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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 17Z3

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 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 **04/12/2016** (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 04/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 04/12/2016 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/04/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245422
April 12, 2016

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 April 1, 2016 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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 12, 2016

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

RE: Project Number S5422026

Dear Ms. Broberg:

On March 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 3, 2016. 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 April 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 7, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 3, 2016, effective April 1, 2016 and therefore remedies outlined in our letter to you dated March 15, 2016, 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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245422	A. Building B. Wing	4/12/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 04/01/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 04/01/2016	ID Prefix F0520 Reg. # 483.75(o)(1) LSC	Correction Completed 04/01/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) BF/KJ	DATE 04/12/2016	SIGNATURE OF SURVEYOR 10562	DATE 04/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245422 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/7/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	03/10/2016	LSC K0017	03/18/2016	LSC K0022	03/09/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	03/10/2016	LSC K0029	03/09/2016	LSC K0046	03/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0048	03/08/2016	LSC K0052	04/01/2016	LSC K0054	04/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0056	03/23/2016	LSC K0067	04/01/2016	LSC K0144	03/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/KJ	04/12/2016	27200	04/07/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245422 Y1	A. Building 02 - ELIM HOME MILACA B. Wing Y2	4/7/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0046	03/04/2016	LSC K0048	03/08/2016	LSC K0054	04/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0056	03/23/2016	LSC K0067	04/01/2016	LSC K0144	03/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/KJ	04/12/2016	27200	04/07/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245422	ELIM HOME MILACA

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 10562	04-13-2016	04-13-2016	0.25	0.00	0.00	0.25	0.25	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours	0.00
Total Clerical/Data Entry Hours.....	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245422	ELIM HOME MILACA

Type of Survey (select all that apply):

D	H				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 27200			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.00

Total Clerical/Data Entry Hours.....

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 17Z3

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: **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 **03/03/2016** (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

X 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: **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 :
Timothy Rhonemus, HFE NE II 03/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/31/2016 (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 04/04/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 15, 2016

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

RE: Project Number S5422026

Dear Ms. Broberg:

On March 3, 2016, 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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
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 April 12, 2016, 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 April 12, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 3, 2016 (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 September 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

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
	245422	A. BUILDING _____ B. WING _____	03/03/2016

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that a medical justification for the use of a urinary catheter was obtained for 1 of 3 residents (R134) who utilized a foley catheter. Findings included:	F 315	R134 was admitted on 2/26/2016 with a Foley catheter to this facility only for transportation due to his weakened condition, so he would not have to transfer during the trip from Oklahoma to Milaca, MN. The order for the catheter and removal of the catheter were not obtained	4/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 1 R134 had the diagnoses of bacterial pneumonia with acute respiratory failure, atrial fibrillation, chronic disability with severe deconditioning. In review of the admission assessment review, on 02/26/16 at 6:39 p.m., the facility nursing staff documented that, "Catheter patent, urine dark amber but clear." In review of R134's medical records (both paper and electronic), lacked evidence that the facility had assessed the need for a foley catheter to remain in place. During interview on 02/29/2016 at 2:40 p.m., licensed practical nurse (LPN)-A stated R134 arrived from a hospital in Oklahoma City, Oklahoma via medical van service on Friday 02/26/2016. When R134 arrived to the facility, it was noted that this resident had a foley catheter placed by the hospital. LPN-A stated that R134 did not have a current order for the catheter nor if it should discontinued. In a resident interview on 03/01/2016 09:11 a.m., R134 was observed in a wheel chair with a foley catheter attached to a large covered drainage bag. R132 stated that he had the catheter placed last Friday morning when he was transported from Oklahoma to Milaca, so he would not have to go to the bathroom on the ride, due to his weakness. R134 stated that he thought it was coming out today, but had not heard, or seen anyone yet. In review of the R134's admission physician's orders by the facility, lacked orders for a foley catheter, nor indicated a medical justification for its use. In review of the orders received by this facility from Kindred Hospital, it was noted on 02/25/2016 and order for, "Place foley cath [sig]	F 315	from Kindred Hospital prior to his arrival. The wife and resident questioned the floor nurse on 3/01/2016 and nursing concern was written for nurse practitioner to address. Order received to remove catheter the morning of 3/02/2016. Catheter was removed on 3/02/2016 with no adverse effects. Resident has been continent of urine since removal of catheter. He continues without a catheter at this time. The facility will develop a comprehension pre - admission screening that will identify potential residents being admitted with catheters. The screening will include but not limited to order date of removal of catheter. Education will be provided to nursing staff in regarding changes made to the pre-admission screening process for recognizing residents admitted with catheters found on pre □ admission screening form. The admitting nurse will note physician orders for date a catheter, diagnosis of catheter, and follow up concerning catheter placement and/ removal of catheter. If no order for catheter is found admitting nurse will call physician for clarification. Audits will be conducted weekly for one month, then monthly x3 months, then quarterly from then on to ensure proper compliance with pre- admission screening forms and orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ELIM HOME - MILACA	730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353

