated, "It is the portion of the policy indicated the would review all infections with the policy indicated the would review all infections with policy indicated, "Analy Discuss as needed."	the reviews the collected data she is aware of all the ling because, "I just know it." Bew was held with the DON on the garding the facility infection to a pool of an infection, but doesn't write, it is just tracked in the list not wrote down." She list not wrote down." She list hough she identified the affected. Further, the is no analysis or trending of divide was unable to identify her in, or if there was any crossing in the facility even had multiple residents with the facility." Further, the infection control nurse citions in the building, usually monthly, and the review yee and summarize findings. The policy lacked any ing ongoing surveillance, of any collected data in control.	F 4	Facility ID: 00376	If continuation (sheet Page 39 of 39	



Printed: 01/09/2015 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - ELIM HOME MILACA COMPLETED 245422 B. WING 01/07/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **ELIM HOME - MILACA** 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Elim Home Milaca was found 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 18 New Health Care. Elim Home Milaca is a one (1) story building with no basement. The building construction type has been determined to be Type II (111). This inspection only reflects the building that was constructed in 2004 and consisted of 4 resident rooms and a dining room. In 2006 a chapel addition was added with a connector link to the assisted living building. The chapel and the assisted living are separated by 2 hours fire resistive rating, with 1.5 hour doors. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a licensed capacity of 98 beds and had a census of 92 at the time of inspection. The requirement at 42 CFR, Subpart 483.70(a) is MET.

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

TITLE

(X6) DATE

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 Minnesotans

Certified Mail # 7013 2250 0001 6357 1034

January 23, 2015

Ms. Laura Broberg, Administrator Elim Home - Milaca 730 Second Street Southeast, P.O. Box 157 Milaca, Minnesota 56353

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5422025

Dear Ms. Broberg:

The above facility was surveyed on January 5, 2015 through January 8, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Elim Home - Milaca January 23, 2015 Page 2

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.

When all orders are corrected, the order form should be signed and returned to Brenda Fischer at Minnesota Department of Health, 3333 W Division, #212 St. Cloud MN 56301. 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 me.

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.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00376	B. WING		01/08/2015	
NAME OF PF	ROVIDER OR SUPPLIER		RESS, CITY, STA			
ELIM HOM	IE - MILACA	730 SECOI MILACA, N		DUTHEAST, PO BOX 157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE COMPLETE	
2 000	Initial Comments		2 000			
	****ATTEN	TION*****				
-	NH LICENSING CO	DRRECTION ORDER				
	144A.10, this correction pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Live-inspection with any result in the assessment.	ther a violation has been mpliance with all				
	that may result from rorders provided that a	paring on any assessments con-compliance with these a written request is made to a 15 days of receipt of a for non-compliance.				
	the following correction corrections are complemake a copy of these original to the Minnes	15 surveyors of this sited the above provider and on orders are issued. When eted, please sign and date,		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.		

Minnesota Department of Health

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

TITLE

(X6) DATE 2/3/0015

Youn Boby

Administrator

If continuation sheet 1 of 39

01/08/2015

(X3) DATE SURVEY COMPLETED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: __ B. WING _ 00376

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELIM HOME - MILACA

730 SECOND STREET SOUTHEAST, PO BOX 157

LLIMITION	IE - MILACA	MILACA, MN 56353		
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2 000	Continued From page 1	2 000		
	Certification Program, 3333 West Division Suite 212, St Cloud, MN 56301.	on St,	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE	
2 565	MN Rule 4658.0405 Subp. 3 Comprehe	nsive 2 565	STATUTES/RULES.	
_ 33	Plan of Care; Use			
	Subp. 3. Use. A comprehensive plan o must be used by all personnel involved i care of the resident.			
	This MN Requirement is not met as evid	denced		

Minnesota Department of Health

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 00376 01/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 2 565 Continued From page 2 Based on observation, interview, and document review, the facility failed to follow care plan interventions to prevent pressure ulcer development, prevent skin irritation, and prevent falls out of a chair for 1 of 10 residents (R16) reviewed for care plan implementation. Findings include: R16's quarterly Minimum Data Set dated 10/17/14, included, severe cognitive impairment, Alzheimer's disease, required total staff assistance for all ADL's, had functional limitations of range of motion (ROM) of upper extremities, and was at risk for pressure ulcers. R16 had not had any falls since the prior assessment. R16's care plan dated 10/22/14, included, "At risk for falls r/t [related to] falls/crawls out of bed, hallucinations, delusions, limited mobility, needs mech [mechanical] assist for transfers, severe cognitive impairment, scheduled and PRN [as needed] pain meds [medication]. Fall risk, high risk. Use of broda [brand name reclining wheel chair] d/t [due to] leans forward, comfort and HX [history] of fall out of wheel chair." Staff were instructed from the "Impaired Mobility" care plan to, "May remove Hoyer [brand name mechanical lift] sling when in wheel chair d/t scooting and sliding down in wheel chair. Dycem [non skid mat] in w/c [wheel chair] to keep resident from sliding in chair." R16's skin care care plan dated 10/22/14, included, "At risk for skin breakdown R/T limited

