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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0TUG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00376

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245422**

2.STATE VENDOR OR MEDICAID NO.
(L2) **695342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME - MILACA**
(L4) **730 SECOND STREET SOUTHEAST, PO BOX 157**
(L5) **MILACA, MN** (L6) **56353**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/02/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **86** (L18)

13.Total Certified Beds **86** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	86			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 03/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 04/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00130
(L31)

30. REMARKS
Posted 04/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/26/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245422	A. Building B. Wing	3/2/2015

Name of Facility	Street Address, City, State, Zip Code
ELIM HOME - MILACA	730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/16/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/16/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **02/16/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/16/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	3/4/2015	10562	3/2/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/8/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0TUG

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(L2) **695342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME - MILACA**
(L4) **730 SECOND STREET SOUTHEAST, PO BOX 157**
(L5) **MILACA, MN** (L6) **56353**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/08/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **86** (L18)

13.Total Certified Beds **86** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	86			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 02/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00130
(L31)

30. REMARKS
Posted 02/26/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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;

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

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

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

DEPARTMENT CONTACT

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

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.

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:

Nursing Home Informal Dispute Process

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING _____ B. WING _____ RECEIVED	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - MILACA	730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353 FEB 04 2015

(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) MN Dept. of Health St.Cloud	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	1. The facility informed residents (R10, R36, R67, R103) of failure to provide them with the advanced beneficiary notice on 2/5/15. R11 has expired. 2. The facility's business office and social services will inform all residents who receive Medicare Part A of their potential for liability SNFABN (CMS)-10055 residents both orally and in writing at the time that the notice of Medicare non-coverage is issued. 3. Audits will be conducted weekly for one month, monthly x3 months, then quarterly from then on to ensure proper compliance.	

2/23/15 see addendum pt

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Bibey — TITLE: Administrator — (X6) DATE: 2/3/2015

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.

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.

2/23/15
BK

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.

Kalla Burbey, Administrator.
2/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - MILACA	730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156	4. Completion Date: 2/16/15 5. Correction will be monitored by the Director of Social Services and Administrator. 6.Issues detected in audits will be reported to QA committee for improvement suggestions.	

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: 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 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	F 156		

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F 156	Continued From page 3 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 facility. R67 was given and signed the Elim Care & Rehab Center, Notice of Medicare Non-Coverage form on 12/8/2014. The facility	F 156		

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F 156	Continued From page 4 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.	F 156		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		

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F 278	Continued From page 5 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to correctly document each resident's continence status on the Minimum Data Set for 1 of 3 residents (R16) reviewed for urinary incontinence. Findings include: R16 's quarterly Minimum Data Set (MDS) dated	F 278	1. Resident (R16) had an MDS modification completed 2/2/15 to correct urinary status. Staff will ensure proper documentation of continence status in resident's (R16) MDS by following quarterly report. Resident (R16) will have an evaluation of voiding patterns to assess continence status. 2. All other residents in facility will have an evaluation of voiding pattern analysis completed with each full MDS from this point forward.	

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F 278	Continued From page 6 10/17/14, included the resident was completely continent of urine. However, R16 's progress note dated 10/22/14, " Quarterly MDS completed ...always incontinent of bowel and bladder ... " When interviewed on 1/8/15, at 9:23 a.m. the MDS coordinator (RN)-B stated R16 should have been coded as always incontinent of urine versus always continent of urine. RN-B stated the nurses working on the floor fill out assessments in the computer that transfer into the MDS and, " unless you check every answer, there could be errors. " RN-B did not review records or talk with direct care staff in coding, but relied on the auto-fill property of the facilities medical record system. The Resident Assessment Instrument Manual dated 12/2014, included instructions for assessment of urinary incontinence, " Review the medical record for bladder or incontinence records of flow sheets, nursing assessments and progress notes, physician history, and physical exams. " " Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes. "	F 278	3. Reoccurrence will be prevented by verifying incontinence status with direct care staff. Staff will be educated on the importance of proper documentation of incontinence status. 4. Audits will be conducted by verifying correct coding with direct care staff weekly for one month, then monthly x3 months, then quarterly until consistent compliance is achieved. 5. Completion Date: 2/16/15 6. Correction will be monitored by DON and MDS Coordinator 7. Issues detected in audits will be reported to QA committee for improvement suggestions	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 282		