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F 315	Continued From page 2 today and obtain UA (urine analysis)." Orders received from the sending hospital also lacked medical justification and duration that the catheter remain in place. During interview on 03/01/2016 1:58 p.m., the unit manager (RN)-A stated that she had not yet met R134 or had reviewed this resident's orders. After RN-A had reviewed of R134's medical records, this nurse stated that the facility did not have orders for R134's catheter nor medical justification for its continued placement, and should have been addressed when resident was admitted last Friday. During a later interview on 03/01/2016 3:00 p.m., RN-A stated that medical records called and requested a copy of the hospital discharge record, however was unable to obtain as Oklahoma state law allows hospitals up to 30 days to provide that documentation. On 03/01/2016 at 3:04 p.m., the facility's nurse consultant (RN)-B, provided a voice order to "D/C (discontinue) catheter a.m. of 3/2/16." During a telephone interview on 03/02/2016 1:18 p.m., phone call made to primary physician's office and spoke to his medical assistant (MA)-A, to see if resident's physician was aware that R134 had had a catheter upon admission until it was removed this morning. After checking with the physician, MA-A stated that the physician was not aware of the catheter until an order was requested for it to be discontinued, and was unaware that a foley had been placed prior to transport from Oklahoma.	F 315	Completion date: 4/1/2016. Correction will be monitored by assigned RN Unit manager. Issues detected in audits will be reported to QA committee for improvement suggestions.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 3 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 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:	F 441		

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F 441	Continued From page 4 Based on interview and document review, the facility failed to implement comprehensive data collection procedures, including identification of culture results/ organisms and the antibiotics used to treat infections, for the purpose of tracking and trending resident infections as part of the infection control program. This had the potential to affect all 77 residents who resided in the facility. Findings include: Review of the facility's infection control surveillance logs from 3/1/15, through 3/1/16, identified resident infections, separated by the category of infection and the year. Infection categories included urinary tract infections (UTI), methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (C. Diff.), upper respiratory, pneumonia, influenza and other. The data collection log was to document the following for each infection: the date of the entry, unit location, resident initials, notation of whether the infection was facility acquired or community acquired, resident's gender, vaccination date (if applicable), date of symptom onset, the identified organism, date of symptom resolution and a description of the presenting symptoms. The data did not identify whether a culture was collected and any resulting organisms identified. The data also lacked notation of antibiotics used to treat the infections. Current, unresolved infections identified in the logs included the following: one (1) skin boil, one (1) abscessed tooth, five (5) pneumonia, one (1) upper respiratory, one (1) C. Diff., two (2) UTI, zero (0) MRSA, and zero (0) influenza.	F 441	The facility will develop an efficient and effective infection control program detailing residents instance of infection, which will include residents name and room number, admission data, attending physician□s name, data of onset, specific symptoms, infection site data of culture (if applicable), antibiotic therapy, including start and stop dates, resolution date or notation of on □ going , and comments. There will be a consistently maintained and thoroughly documented infection control program. Residents 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. Audits will be conducted weekly for one month, then monthly x3 months, then quarterly from then on to ensure proper compliance with infection control. Completion date: 4/1/2016. Correction will be monitored by assigned RN. Issues detected in audits will be reported to QA committee for improvement suggestions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 5	F 441		