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 2 565 Continued From page 3 mobility..." Staff were directed to turn and reposition every 2 hours while awake and not to use "peri wipes" (pre-packaged cleansing wipes) on her skin. R16's nursing assistant care sheet dated 1/7/15, included, to reposition every 2 hours while awake, and "Must have dycem mats in geri chair." R16 was observed on in a Broda chair on 1/5/15, at 7:14 p.m. the back of the chair was reclined approximately 45 degrees. R16 had slid down in the chair so that her buttocks was toward the front of the chair, and was lying almost flat. Activity aide (AA)-A stopped and talked to R16 at 7:15 p.m., but did not assist her up into the chair. At 7:16 p.m. nursing assistant (NA)-G took R16's chair and pulled her backwards down the hall without assisting her up into the chair. At 7:25 p.m. NA-H and NA-I assisted R16 to bed using a mechanical lift. It was noted R16's Broda chair did not have any dycem in it. R16 was observed for morning cares on 1/7/15, at 8:13 a.m. with NA-A and NA-B. NA-A used peri-wipes with a cleansing cream to wash peri-are and buttocks. R16 was assisted in the Broda chair at 8:25 a.m. without any dycem in the chair or on top of the lift sling. R16 was then brought to the day room until 8:50 a.m. at which time she was brought to the dining room. R16 remained in the dining room until 9:25 a.m. where she was brought to the day room again. R16 remained in the day room until 9:39 a.m. at which time she was brought to the chapel. At 10:57 a.m. R16 was again brought to the day room. At

Minnesota Department of Health

10:58 a.m. R16 was brought to the beauty shop

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 565 2 565 Continued From page 4 where she remained until 11:33 a.m. when she was brought to the nurse 's station for a reading activity. R16 slept in the chair during the activity, until 11:51 a.m. at which time she was brought to the dining room. R16 remained in the dining room until 12:48 p.m. at which time she was brought to her room, 4 hours and 23 minutes without being repositioned. NA-A and NA-B assisted R16 into bed, there was still no dycem under the sling or on top of it. R16 was incontinent of a small amount of loose stool on her buttocks and peri-area which was removed by NA-B with peri-wipes. NA-A stated they had not repositioned R16 at any time since she had gotten up in the chair at 8:25 this morning, 4 hours and 23 minutes ago. NA-A stated R16 had gone to activities, chapel, breakfast, lunch and to get her hair cut and they were unable to catch her in between activities. Normally they would lay her down to get her off her buttocks every 2 hours. When interviewed on 1/8/15, at 9:23 a.m. the MDS coordinator (RN)-B stated R16 had broken out in a rash from the peri wipes back in 2011 and this is why they were not to be used for peri-care. RN-B stated R16 should be repositioned off her buttocks every 2 hours to prevent skin breakdown. RN-B reviewed the nurse aide worksheet and stated the worksheet failed to indicate the peri-wipes should not be used for R16. The nurse aides would refer to this sheet, rather than the care plan for routine care. R16 was observed for pericare on 1/8/15, at 9:42 a.m. with the director of nursing, registered nurse (RN)-A, and NA-B. The director of nursing stated R16 had been repositioned on 1/7/15 in the morning. NA-B stated R16 had not actually been repositioned, but only boosted up in the chair, this

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would not have relieved pressure on her buttocks.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00376	B. WING		01/0	08/2015
	ROVIDER OR SUPPLIER			TE, ZIP CODE DUTHEAST, PO BOX 157		
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2 565	RN-A stated R16 sho hours and peri-wipes stated R16 should ha mechanical lift sling a was not present at th A policy was requeste facility. SUGGESTED METH The director of nursin inservice staff regardiplan of care.	uld be repositioned every 2 were not to be used. RN-A ve dycem under the is well as on top, but this is time either. ed but not provided by the OD OF CORRECTION:	2 565			
2 830	receive nursing care custodial care, and st individual needs and the comprehensive replan of care as desci 4658.0405. A nursing of bed as much as powritten order from the	eneral. A resident must and treatment, personal and upervision based on preferences as identified in esident assessment and ribed in parts 4658.0400 and g home resident must be out ossible unless there is a eattending physician that the in bed or the resident	2 830			
	by: Based on observation	t is not met as evidenced n, interview, and document led to ensure optimal wheel				

Minnesota Department of Health

PRINTED: 01/23/2015 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 Continued From page 6 2 830 chair positioning for 2 of 3 residents (R16 and R73) who were reviewed for positioning. In addition, the facility failed to provide pain management to allow comfort with passive range of motion (PROM) and hand care for 1 of 1 residents (R16) reviewed with contractures. Findings include: Wheel Chair Positioning R16 's quarterly Minimum Data Set (MDS) dated 10/17/14, included severe cognitive impairment with a diagnosis of Alzheimer 's disease. The MDS included R16 was totally dependent upon staff for all activities of daily living (ADL's) R16 's Impaired Mobility care plan dated 10/22/14, included, "May remove Hoyer [mechanical lift sling] sling when in wheel chair d/t [due to] scooting and sliding down in wheel chair. Dycem in w/c [wheel chiar] to keep resident from sliding in chair." R16 's At Risk for Falls care plan dated 10/22/14, included. "Broda chair [a large reclining wheeled chair]. Dycem (a non-skid mat) mats in geri chair." R16's nurse aide worksheet dated 1/7/15, included, "Must have dycem mats in geri chair." R16 was observed in a Broda chair on 1/5/15, at 7:14 p.m. the back of the chair was reclined approximately 45 degrees. R16 had slid down in the chair so that her buttocks was towards the

Minnesota Department of Health

front of the seat and she was lying almost flat. Activity aide (AA)-A stopped and talked to R16 at 7:15 p.m., but did not assist to sit back into chair. At 7:16 p.m. nursing assistant (NA)-G took R16 's wheel chair and pulled her backwards down the hall, without assisting R16 to sit upright in chair. At 7:25 p.m. NA-H and NA-I assisted R16 to lie in