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F 282	Continued From page 7 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 mobility..." Staff were directed to turn and	F 282	1. Resident had a comprehensive skin assessment completed 2/2/15. Resident's care plan was updated. 2. All other residents will be monitored for pressure ulcer development. Residents will be turned and repositioned based on their skin assessment. 3. Staff will be educated on proper offloading techniques, which is equal to one minute per patient per turn/reposition. 4. Audits conducted weekly for one month, then monthly x3 months then quarterly until consistent compliance is achieved. 5. Completion date: 2/16/2015 6. Correction will be monitored by DON and Nurse Unit Managers. 7.Issues detected in audits will be reported to QA committee for improvement suggestions.	

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F 282	Continued From page 8	F 282		

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

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F 282	Continued From page 9	F 282		

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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F 282	Continued From page 10 would not have relieved pressure on her buttocks. RN-A stated R16 should be repositioned every 2 hours and peri-wipes were not to be used. RN-A stated R16 should have dycem under the mechanical lift sling as well as on top, but this was not present at this time either. A policy was requested but not provided by the facility.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure optimal wheel 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	F 309	1. Resident (R16) care plan was updated by staff for wheelchair positioning and the Dycem was replaced to prevent slipping in chair. Resident (R73) care plan was updated to add a back pillow along with anti-thrust cushion to ensure proper positioning in chair. Resident (R16) was screened by occupational therapy on 1/8/15 for bilateral hand contractures. Resident received new orders for scheduled pain medication on 1/9/15.	

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F 309	Continued From page 11 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 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 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	F 309	2. All other residents will be monitored to ensure proper wheelchair positioning and will be referred to therapy if needed. Staff will be re-educated on monitoring for signs and symptoms of pain, verbal and nonverbal, during completion of restorative programs. 3. Audits conducted weekly for one month, then monthly x3 months, then quarterly from then on to ensure proper compliance with wheelchair positioning and pain management. 4. Completion date: 2/16/15 5. Correction will be monitored by DON and Nurse Unit Managers 6.Issues detected in audits will be reported to QA committee for improvement suggestions	

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F 309	Continued From page 12 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 to or from bed, chair, and wheelchair. The MDS also identified R73 had lower extremity (hip, 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	F 309		

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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.

A review of the Pro Rehab Nursing Referral for Therapy Screen form, dated 7/28/14, indicated R73 was having increased weakness and not able to position himself in his wheelchair and slides down in his chair frequently. On 7/29/14 COTA-B identified that R73 was sliding down in his wheelchair and issued an anti-thrust cushion for his wheelchair.

On 1/8/15, at 10:13 am COTA-B observed R73

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with the surveyor. R73 was sliding down in his wheelchair with his hips were not touching the back of the wheelchair. COTA-B stated R73 often slides down in 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.

R73 was observed in his wheelchair with physical therapy assistant (PTA)-D on 1/8/15, at 10:43 a.m. (30 minutes after being repositioned by COTA-B and NA-D). R73 was again sliding down in his wheelchair.

When interviewed (PTA)-D on 1/8/15, at 10:43 a.m. PTA-D stated R73 was sliding down in his wheelchair. PTA-D suggested a back pillow/support would be beneficial for R73 to help prevent him from sliding down in his wheelchair. PTA-D asked R73 to push himself back into his wheelchair with his arms, but R73 was unable to reposition himself.

A discussion was held in regards to a back pillow/cushion for R73 on 1/8/15, at 11:03 a.m. with COTA-B and PTA-D. COTA-B and PTA-D both agreed that a back pillow/support would be 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

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F 309	Continued From page 15 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, 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," it hurts her too much. R16 is supposed to have wash cloths placed in	F 309		

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F 309	Continued From page 16	F 309		

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.