During interview on 3/2/16, at 1:51 p.m. registered nurse (RN)-A and corporate RN-consultant reported the facility's director of nursing (DON) was typically responsible for tracking and trending infections within the facility. However, they added the DON had recently taken a leave of absence, during which RN-A and RN-consultant would be covering these responsibilities. RN-A and RN-consultant confirmed the facility's infection control logs did not include notations of cultures drawn, organisms identified and/or antibiotics used. Both RNs stated the facility's daily stand-up meetings included discussion of any residents with cultures drawn or antibiotics ordered. RN-A stated this discussion prompted the DON to review the individual medical records for each of the residents discussed, to identify the specific organism and/or antibiotic used. RN-A and RN-consultant stated the DON was able to track and trend cultures, organisms and antibiotics via these individual medical record reviews and that gathering documentation of this data or including it on the infection control logs was not necessary for accurate analysis. RN-consultant reported it was not an expectation for this information to be included in the surveillance logs. RN-consultant added that it was not necessary to re-write this information in one place in order to track/ trend and she indicated the facility's process for unveiling and analyzing cultures, organisms and antibiotics was sufficient.

The facility's undated Infection Control Data Collection policy directed surveillance data be entered onto infection control logs on at least a weekly basis and be analyzed by the infection control coordinator and the infection control committee or the facility's Quality Assessment

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F 441	Continued From page 6 and Assurance (QA&A) committee. The policy directed the following information be included in the surveillance data collected: 1. Resident's name and room number 2. Admission data 3. Attending physician's name 4. Date of onset 5. Specific symptoms 6. Infection site 7. Date of culture (if applicable) 8. Antibiotic therapy, including start and stop dates 9. Resolution date or notation of on-going 10. Comments/ follow-up The facility policy reflected the current standard of practice recommended by the Center for Disease Prevention and Control (CDC). The facility did not follow their policy of including culture and antibiotic therapy information in their infection surveillance processes.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		4/1/16

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 _____	03/03/2016

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F 520	Continued From page 7 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the quality assurance and assessment committee implemented measures to improve upon identified quality concerns in infection control, identified in consecutive surveys. Findings include: The facility failed to implement and maintain a plan for infection control monitoring for resident infections that were acquired both prior to admission, as well as, while residing in the facility. A review of the previous certification survey, exited 01/08/15, identified that 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 See F441: the facility failed to implement comprehensive data collection procedures, including identification of culture results/ organisms and the antibiotics used to treat infections, for the purpose of tracking and	F 520	The Medical Director will review the infection control logs and trends on a quarterly basis in QA that includes, but is not limited to the type of infection. Medical Director will sign off on all infection control logs at the quarterly QA meeting. Audits will be conducted quarterly QA meeting x4 from then on to ensure proper compliance with QA meetings. Completion date: 4/1/2016. Correction will be monitored by Administrator. Issues detected in audits will be reported to QA committee for improvement suggestions.	

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F 520	Continued From page 8	F 520		

trending resident infections as part of their infection control program. This had the potential to affect all 77 residents who resided in the facility.

The facility's policy, entitled: Quality Assurance and Assessment Committee (dated June 2000), identified one of the function of the committee was to: "Review pertinent Quality Improvement/Assurance issues including infection control, incident/accident reports, vulnerable adult reports, pharmacy reports, etc."

During interview 03/03/2016 12:33 p.m., the facility administrator (ADM) stated she was trying to contact the director of nursing, who was currently on medical leave. At 12:51 p.m., ADM provided documentation that the facility had in regards to urinary tract infection monitoring only, which included organism and medication orders. However, in the concurrent telephone conversation with the director of nursing (DON), she stated when preparing for the facility's monthly quality assurance reviews, the DON reviews the charts for current infections however does not always document the cultured organism or medication used to treat the infections.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2016

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

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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	Continued From page 1 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Elim Home Milaca is a 1-story building with small partial basement. The basement is not used by the nursing home residents. The building was constructed in 1963, with additions in 1973 77 & 89. A chapel and connector link to the assisted living unit was constructed in 2006. The original building and the additions are all Type II (111) construction. Therefore, the facility was inspected as two buildings. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 86 beds and had a census of 75 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 fire separations was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 75 of 75 residents, visitors, and staff members of the facility. Findings include: On facility tour between 1:30 AM to 4:30 PM on 03/01/2016, observations revealed that a wiring conduit with an open end that passed through the fire barrier wall above the double doors in the 2 hour separation that runs between the chapel and the main nursing building. This deficient condition was verified by a Maintenance Supervisor.	K 011	Conduit was sealed with approved fire caulking on 3-10-16 by Pat Johnson,Environmental Service Director. This Was verified by administrator.	3/10/16
K 017	NFPA 101 LIFE SAFETY CODE STANDARD	K 017		3/8/16

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	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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K 017 SS=C	Continued From page 3 Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had a penetration located in the ceiling tile located in the facility that are not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 75 of 75 residents, visitors, and staff members of the facility. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, observations revealed that there was a 1 inch corner missing from the ceiling tile that is located by the entrance to the main dining room. This deficient condition was verified by a Maintenance Supervisor.	K 017	Ceiling tile replaced on 3-18-16 by Pat Johnson and verified by Administrator.	