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: 00376 01/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 7 bed, utilizing a mechanical lift. Once lying down, it was noted, there was no dycem under R16 or the mechanical lift sling. R16 was observed on 1/7/14, from 8:13 a.m. until 8:28 a.m. for morning cares. NA-A and NA-B assisted R16 into the Broda chair with a mechanical lift at 8:25 a.m. There was no dycem under the lift sling, nor on top of the sling, the sling was left under R16 's buttocks. R16 was observed on 1/7/15, at 11:30 a.m. until 11:47 a.m. she was in the day room, and had slid down in her Broda chair to where her buttocks was at the front of the seat, her head was lying on the left arm rest. No Dycem was noted under resident, and she was sitting on a blue mechanical lift sling. R16 was observed on 1/8/14, at 9:42 a.m. NA-B, registered nurse (RN)-A and the director of nursing had assisted R16 out of Broda chair and into bed. There was no dycem in the Broda chair. When interviewed on 1/8/15, at 10:22 a.m. RA-A stated there should be dycem both under the mechanical lift sling and on top to prevent R16 from sliding down in her chair. This intervention had been placed after R16 had slid out of her chair. RN-A verified R16 did not have any dycem in her chair. R73's quarterly Minimum Data Set (MDS) dated 10/1/14, included moderate cognitive impairment with diagnoses of Parkinson's disease (impaired muscular coordination) and rheumatoid arthritis (painful swelling of the joints). The MDS included R73 required extensive assistance with transfers

Minnesota Department of Health

to or from bed, chair, and wheelchair. The MDS also identified R73 had lower extremity (hip,

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Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 8 knee, ankle, foot) impairment on both sides. R73's Mobility care plan dated 10/22/14, included the following interventions, a stand-up lift for all transfers, physical assist of one with wheelchair mobility, and occupational therapy (OT) issued an anti-thrust cushion to R73's wheelchair to promote R73 to sit in an upright sitting position. R73 was observed during a transfer from his bed into his wheelchair on 1/7/15, at 7:18 a.m. by nursing aide (NA)-D and (NA)-B. After the transfer, R73's hips were not positioned into the back of his wheelchair, his lumbar area was not touching the back of the chair. At 8:22 a.m. R73 was in the hallway sliding down in his wheelchair, and was not sitting in an upright position. On 1/8/15, at 8:49 a.m. R73 was observed in the dining room eating breakfast. R73's hips were not back in his wheelchair and was in a reclining position, sliding down in his wheelchair. During interview on 1/7/15, at 7:45 a.m. NA-D stated that R73 often slides down in his wheelchair throughout the day. When interviewed on 1/7/15, at 8:25 a.m. R73 stated it is hard to get comfortable in my wheelchair because my knees bother him. During interview with certified occupational therapist assistant (COTA)-B on 1/8/15, at 10:00 a.m. COTA-B stated the resident had very contracted knees and he often sits sideways in his wheelchair. We have placed a cushion on his foot pedals to keep his feet in place and are using an anti-thrust cushion on his wheelchair seat to promote an upright sitting position.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMITE	LILD
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ELIM HON	ME - MILACA	730 SECOI MILACA, N		DUTHEAST, PO BOX 157		
(XA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	. ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETE DATE
2 830	Continued From page	9	2 830			
	A review of the Pro R Therapy Screen form R73 was having increable to position himself slides down in his character of the his wheelchair and is for his wheelchair. On 1/8/15, at 10:13 a with the surveyor. R7 wheelchair with his hiback of the wheelcha often slides down in his correction.	ehab Nursing Referral for , dated 7/28/14, indicated eased weakness and not elf in his wheelchair and air frequently. On 7/29/14 at R73 was sliding down in sued an anti-thrust cushion m COTA-B observed R73 73 was sliding down in his ps were not touching the ir. COTA-B stated R73 his chair and she added an				
	anti-thrust cushion, which was currently in R73's wheelchair. COTA-B agreed R73 was not sitting in an upright position and found NA-D to help reposition R73 in his wheelchair so his hips would be touching the back of his wheelchair and sitting in an upright position.					
	therapy assistant (PT a.m. (30 minutes afte	his wheelchair with physical (A)-D on 1/8/15, at 10:43 r being repositioned by R73 was again sliding down				
	a.m. PTA-D stated R7 wheelchair. PTA-D s pillow/support would be prevent him from slidit PTA-D asked R73 to wheelchair with his arreposition himself. A discussion was held pillow/cushion for R73 with COTA-B and PTA-D stated R73 to wheelchair with his arreposition himself.	be beneficial for R73 to help ing down in his wheelchair. push himself back into his rms, but R73 was unable to				

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FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 10 beneficial for R73 to prevent him from sliding down in his wheelchair. If the support did not work, then occupational therapy would be ordering a new wheelchair for R73 that would prevent him from sliding down in his wheelchair. PAIN R16's quarterly Minimum Data Set (MDS) dated 10/17/14, included severe cognitive impairment, Alzheimer's disease, required total assistance from staff for all activities of daily living (ADL's), had functional limitations of range of motion (ROM) of both upper extremities, and did not have any pain. R16's Pain care plan dated 12/18/12, included, "At Risk For Alteration in Comfort RT [related to] hand contractures, HX [history] of pain in hands." Staff were directed, dated 12/18/12, to "Sheep skin palm protectors to both hands to prevent further contractures. Resident also enjoys having staff rub lotion on her hands, very lightly. The warmth of a blanket over the resident's hands also helps to relieve pain." R16's progress note dated 10/22/14, included, "Pain: no pain indicators reported in this assessment period." R16 was observed for morning cares on 1/7/15,

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at 8:13 a.m. with nursing assistant (NA)-A and NA-B. NA-B placed some cleansing cream on a toothette (a small sponge on a stick) and attempted to shove it into R16's fists, R16 cried

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ 01/08/2015 00376 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 830 Continued From page 11 2 830 out, "Ouch, there are bad reindeer that try to hurt me and you are doing that." NA-B stated R16's hands are so tight, every time they try to open and clean them, she "fights," she has pain. NA-B stated they are able to, "pry" them open with a lot of effort to get her fingernails cut on bath day, "but barely," it hurts her too much. R16 is supposed to have wash cloths placed in her hands, but, "she gets them out as soon as we are done." NA-A stated R16 hates it when her hands are touched, it hurts. R16 was observed for cares on 1/7/15, at 12:48 a.m. NA-A and NA-B assisted R16 into bed. When cares were completed the NA's were asked about PROM for R16. NA-A stated they try to do it either with morning cares or at this time, but only if R16 is sleepy. They are unable to do PROM on R16's hands, for over 6 months, because. "she doesn't let you get into her hands, she has pain, she can't open them, we can't get the wash cloth in most of time, or once in, she gets really agitated and suddenly it is out." NA-A attempted to open R16's left hand, R16 cried out, "owe, stop hurting me." The same was attempted with R16's right hand and R16 yelled out. NA-A and NA-B stated they have reported this to the nurses and the nurses know she has pain with attempts at washing R16's hands and attempting PROM. A Pro Rehab Nursing Referral For Therapy Screen form dated 7/7/09 indicated R16 was having pain with finger separators. Therapy then issued, "palm protector," for left hand.