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

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F 309	Continued From page 17 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 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.	F 309		

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F 309	Continued From page 18 A policy was requested, but not provided by the facility.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This 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	F 314	R16 1. Resident had a comprehensive skin assessment completed 2/2/15. Resident's care plan was updated. 2. All other residents will be monitored for pressure ulcer development. Residents will be turned and repositioned based on their skin assessment. 3. Staff will be educated on proper off-loading techniques, which is equal to one minute per patient per turn/reposition. 4. Audits conducted weekly for one month, then monthly x3 months then quarterly until consistent compliance is achieved. 5. Completion date: 2/16/15 6. Correction will be monitored by DON and Nurse Unit Managers 7. Issues detected in audits will be reported to QA committee for improvement suggestions	

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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 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.

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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 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,

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F 314	Continued From page 21 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 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.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services to prevent further decline in range of motion for 1 of 1 residents (R16) reviewed for contractures.	F 318	1. Resident (R16) was screened by occupational therapy on 1/8/15 for bilateral hand contractures. Resident received new orders for scheduled pain medication on 1/9/15. 2. All other residents will receive ample time and opportunity to complete PROM and will receive sufficient pain management techniques, non-pharmacological and pharmacological, before therapies.	

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F 318	Continued From page 22 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." 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	F 318	3. Staff will be re-educated on the importance of restorative programs and the signs and symptoms of verbal and nonverbal pain. 4. Audits conducted weekly for one month, then monthly x3 months, then quarterly from then on to ensure proper compliance with pain management and restorative programs. 5. Completion Date: 2/16/15 6. Correction will be monitored by DON and Nurse Unit Managers. 7. Issues detected in audits will be reported to QA committee for improvement suggestions.	

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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, "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

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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 stated there would be no way to tell from the Point of Care History if the PROM was being

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F 318	Continued From page 25 performed to R16's hands or just her other joints. 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. When she does her evaluation she looks at the Point of Care History, Restorative Nursing report. It looked like it was being completed. RN-A stated there would be no way to tell from this report if the PROM was occurring with R16's hands or other joints. The order was for them to do bilateral upper extremity joints. RN-B stated R16 has had contracted hands for quite some time and back in May of 2011 she had developed pressure ulcers between her finger related to the contractures. She did not know if R16's contractures were more contracted now than they were in 2011.	F 318		

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F 318	Continued From page 26 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.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively	F 323	1. The barrier that was in place to prevent Resident (R7) from falling out of bed was removed on 1/7/15. Education was provided to staff members involving use of restraint policy and fall prevention on 1/7/15. 2. Facility rounds were conducted 1/8/15 to ensure that no other residents had unassessed positioning devices.	

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F 323	Continued From page 27 assess and safely implement interventions to reduce the risk of injury and falls for 1 of 3 residents (R7) reviewed for accidents and hazards. Findings include: R7's quarterly Minimum Data Set (MDS), dated 12/2/14, identified he had short and long term memory problems, was totally dependant on staff for transfers and bed mobility. During observation on 1/5/15 at 4:01 p.m., R7 was in bed with his eyes closed. The bed was in the low position (close to the floor), with one side placed against the wall, and had two rolled up pillows shoved underneath the mattress on the left side causing the mattress to bend upwards on one side at approximately a 30 degree angle. When interviewed on 1/5/15 at 5:38 p.m., registered nurse (RN)-A stated R7 had sustained a fall from his bed on 12/14/14. He had been found by staff lying on the floor next to his bed. Subsequent observation made on 1/6/15 at 3:00 p.m., and of morning cares on 1/7/15 at 8:53 a.m., found R7 to be in bed having pillows and a cushion wedge placed underneath the mattress, again causing the mattress to bend upwards on one side. Nursing assistant (NA)-E stated the wedge and pillows are used under the mattress to prevent R7 from falling out of bed onto the floor, and they had been used for a couple months now. R7's Safety Event - Falls report, dated 12/22/14, identified R7 was, "...noted on floor at 0740 by NAR [nursing assistant, registered]. Res	F 323	3. Reoccurrence will be prevented by providing sufficient education for staff members. 4. Audits conducted weekly for one month, then monthly x3 months, then 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 DON and Nurse Unit Managers 7.Issues detected in audits will be reported to QA committee for improvement suggestions	

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[resident] laying over one mat, the other mat pushed parcially [sp] against door, wedge laying on floor by res." The report identified R7 obtained minor injury from the fall, however the care plan was being followed.