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	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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K 022 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 1 of several non-required doors leading to the exterior that do not lead to the public way in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 7.10.1.7 and 7.10.8.1. These deficient practices could negatively affect 20 of 75 residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, observations revealed that on the north side of the west solarium has a door to the outside that does not lead to a public way. This door is not part of the facility's required exits and is not labeled with a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO". This deficient condition was verified by a Maintenance Supervisor.	K 022	No Exit sign place on north side door in the west solarium on 3-9-16 by Pat Johnson and verified by administrator.	3/9/16
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and	K 025		3/10/16

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K 025	Continued From page 5 constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19-3.7.3 and 8.3. This deficient practice could affect 50 of 75 residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, observation revealed that there was a 1 inch penetration found around the flexible conduit tubing and communication lines that are passing through the 1 hour smoke barrier above the ceiling tiles over the smoke barrier doors located in the little north wing. This deficient condition was verified by a Maintenance Supervisor.	K 025	One inch penetration sealed with Flame seal a fire, smoke & draft stop sealant on 3-10-16 by Pat Johnson and verified by Administrator.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029		3/9/16

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K 029	Continued From page 6 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19-3.7.3 and 8.3. This deficient practice could affect 20 of 75 residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, observations revealed that the soiled utility room 159 located in the west wing did not have a door latch in the door and will not positively latch into the frame. This deficient condition was verified by a Maintenance Supervisor.	K 029	Door latch set replaced with new latch set on 3-9-16 by Pat Johnson and verified by Administrator.	
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested and maintained in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could affect 75 of 75 residents, staff and visitors in the event of an emergency evacuation during a power outage.	K 046	Required 90 mintue test completed on 3-4-16 by Pat Johnson. Pat Johnson will complete and document the required annual 90 minute and monthly 30 second testing.	3/4/16

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K 046	Continued From page 7 Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, observations revealed the following deficient conditions: 1. during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor revealed the that the facility did not annotate the annual 90 minute and 30 second monthly testing of the battery back-up emergency lights. 2. the battery back-up emergency light/exit sign was inoperative when tested during the facility tour. This deficient condition was verified by a Maintenance Supervisor.	K 046		
K 048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current fire evacuation policy in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.7.1.1. This deficient practices could affect 75 of 75 residents, staff, and visitors in the event of an emergency.. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, during the documentation review it was revealed that the facility's floor sketch was	K 048	Floor plan of the chapel and connector has been added to the existing floor plan on 3-8-16 by Pat Johnson and verified by Administrator.	3/8/16

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K 048	Continued From page 8 found not current nor accurate and did include the chapel and connector link to the assisted living unit that was constructed in 2006 This deficient condition was verified by a Maintenance Supervisor.	K 048		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.4., 9.6, as well as 1999 NFPA 72, Sections 2.2.4.4.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 20 of 75 residents, staff, and visitors of the facility. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, observations revealed the following deficient conditions: 1. the smoke detector that is located in the west solarium was installed within 2 inches of the peck of a vaulted ceiling.	K 052	Facility has contract with Life Safety Systems effective 3-15-16 and will lower the smoke detector and lower the pull station in the boiler room by 4-1-16.	4/1/16

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K 052	Continued From page 9 2. the manual pull station located in the basement boiler room is mounted to high, the manual pull station was found to be 60 inches from the floor to the pull handle at the time of the inspection. This deficient practices was confirmed by the Maintenance Supervisor.	K 052		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code 1999 edition, section 7-3.2.1. This deficient practice could affect 75 of 75 residents, visitors, and staff. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 054	Facility has contract with Life Safety Systems effective 3-15-16. They will do required sensitivity testing on each smoke detector in the facility by 4-1-16.	4/1/16