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 12 2 830 2 830 When interviewed on 1/7/15, at 1:36 p.m. RN-A stated she was not aware R16 was having any pain with the PROM to her hands. When interviewed on 1/8/15, certified occupational therapist (COTA)-A stated six months ago she had looked at R16's hands and she did not have any contractures. She was aware R16 was resistive to PROM and staff should only attempt when the resident is sleeping. R16 had a behavior problem leading to the resistiveness and didn't feel it was pain related. When interviewed on 1/8/15, at 9:16 a.m. RN-A stated R16 gets scheduled pain medication three times a day at 8:00 a.m., 2:00 p.m. and 10:00 p.m. This would not coincide with when staff were attempting to wash hands for morning and bedtime cares, or PROM. No attempts had been made to offer pain medication prior to attempting hand care or PROM. No non-pharmacological methods (such as warm towels to hands prior to cares) had been tried. When interviewed on 1/8/15, at 9:23 a.m. RN-B stated she was in charge of the restorative nursing program. She evaluates the residents quarterly, but was not aware R16 was having pain with PROM or hand care. COTA-A attempted to perform PROM on R16's hands to determine if more contracted than in 2011, on 1/8/15, at 10:25 a.m. During the attempt R16 cried out, "It hurts so bad, I can't do it." The attempt at PROM was discontinued. COTA-A stated, "She is having pain, we can't assess her

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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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		00376	B. WING		01/0	8/2015
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2 830	Continued From page	÷ 13	2 830			
	would contact the nur pain medication with I	point." RN-A stated she se practitioner to coordinate PROM and hand care, as rm towels to hands prior to				
	A policy was requeste facility.	ed, but not provided by the				
	The director of nursing inservice staff regarding	OD OF CORRECTION: g or designee could ng screening residents for l interventions, and pain				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
2 895	MN Rule 4658.0525 S Motion	Subp. 2.B Rehab - Range of	2 895			
	that is directed toward through positioning ar implemented and mai					
	receives appropriate t	a limited range of motion treatment and services to tion and to prevent further motion.				
	This MN Requirement by:	t is not met as evidenced				

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Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 895 2 895 Continued From page 14 Based on observation, interview, and document review, the facility failed to provide the necessary care and services to prevent further decline in range of motion for 1 of 1 residents (R16) reviewed for contractures. Findings include: R16's quarterly Minimum Data Set (MDS) dated 10/17/14, included severe cognitive impairment, Alzheimer's disease, required total assistance from staff for all activities of daily living (ADL's), had functional limitations of range of motion (ROM) of both upper extremities and received a passive ROM 6 out of the 7 assessment days. R16's Restorative Nursing Care Plan dated 7/30/14, included, "Does not walk, hand contractures, Severe cognitive impairment." R16's goal was, "To maintain ability for resident to open hands to allow staff to wash them well." Staff were instructed, "PROM [passive range of motion] to all extremities for 15 min [minutes]/BID [twice a day] daily...Try ROM to hands when napping/sleeping per OT [occupational therapy] d/t [due to] resident being resistive at times. Resident has rolled up wash cloths in hands to prevent further contractures." R16's progress note dated 10/22/14, included, "Restorative Nursing: PROM to all extremities BID daily. Goal is to maintain ability for resident to open hands to allow staff to wash them well and prevent further hand contractures, which is effective." R16's Pain care plan dated 12/18/12, included, "At Risk For Alteration in Comfort RT [related to] hand contractures, HX [history] of pain in hands."

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Staff were directed, dated 12/18/12, to "Sheep

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00376 B. WING 01/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 895 Continued From page 15 2 895 skin palm protectors to both hands to prevent further contractures. Resident also enjoys having staff rub lotion on her hands, very lightly. The warmth of a blanket over the resident's hands also helps to relieve pain." R16 was observed on 1/5/15, at 7:25 p.m. with her hands in fists. R16 was observed for morning cares on 1/7/15, at 8:13 a.m. with nursing assistant (NA)-A and NA-B. NA-B placed some cleansing cream on a toothette (a small sponge on a stick) and attempted to shove it into R16's fists, R16 cried out, "ouch, there are bad reindeer that try to hurt me and you are doing that." NA-B stated R16's hands are so tight, every time they try to open and clean them, she "fights," she has pain. NA-B stated they are able to, "pry" them open with a lot of effort to get her fingernails cut on bath day, "but barely." R16 is supposed to have wash cloths placed in her hands, but, "she gets them out as soon as we are done." NA-A stated R16 hates it when her hands are touched, it hurts. Morning cares were completed at 8:25 a.m. and R16 was brought to the day room awaiting breakfast. R16 was observed for cares on 1/7/15, at 12:48 a.m. NA-A and NA-B assisted R16 into bed. When cares were completed the NA's were asked about PROM for R16. NA-A stated they try to do it either with morning cares or at this time, but only if R16 is sleepy. They are unable to do PROM on R16's hands, for over 6 months, because, "she doesn't let you get into her hands, she has pain, she can't open them, we can't get the wash cloth in most of time, or once in, she gets really agitated and suddenly it is out." NA-A attempted to open R16's left hand, R16 cried out,