R7's care plan, dated 12/23/14, identified R7 was at risk of falling due to decreased physical mobility, bowel and bladder incontinence, medication use, and a history of attempting to transfer out of bed unassisted. A goal was identified of, "Resident will not injure self when crawling out of bed onto mat", and indicated interventions of, "Frequent checks, if restless get out of bed and bring to nurse station", and, "Resident sleeps in low bed in low position. Place mat on floor near bed when resident is in bed." The care plan did not identify an intervention of placing rolled pillows and/or wedge cushions under R7's mattress to prevent him from falling out of bed.

R7's Nursing Observations assessment, dated 12/8/14, identified R7 had sustained no falls since admission, but was determined to be at high risk for falls. The assessment did not identify any interventions to be used to reduce his risk for falls, including the use of rolled pillows and/or cushion wedges being placed underneath his mattress to prevent him from falling out of bed.

During interview on 1/7/15 at 11:03 a.m., NA-F stated the wedge cushion and rolled pillows were used to keep R7 from rolling out of bed onto the floor, and had been in place for about a month.

When interviewed on 1/7/15 at 11:24 a.m., NA-G stated staff had been using the pillows and wedge cushion under R7's mattress for the past few

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months to keep him from falling out of bed, "If it wasn't there, he would roll out onto the floor."

During interview on 1/7/15 at 12:15 p.m., licensed practical nurse (LPN)-A stated in the past R7 used a wedge cushion for his positioning in bed, however it should not be placed underneath his mattress to keep him in bed.

When interviewed on 1/7/15 at 12:30 p.m., registered nurse (RN)-A stated she was unaware R7 had rolled pillows and wedge cushions being placed under his mattress to prevent him from falling out of bed, however would speak to the staff and determine why it was being done. During subsequent interview on 1/7/15 at 1:24 p.m., RN-A stated she was unable to determine who directed the staff to use the devices, but that R7's wife had reported he (R7) was trying to crawl over the elevated mattress side one day and she had to help him to keep him from falling out of bed. Further, R7 had potential for increased injury with the pillows and wedge cushion placed underneath the mattress because he could fall from a higher elevation. Using the devices in this manner was not appropriate and could be more of a accident hazard for R7.

During interview on 1/7/15 at 10:54 a.m., the director of nursing (DON) stated she was unaware of rolled pillows and wedge cushions being placed under R7's mattress as an intervention to reduce his falls from bed. The devices had not been assessed as an appropriate intervention to keep R7 from falling out of his bed, "the proper steps weren't taken for it."

A facility policy on fall interventions and their assessment was requested, but none was

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F 323	Continued From page 30 provided.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to reheat precooked food to an internal temperature of 165 degrees for at least 15 seconds to prevent potential forborne illness for 16 of 76 residents who ate reheated foods on a regular basis. Findings include: During observation of the main kitchen on 1/7/15, at 11:23 a.m. cook (C)-A removed a baggie of precooked carrots from the freezer. He then placed the carrots into the microwave for approximately 50 seconds. After taking the carrots out of the microwave, they were placed on a plate for resident consumption. C-A made no attempt to take the temperature of the food before serving the food to a resident. Surveyor asked C-A to check the temperature of the carrots. C-A obtained the temperature of the carrots and it measured 100 degrees Fahrenheit	F 371	1. 76/76 Residents, who receive meals, will not have the potential for foodborne illness by the lack of monitoring of food temperatures of reheated foods to ensure that they reach 165 degrees. The dietary manager will educate all appropriate staff on these policies and procedures. The Certified Dietary manager or designee will audit the proper procedure for reheating of food to ensure ongoing compliance. 2. All other residents who are identified of the potential for foodborne illness will receive services that follow food safety policies and procedures. 3. All dietary staff were educated and trained on the proper procedures for reheating foods on 1/7/15 4. CDM or designee has developed an auditing tool and started auditing meal service/reheating foods immediately and will continue to do so three times per week for one month and then weekly for three months to ensure compliance or until considered resolved by QA Committee	