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 01/08/2015 00376 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 895 2 895 Continued From page 16 "owe, stop hurting me." The same was attempted with R16's right hand and R16 yelled out. NA-A and NA-B stated they have reported this to the nurses and the nurses know she has pain with attempts at washing R16's hands and attempting PROM. A Pro Rehab Nursing Referral For Therapy Screen form dated 6/4/09, indicated R16's left hand middle finger was contracted. The form did not indicate the other fingers, or right hand were contracted. A Pro Rehab Nursing Referral For Therapy Screen form dated 7/7/09 indicated R16 was having pain with finger separators. Therapy then issued, "palm protector," for left hand. There was no mention about the right hand or what fingers were contracted on the left hand. A Pro Rehab Nursing Referral For Therapy Screen form dated 6/7/11 indicated R16 had an open area on left palm and ROM while R16 is sleeping. Staff were instructed to wash hands day and evening, to apply palm protectors, and check skin each shift. The form did not indicate which hand or fingers were contracted. There were no further therapy notes regarding hand contractures. R16's Point of Care History, Restorative Nursing revealed R16 was receiving PROM for 8-20 minutes twice a day. The report did not identify which joints were being exercised. When interviewed on 1/7/15, at 1:36 p.m. RN-A stated she was aware the nurse aides were having trouble getting the wash clothes to stay in

R16's hands, but did not know if R16 was having any pain with the PROM to her hands. RN-A

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,			A. BUILDING: _			
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓΕ, ZIP CODE		
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LLIM HON	IL - WILAGA	MILACA,	MN 56353			
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2 895	Continued From page	÷ 17	2 895			
	stated there would be Point of Care History performed to R16's had When interviewed on occupational therapis months ago she had she did not have any aware R16 was resist should only attempt w R16 had a behavior presistiveness and did	in no way to tell from the if the PROM was being ands or just her other joints. 1/8/15, certified t (COTA)-A stated six looked at R16's hands and contractures. She was give to PROM and staff when the resident is sleeping. In other leading to the not feel it was pain related.				
	stated R16 gets sche times a day at 8:00 a. p.m. This would not of were attempting to wa bedtime cares, or PR made to offer pain me hand care or PROM.	1/8/15, at 9:16 a.m. RN-A duled pain medication three m., 2:00 p.m. and 10:00 coincide with when staff ash hands for morning and OM. No attempts had been edication prior to attempting No non-pharmacological rm towels to hands prior to				
	stated she was in chanursing program. She quarterly, but was not with PROM or hand devaluation she looks. Restorative Nursing ribeing completed. RN way to tell from this reoccurring with R16's lorder was for them to joints. RN-B stated Finands for quite some 2011 she had developher finger related to the	1/8/15, at 9:23 a.m. RN-B arge of the restorative endeates the residents aware R16 was having pain are. When she does her at the Point of Care History, eport. It looked like it was lands or other joints. The do bilateral upper extremity late has had contracted time and back in May of one contractures. She did not tures were more contracted				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 00376 01/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 895 2 895 Continued From page 18 now than they were in 2011. COTA-A attempted to perform PROM on R16's hands to determine if more contracted than in 2011, on 1/8/15, at 10:25 a.m. During the attempt R16 cried out, "It hurts so bad, I can't do it." The attempt at PROM was discontinued. COTA-A stated, "She is having pain, we can't assess her for contracture at this point." RN-A stated she would contact the nurse practitioner to coordinate pain medication with PROM and hand care, as well as see about warm towels to hands prior to attempts. Because of R16's pain with attempt at PROM, they were unable to determine if she had a decline in ROM of the hands. Even though the facility was aware from her care plan that she experienced hand pain, staff identified hand pain with attempts at PROM and washing hands, and were unable to perform the ordered PROM, the facility failed to address R16's pain and/or offer any alternatives to prevent R16's hands from becoming more contracted. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding range of motion and audit to ensure it is completed as directed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 2 900 MN Rule 4658.0525 Subp. 3 Rehab - Pressure 2 900 Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director

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of nursing services must coordinate the

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ 00376 B. WING 01/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 | Continued From page 19 2 900 development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with repositioning to prevent pressure ulcer development for 1 of 2 residents (R16) reviewed for pressure ulcer risk. Findings include: R16 's quarterly Minimum Data Set (MDS) dated 10/17/14, included a diagnosis of Alzheimer 's disease. R16 had severe cognitive impairment, was totally dependent upon staff for all mobility issues, and was at risk for pressure ulcer development. R16 's Pressure Ulcer Care Area Assessment (CAA) dated 7/30/14, included, "Resident is at risk for skin breakdown. Resident requires total assistance from staff for toileting. Resident is always incontinent of bowel and frequently incontinent of bladder. Resident will seldomly void in the bedpan but is unable to make her need for toileting known d/t [due to] cognitive

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 00376 01/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 Continued From page 20 2 900 impairment. Resident is checked/changed or toileted every 2 hours on days and pms [afternoons] and every 3 hours on nocs [nights]. Resident has a hx [history] of skin breakdown to periarea. Staff applies zinc oxide to periarea with every incontinent episode to promote skin integrity. Resident also has a hx of pressure ulcer to coccyx." R16 's At risk for skin breakdown care plan dated 10/22/14, directed staff to, "T&R [turn and reposition] A2 [assist of two] every 2 hours awake and 3 hours on nocs ... Do not use peri wipes on res [resident], use wash cloth only ... " R16's nurse aide worksheet dated 1/7/15. included a need to reposition ever 2 hours while awake and every 3 hours at night. To use zinc oxide with every change. However, the worksheet failed to indicate peri-wips should not be used for R16. R16 was observed for morning cares on 1/7/15, at 8:13 a.m. with nursing assistant (NA)-A and NA-B. R16 was noted to have a large red area on left hip (approximately 5 by 5 cm (centimeters) and on coccyx (approximately 4 by 2.5 cm). The coccyx area had a approximately 2 x 0.5 cm white area on in the center, which did not wash off with pericare. NA-A used peri-wipes with a cleansing cream to wash area, followed by zinc oxide cream. R16 was assisted in a reclining wheeled chair (a Broda chair) at 8:25 a.m. by NA-A and NA-B utilizing a mechanical lift. R16 was then brought to the day room until 8:50 a.m. at which time she was brought to the dining room. R16 remained in the dining room until 9:25 a.m. where she was brought to the day room again. R16 remained in the day room until 9:39 a.m. at which time she was brought to the chapel. At

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 2 900 Continued From page 21 10:57 a.m. R16 was again brought to the day room. At 10:58 a.m. R16 was brought to the beauty shop where she remained until 11:33 a.m. when she was brought to the nurse 's station for a reading activity. R16 slept in the chair during the activity, until 11:51 a.m. at which time she was brought to the dining room. R16 remained in the dining room until 12:48 p.m. at which time she was brought to her room. NA-A and NA-B assisted R16 into bed. The red area remained on R16's left hip and on her coccyx. R16 had a small amount of loose stool on buttocks and peri-area which was removed by NA-B with peri-wipes. Zinc oxide was re-applied. NA-A stated they had not repositioned R16 at any time since she had gotten up in the chair at 8:25 (4 hours and 23 minutes) this morning. NA-A stated R16 should be repositioned every 2 hours, but had gone to activities, chapel, breakfast, lunch and to get her hair cut and they were unable to catch her in between activities. Normally they would lay her down to get her off her buttocks every 2 hours. When interviewed on 1/8/15, at 9:23 a.m. the MDS coordinator (RN)-B stated R16 had broken out in a rash from the wipes back in 2011 and this is why they were not to be used for peri-care. RN-B stated R16 should be repositioned off her buttocks every 2 hours to prevent skin breakdown. RN-B reviewed the nurse aide worksheet and stated the worksheet failed to indicate the peri-wipes should not be used for R16. The nurse aides would refer to this sheet, rather than the care plan for routine care. R16 was observed for pericare on 1/8/15, at 9:42 a.m. with the director of nursing, registered nurse (RN)-A, and NA-B. The director of nursing stated

R16 had been repositioned on 1/7/15 in the

PRINTED: 01/23/2015 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING_ 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 900 2 900 Continued From page 22 morning. NA-B stated R16 had not actually been repositioned, but only boosted up in the chair, this would not have relieved pressure on her buttocks. R16's left hip was pink, the skin blanched when pressed by RN-A. The coccyx area also was pink and the white area in the center was more pink than white, this area too blanched when pressed by RN-A. When interviewed RN-A stated R16 should be repositioned every 2 hours and peri-wipes were not to be used. A skin care/pressure ulcer policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding prompt repositioning and audit for compliance to help reduce risk of pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21025 21025 MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time

by:

and temperature controls in order to prevent the rapid and progressive growth of infectious or

This MN Requirement is not met as evidenced

Based on observation, interview, and document review, the facility failed to reheat precooked food to an internal temperature of 165 degrees for at

toxigenic microorganisms.

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meal.

stated they do not have any raw items that are cooked in the microwave. All the microwave items are precooked and we reheat them for residents who do not want the main entree for the

When interviewed on 1/7/15, at 11:37 a.m. dietary

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED					
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION										
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DMPLETE DATE				
21025	Continued From page 24		21025							
	aide (DA)-B stated we warm the precooked food									
	in the microwave for approximately 50 seconds. During observation on 1/7/15, at 11:38 a.m. DA-B retrieved eight individual bags of frozen spaghetti									
	noodles from the freezer. She placed two									
	individual servings into the microwave and then									
		to the steam table without								
		re of the noodles. At 11:39								
		e preheated noodles from out them into the microwave.								
	She then grabbed Alf									
	_	ed it into the microwave. She								
	,	ace the noodles and sauce								
		ecking the temperature to								
	,	grees F. The plate was								
	served to a resident.	The Alfredo sauce was not								
	_	.m. C-B reheated precooked								
	, , ,	the microwave, and then								
		ce in the microwave. She								
	1	e over the noodles. No								
		en of the spaghetti and the								
		veyor requested that C-B of the spaghetti noodles								
		The temperature was 120								
	degrees F. C-B place	ed the plate back into the								
		ditional 50 seconds. C-B								
		iture again and it was 147								
	degrees F. C-B put p	plate of spaghetti and								
		into the microwave again								
	for approximately 50	seconds. C-B used a								
	Į.	r to obtain the temperature								
		marinara sauce, temperature								
		The spaghetti and marinara								
	sauce were served to	a resident.								
	During observation o	n 1/7/15, at 11:46 a.m. staff								
	began checking all fo	od temperatures of all								
		were reheated in the								
	1 -	em being served to the								

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(21) days.

21390 MN Rule 4658.0800 Subp. 4 A-I Infection Control

Subp. 4. Policies and procedures. The infection control program must include policies and

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 00376 01/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) 21390 21390 Continued From page 26 procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced Based on observation, interview, and document review, the facility failed to develop an infection control program to include the trending and analysis of collected infection data to reduce the risk of transmission to other residents in the facility. This had potential to affect all 76 residents whom resided in the facility.