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F 371	Continued From page 31 (F). C-A agreed this was not hot enough and placed the carrots back into the microwave for approximately 50 seconds. He then removed the carrots from the microwave and took the temperature again. Temperature was 120 degrees F. C-A again placed the carrots back into the microwave for approximately 50 seconds. The temperature was 170 degrees F and the plate was then served to a resident. C-A stated they do not take the temperature of the food they microwave. Usually the food is steaming when it comes out of the microwave, so "we do not temp [temperature] the food." During interview on 1/7/15, at 11:30 a.m. C-B 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 meal. When interviewed on 1/7/15, at 11:37 a.m. dietary 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 placed these bags into the steam table without taking the temperature of the noodles. At 11:39 a.m. C-B grabbed the preheated noodles from the steam table and put them into the microwave. She then grabbed Alfredo sauce from the refrigerator and placed it into the microwave. She then proceeded to place the noodles and sauce on a plate without checking the temperature to ensure it was 165 degrees F. The plate was served to a resident. The Alfredo sauce was not	F 371	5.Completion Date: 2/16/15 6.Correction will be monitored by the Certified Dietary Manager or designee 7.Issues detected in audits will be reported to QA committee for improvement suggestions	

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steaming. At 11:41 a.m. C-B reheated precooked spaghetti noodles in the microwave, and then heated marinara sauce in the microwave. She then poured the sauce over the noodles. No temperature was taken of the spaghetti and the marinara sauce. Surveyor requested that C-B take the temperature of the spaghetti noodles and marinara sauce. The temperature was 120 degrees F. C-B placed the plate back into the microwave for an additional 50 seconds. C-B obtained the temperature again and it was 147 degrees F. C-B put plate of spaghetti and marinara sauce back into the microwave again for approximately 50 seconds. C-B used a different thermometer to obtain the temperature of the spaghetti and marinara sauce, temperature was 180 degrees F. The spaghetti and marinara sauce were served to a resident.

During observation on 1/7/15, at 11:46 a.m. staff began checking all food temperatures of all precooked items that were reheated in the microwave prior to them being served to the residents.

When interviewed on 1/7/15, at 11:50 a.m. certified dietary manager (CDM) and director of operations (DO) stated they were not aware that staff were not checking temperatures of the reheated food items. They will re-educate staff and look at changing our system. CDM and DO also stated that when they first started the process of reheating foods a few years ago, staff would take the temperature of reheated foods. Our system included that we knew how long it took for specific items to be reheated in the microwave to be at the correct temperature (for example: beans took approximately 50 seconds). Staff were to continually test temperatures

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F 371	Continued From page 33 periodically if the precooked food was reheated in the microwave. The facility policy entitled Food Preparation and Service, dated 11/11/13, included, "Previously cooked food must be reheated to an internal temperature of 165 degrees for at least 15 seconds. Reheated foods that are not consumed within 2 hours will be discarded."	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	1. The facility will develop an efficient and effective infection control program detailing resident instances of infection, building location of infection, and statistical analysis of incidence and prevalence identified in each unit and the facility as a whole. 2. There will be a consistently maintained and thoroughly documented infection control program. Residents and employees will benefit from a localized log of infection trends within the unit and across the facility. The facility will be able to recognize areas in which infection is prevalent and will be able to take measures to prevent the spread of infection to other units. 3. Audits conducted weekly for one month, then monthly x3 months, then quarterly from then on to ensure proper compliance with infection control.	

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F 441	Continued From page 34 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: 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. Findings include: 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	F 441	4. Completion date: 2/16/2015 5. Correction will be monitored by DON 6. Issues detected in audits will be reported to QA committee for improvement suggestions	

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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 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

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F 441	Continued From page 36	F 441		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - MILACA	730 SECOND STREET SOUTHEAST, PO BOX 157 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) COMPLETION DATE
F 441	Continued From page 37	F 441		

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 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.