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Findings include:

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 00376 01/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21390 21390 Continued From page 27 During entrance into the facility on 1/5/15 at 12:30 p.m. a sign was observed on the facility main entrance door that identified the facility had residents with influenza dated 12/21/2014. A facility Infection Summary Report, dated 12/1/14 to 12/31/14, identified the following infections: 1 eye, 5 respiratory (URI), 1 skin, 3 urinary (UTI), and 9 others. The report did not identify the specific, "other" infections, however separated which infections were present upon admission, and acquired while at the facility, for a total of 19 infections for the month. A total of 16 of the 19 residents had "one or more infections" for the reporting period, 3 residents required isolation, and 1 resident had a repeat infection from the past 90 days; however the report did not identify who these resident were or where they were located in the facility. The form identified, "Was it necessary to perform one or more Case Study Reports for the period reported on?" This was identified by the facility as "yes" but there were no case study reports completed for this reporting period. The facility had a data collection report identified as Order Report by Category form, for each month. These reports were divided into two categories of antibiotics and antifungals. The 12/1/14 to 12/31/14, antibiotics Order Report by Category identified 47 residents had active orders for an antibiotic, and listed their name, room number, medication (antibiotic) received and the start date of taking it. The report was not specific to antibiotics being started during that month, it identified all current orders for antibiotics, making it difficult to determine who currently had an active infection. The antifungal Order Report by Category form identified 22

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Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21390 21390 Continued From page 28 resident had current orders for antifungal medication and listed their name, room number, medication received and start date for taking it. Both of these reports lacked any organism identification, symptoms identified with the infections, trending of the collected data, or analysis to determine if infectious disease was spreading in the facility or if education to the staff was required. A facility Infection Summary Report, dated 11/1/14 to 11/30/14, identified the following infections: 1 gastrointestinal (GI), 4 URI, 1 skin, 5 UTI, and 1 other. The report did not identify the specific, "other" infections, however separated which infections were present upon admission, and acquired while at the facility, for a total of 12 infections for that month. A total of 10 of the 12 residents experienced one or more infections for the reporting period, 1 resident required isolation, and 1 resident had a repeat infection from the past 90 days; however the report did not identify which residents these were. The form identified, "Was it necessary to perform one or more Case Study Reports for the period reported on?" This was identified by the facility as "yes" but there were no case study reports completed for this reporting period. A facility antibiotic Order Report by Category form, dated 11/1/14 to 11/30/14, identified 26 residents had active orders for an antibiotic, and listed their name, room number, medication (antibiotic) received and the start date of taking it. The report was not specific to antibiotics started during the month in review. There were no antifungal report identified for this time frame. The antibiotic report lacked any organism identification, symptoms identified with the infections, trending of the collected data, or

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ 00376 B. WING 01/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21390 Continued From page 29 21390 analysis to determine if infectious disease was spreading in the facility or if education to the staff was required. A facility Infection Summary Report, dated 10/1/14 to 10/31/14, identified the following infections: 1 GI, 3 skin, 3 UTI, and 3 other. The report did not identify the specific, "other" infections, however separated which infections were present upon admission, and acquired while at the facility, for a total of 10 infections. A total of 9 residents had experienced one or more infections for the reporting period, none required isolation, and 2 residents had a repeat infection from the past 90 days; however the report did not identify which residents these were or their location in the facility. The form identified, "Was it necessary to perform one or more Case Study Reports for the period reported on?" This was identified by the facility as "yes" but there were no case study reports completed for this reporting period. A facility antibiotic Order Report by Category form, dated 11/1/14 to 11/30/14, identified 24 residents had active orders for an antibiotic, and listed their name, room number, medication (antibiotic) received and the start date of taking it. The report was not specific to antibiotics started during the month in review, making it difficult to determine who had an active infection. The antifungal Order Report by Category form identified 24 resident had active orders for antifungal medication and listed their name, room number, medication received and start date for taking it; however was not specific to antifungals started that month. The reports lacked any organism identification, symptoms identified with

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the infections, trending of the collected data, or analysis to determine if infectious disease was

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 00376 01/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21390 21390 Continued From page 30 spreading in the facility or if education to the staff was required. During interview on 1/8/15 at 10:40 a.m., the director of nursing (DON) stated she was responsible for the facility infection control program since September 8, 2014. The Infection Summary Report was used to determine if infections were acquired in-house or not, but the report was based on active orders, and not specific to each month. Infections are also verbally tracked in the daily morning report, and reviewed at the monthly Quality Assurance meetings. Further, she reviews the collected data in the computer, and she is aware of all the infections in the building because, "I just know it." A subsequent interview was held with the DON on 1/8/15 at 1:20 p.m. regarding the facility infection control program. The DON stated if a resident develops symptoms of an infection, but doesn't get started on antibiotics, it is just tracked in the morning report, "Its just not wrote down." She stated she did not track the residents who developed influenza, even though she identified multiple residents were affected. Further, the DON stated there was no analysis or trending of the collected data and was unable to identify her current infection rate, or if there was any cross contamination occurring in the facility even though they recently had multiple residents with influenza. A facility Infection Control policy, dated 10/18/11, indicated, "It is the policy of the Milaca Care & Rehab Center to ensure the minimization of spread of infections within the facility." Further, the policy indicated the infection control nurse would review all infections in the building, usually

weekly, but at least monthly, and the review

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	MILACA,	MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 31 would include, "Analyze and summarize findings. Discuss as needed." The policy lacked any procedures for ensuring ongoing surveillance, trending, or analysis of any collected data pertaining to infection control.	21390		
	SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review their infection control program to ensure policies and procedures are established, inservice staff regarding policy and procedure, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control	21426		
	(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.			
	be maintained by the nursing home.			