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

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	245422	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 38 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 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.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING **02 - ELIM HOME MILACA** B. WING _____	**01/07/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - MILACA	**730 SECOND STREET SOUTHEAST. PO BOX 157 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) COMPLETION DATE
K 000	INITIAL COMMENTS 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.	K 000		

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

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 OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00376	A. BUILDING: _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - MILACA	730 SECOND STREET SOUTHEAST, PO BOX 157 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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 5-8th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

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2 000	Continued From page 1 Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000	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 STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		

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2 565	Continued From page 2 by: 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	2 565		

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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 10:58 a.m. R16 was brought to the beauty shop	2 565		

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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 would not have relieved pressure on her buttocks.	2 565		

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2 565	Continued From page 5 RN-A stated R16 should be repositioned every 2 hours and peri-wipes were not to be used. RN-A stated R16 should have dycem under the mechanical lift sling as well as on top, but this was not present at this time either. A policy was requested but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding following an established plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure optimal wheel	2 830		

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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 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

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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 to or from bed, chair, and wheelchair. The MDS also identified R73 had lower extremity (hip,	2 830		

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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.	2 830		

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2 830	Continued From page 9 A review of the Pro Rehab Nursing Referral for Therapy Screen form, dated 7/28/14, indicated R73 was having increased weakness and not able to position himself in his wheelchair and slides down in his chair frequently. On 7/29/14 COTA-B identified that R73 was sliding down in his wheelchair and issued an anti-thrust cushion for his wheelchair. On 1/8/15, at 10:13 am COTA-B observed R73 with the surveyor. R73 was sliding down in his wheelchair with his hips were not touching the back of the wheelchair. COTA-B stated R73 often slides down in 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. R73 was observed in his wheelchair with physical therapy assistant (PTA)-D on 1/8/15, at 10:43 a.m. (30 minutes after being repositioned by COTA-B and NA-D). R73 was again sliding down in his wheelchair. When interviewed (PTA)-D on 1/8/15, at 10:43 a.m. PTA-D stated R73 was sliding down in his wheelchair. PTA-D suggested a back pillow/support would be beneficial for R73 to help prevent him from sliding down in his wheelchair. PTA-D asked R73 to push himself back into his wheelchair with his arms, but R73 was unable to reposition himself. A discussion was held in regards to a back pillow/cushion for R73 on 1/8/15, at 11:03 a.m. with COTA-B and PTA-D. COTA-B and PTA-D both agreed that a back pillow/support would be	2 830		

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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, 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	2 830		

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2 830	Continued From page 11 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.	2 830		

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2 830	Continued From page 12 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	2 830		

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2 830	Continued From page 13 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. A policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding screening residents for proper positioning, fall interventions, and pain management. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by:	2 895		

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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." Staff were directed, dated 12/18/12, to "Sheep	2 895		

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2 895	Continued From page 15 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,	2 895		

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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	2 895		

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2 895	Continued From page 17 stated there would be no way to tell from the Point of Care History if the PROM was being performed to R16's hands or just her other joints. 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. When she does her evaluation she looks at the Point of Care History, Restorative Nursing report. It looked like it was being completed. RN-A stated there would be no way to tell from this report if the PROM was occurring with R16's hands or other joints. The order was for them to do bilateral upper extremity joints. RN-B stated R16 has had contracted hands for quite some time and back in May of 2011 she had developed pressure ulcers between her finger related to the contractures. She did not know if R16's contractures were more contracted	2 895		

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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.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the	2 900		

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2 900	Continued From page 19 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	2 900		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME - MILACA	730 SECOND STREET SOUTHEAST, PO BOX 157 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
2 900	Continued From page 20 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	2 900		

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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	2 900		

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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.	2 900		
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 and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to reheat precooked food to an internal temperature of 165 degrees for at	21025		