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ B. WING 00376 01/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21426 21426 Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to complete an initial tuberculosis (TB) screening upon admission for 5 of 5 residents (R30, R109, R120, R129, and R131), and accurately record the results for 1 of 5 residents (R109) tuberculin skin test (TST). In addition, the facility failed to appropriately administer a 2nd step TST for 2 of 5 employees (CK-A, and DA-A) reviewed. Findings include: TB SCREENINGS: During review of the medical records for R30, R109, R120, R129, and R131; no TB symptom screenings were located. When interviewed on 1/6/15 at 12:52 p.m., unit secretary (US)-T stated she did not know where the TB symptom screenings for residents where kept, nor if there were any completed. During interview on 1/8/15 at 9:58 a.m., registered nurse (RN)-A stated nursing did not complete a TB symptom screening for residents upon admission. When interviewed on 1/8/15 at 10:33 a.m., the director of nursing (DON) stated no TB symptom screenings are completed for residents when they are admitted to the facility, however would be going forward. **RECORDING RESULTS:**

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 00376 01/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21426 21426 Continued From page 33 R109's Medication Record, dated 6/1/14 to 6/30/14, identified she received a 2nd step TST in her right forearm on 6/28/14. Further, the record provided direction on 6/30/14 to, "PM nurse read and record result on MAR [Medication Administration Record] and Matrix [electronic medical record system] Progress Notes. Must record number of mm [millimeter] induration...". However, the fields to write on the record, to record the results of R109's 2nd step TST, were left blank. R109's Resident Progress Note, dated 6/28/14 to 7/11/14, identified she received a TST on 6/28/14, "Mantoux [another term for a TST] given right fore arm." No documention in the progress notes identified the results of the TST. When interviewed on 1/6/15 at 12:52 p.m., US-T stated all residents TST results should be recorded on the MAR and in the nursing progress notes. During interview on 1/8/15 at 9:58 a.m., RN-A stated all TST results should be recorded in millimeters on the MAR or in the progress notes. When interviewed on 1/8/15 at 10:33 a.m., the DON stated all TST results should be recorded in the MAR or progress notes. **EMPLOYEE SKIN TESTS:** Cook (CK)-A's Baseline TB Screening Tool for Healthcare Workers record, dated 10/2/14, indicated he had received a 1st step TST with a

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negative result. However, the field to record administration and results of the 2nd step TST were blank. Dietary aide (DA)-A's Baseline TB

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21426 21426 Continued From page 34 Screening Tool for Healthcare Workers record, dated 9/8/14, indicated he had received a 1st step TST with a negative result. However, the field to record administration and results of the 2nd step TST were blank. RN-A and the DON were interviewed on 1/8/15 at 12:43 p.m. regarding the lack of a 2nd step TST for CK-A and DA-A. RN-A stated the facility lacked a system to ensure employees were given their 2nd step TST's within 7-21 days (the recommended period to receive the 2nd step TST) after the 1st step. A policy on tuberculosis control in the facility was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding current tuberculosis regulations for health care facilities and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21800 21800 MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac. Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs

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as defined in section 253C.01, the written

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 01/08/2015 00376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21800 21800 Continued From page 35 statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of Medicare Part A skilled services, to 5 of 6 residents (R36, R11, R103, R10 and R67) in the sample reviewed for liability notice and beneficiary appeal rights. Findings include: R36 was discharged from Medicare Part A services on 7/26/2013, and remained in the facility. R36's representative was given the Elim Care & Rehab Center, Notice of Medicare Non-Coverage form [Centers for Medicare and Medicaid Services (CMS)-10123] on 7/24/2014

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 00376 01/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21800 Continued From page 36 21800 via telephone. The facility did not provide R36 and/or her legal representative with a SNFABN (CMS)-10055 to inform her of potential liability for non-covered services even though they remained in the facility. R11 was discharged from Medicare Part A services on 1/7/2015, and remained in the facility. R11's representative was given and signed the Elim Care & Rehab Center, Notice of Medicare Non-Coverage form on 1/5/2015. The facility did not provide R11 and/or his legal representative with a SNFABN (CMS)-10055 to inform him of potential liability for non-covered services even though they remained in the facility. R103 was discharged from Medicare Part A services on 10/29/2014, and remained in the facility. R103 was given and signed the Elim Care & Rehab Center, Notice of Medicare Non-Coverage form on 10/27/2014. The facility did not provide R103 and/or her legal representative with a SNFABN (CMS)-10055 to inform her of potential liability for non-covered services even though they remained in the facility. R10 was discharged from Medicare Part A services on 12/19/2014, and remained in the facility. R10 was given and signed the Elim Care & Rehab Center, Notice of Medicare Non-Coverage form on 12/17/2014. The facility did not provide R10 and/or her legal representative with a SNFABN (CMS)-10055 to inform her of potential liability for non-covered services even though they remained in the facility. R67 was discharged from Medicare Part A

services on 12/10/2014, and remained in the

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 01/08/2015 00376 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21800 Continued From page 37 21800 facility. R67 was given and signed the Elim Care & Rehab Center, Notice of Medicare Non-Coverage form on 12/8/2014. The facility did not provide R67 and/or her legal representative with a SNFABN (CMS)-10055 to inform her of potential liability for non-covered services even though they remained in the facility. During an interview on 1/7/2015 at 1:37 p.m., registered nurse (RN)-A stated that residents, whose skilled services were ending, "are given the facility's liability notice at least 48 hours prior to that service ending." RN-A stated if a resident's PT/OT (physical or occupational therapy) was ending, for example, and the resident remained in the facility, "I would give that resident, or the representative, the liability notice." RN-A confirmed the form given to residents was the "Elim Care & Rehab Center, Notice of Medicare non-Coverage" form, or CMS-10123. RN-A said this liability notice "was the only form I have ever given residents." During an interview on 1/8/2015 at 10:30 a.m., the director of nursing (DON) stated she was not aware of which liability notice form residents were receiving, but said "I understand we have not been giving the correct one." The DON said they would have to look at the process and make a change, and added, "I think this would be an easy fix, but it has to get corrected." In an interview on 1/8/2015 at 2:25 p.m., RN-A stated the facility did not have a policy/procedure related to resident liability, and appeal rights but they follow the federal guidelines.

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SUGGESTED METHOD OF CORRECTION:

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 00376 01/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 **ELIM HOME - MILACA** MILACA, MN 56353 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21800 21800 Continued From page 38 The director of nursing or designee could inservice staff regarding the correct liability notices to provide to residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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