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21025	Continued From page 23 least 15 seconds to prevent potential forborne illness for 16 of 76 residents who ate reheated foods on a regular basis. Findings include: During observation of the main kitchen on 1/7/15, at 11:23 a.m. cook (C)-A removed a baggie of precooked carrots from the freezer. He then placed the carrots into the microwave for approximately 50 seconds. After taking the carrots out of the microwave, they were placed on a plate for resident consumption. C-A made no attempt to take the temperature of the food before serving the food to a resident. Surveyor asked C-A to check the temperature of the carrots. C-A obtained the temperature of the carrots and it measured 100 degrees Fahrenheit (F). C-A agreed this was not hot enough and placed the carrots back into the microwave for approximately 50 seconds. He then removed the carrots from the microwave and took the temperature again. Temperature was 120 degrees F. C-A again placed the carrots back into the microwave for approximately 50 seconds. The temperature was 170 degrees F and the plate was then served to a resident. C-A stated they do not take the temperature of the food they microwave. Usually the food is steaming when it comes out of the microwave, so "we do not temp [temperature] the food." During interview on 1/7/15, at 11:30 a.m. C-B 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 meal. When interviewed on 1/7/15, at 11:37 a.m. dietary	21025		

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21025	Continued From page 24 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 placed these bags into the steam table without taking the temperature of the noodles. At 11:39 a.m. C-B grabbed the preheated noodles from the steam table and put them into the microwave. She then grabbed Alfredo sauce from the refrigerator and placed it into the microwave. She then proceeded to place the noodles and sauce on a plate without checking the temperature to ensure it was 165 degrees F. The plate was served to a resident. The Alfredo sauce was not steaming. At 11:41 a.m. C-B reheated precooked spaghetti noodles in the microwave, and then heated marinara sauce in the microwave. She then poured the sauce over the noodles. No temperature was taken of the spaghetti and the marinara sauce. Surveyor requested that C-B take the temperature of the spaghetti noodles and marinara sauce. The temperature was 120 degrees F. C-B placed the plate back into the microwave for an additional 50 seconds. C-B obtained the temperature again and it was 147 degrees F. C-B put plate of spaghetti and marinara sauce back into the microwave again for approximately 50 seconds. C-B used a different thermometer to obtain the temperature of the spaghetti and marinara sauce, temperature was 180 degrees F. The spaghetti and marinara sauce were served to a resident. During observation on 1/7/15, at 11:46 a.m. staff began checking all food temperatures of all precooked items that were reheated in the microwave prior to them being served to the	21025		

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21025	Continued From page 25 residents. When interviewed on 1/7/15, at 11:50 a.m. certified dietary manager (CDM) and director of operations (DO) stated they were not aware that staff were not checking temperatures of the reheated food items. They will re-educate staff and look at changing our system. CDM and DO also stated that when they first started the process of reheating foods a few years ago, staff would take the temperature of reheated foods. Our system included that we knew how long it took for specific items to be reheated in the microwave to be at the correct temperature (for example: beans took approximately 50 seconds). Staff were to continually test temperatures periodically if the precooked food was reheated in the microwave. The facility policy entitled Food Preparation and Service, dated 11/11/13, included, "Previously cooked food must be reheated to an internal temperature of 165 degrees for at least 15 seconds. Reheated foods that are not consumed within 2 hours will be discarded." SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could inservice staff regarding proper reheating of foods for resident consumption, and audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and	21390		

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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 by: 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. Findings include:	21390		

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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	21390		

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21390	Continued From page 28	21390		

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

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21390	Continued From page 29 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 the infections, trending of the collected data, or analysis to determine if infectious disease was	21390		

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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	21390		

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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. 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.	21390		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (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. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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21426	Continued From page 32	21426		

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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(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
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 negative result. However, the field to record administration and results of the 2nd step TST were blank. Dietary aide (DA)-A's Baseline TB	21426		

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	00376	A. BUILDING: _____ B. WING _____	01/08/2015

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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.	21426		
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 as defined in section 253C.01, the written	21800		

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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 by: 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	21800		

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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

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21800	Continued From page 37 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. SUGGESTED METHOD OF CORRECTION:	21800		

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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.	21800		