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	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 75 of 75 residents, visitors and staff of the facility. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, observations reveled that the facility did not have at least 2 spare sprinkler heads of every style and type of sprinkler located throughout the facility, like the sprinkler heads found in the laundry room. This deficient condition was verified by a Maintenance Supervisor.	K 056	Pat Johnson, Environmental Service Director, has scheduled an inspection with Simplex Grinnel for 3-23-16 to assess and order the required supply of spare sprinkler heads.	3/23/16
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply	K 067		4/1/16

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K 067	Continued From page 11 with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility has failed to test,inspect, and maintain fire and smoke dampers in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect 75 of 75 residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide any documentation for the smoke and fire damper testing at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 067	Smoke damper testing will be completed by 4-1-16 by Life Safety System and there- after as required and Pat Johnson will be responsible to ensure proper documentation is recorded and available.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the	K 144	Les Jacobson, environmental services, will do weekly and monthly testing and record information on the logs. Pat	3/22/16

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K 144	Continued From page 12 requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect 75 of 75 residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, it was revealed during the review of the facility's emergency generator testing and maintenance logs that the facility did not complete 3 of 12 monthly generator inspections and 12 of 52 weekly inspections of the emergency power generator. This deficient condition was verified by a Maintenance Supervisor.	K 144	Johnson, Environmental Service Director will review logs monthly to ensure testing and record keeping are up to date.	

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	245422	A. BUILDING **02 - ELIM HOME MILACA** B. WING _____	**03/01/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Elim Home Milaca was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING **02 - ELIM HOME MILACA** B. WING _____	**03/01/2016**

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	Continued From page 1	K 000		

By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Elim Home Milaca is a 1-story building with small partial basement. The basement is not used by the nursing home residents. The building was constructed in 1963, with additions in 1973 77 & 89. A chapel and connector link to the assisted living unit was constructed in 2006. The original building and the additions are all Type II (111) construction. Therefore, the facility was inspected as two buildings.

The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification.

The facility has a licensed capacity of 86 beds and had a census of 75 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 18.2.9.1. This deficient practice could affect 75 of 75 residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, observations revealed during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor revealed the that the facility did not annotate the annual 90 minute and 30 second monthly testing of the battery back-up emergency lights. This deficient condition was verified by a Maintenance Supervisor.	K 046	Required 90 mintue test completed on 3-4-16 by Pat Johnson. Pat Johnson will complete and document the required annual 90 minute and monthly 30 second testing.	3/4/16
K 048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1 This STANDARD is not met as evidenced by:	K 048		3/18/16

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K 048	Continued From page 3 Based on observation and staff interview, the facility has failed to provide a complete fire evacuation policy in accordance with in the event of a fire emergency in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 18.7.1.1. This deficient practices could affect 75 of 75 residents, staff, and visitors in the event of an emergency.. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, during the documentation review it was revealed that the facility's floor sketch was found not current nor accurate and did include the chapel and connector link to the assisted living unit that was constructed in 2006 This deficient condition was verified by a Maintenance Supervisor.	K 048	Floor plan of the chapel and connector has been added to the existing floor plan on 3-8-16 by Pat Johnson and verified by Administrator.	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code 1999 edition, section 7-3.2.1. This deficient practice could affect 75 of 75 residents, visitors, and staff. Findings include:	K 054	Facility has contract with Life Safety Systems effective 3-15-16. They will do required sensitivity testing on each smoke detector in the facility by 4-1-16.	4/1/16

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K 054	Continued From page 4 On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 054		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1. This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 75 of 75 residents, visitors and staff of the facility. Findings include:	K 056	Pat Johnson, Environmental Service Director, has scheduled an inspection with Simplex Grinnel for 3-23-16 to assess and order the required supply of spare sprinkler heads.	3/23/16

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K 056	Continued From page 5 On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, observations reveled that the facility did not have at least 2 spare sprinkler heads of every style and type of sprinkler located throughout the facility, like the sprinkler heads found in the laundry room. This deficient condition was verified by a Maintenance Supervisor.	K 056		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility has failed to test,inspect, and maintain fire and smoke dampers in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect 75 of 75 residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and interview with the Maintenance Supervisor, that the facility could not provide any documentation for the smoke and fire damper testing at the time of the inspection.	K 067	Smoke damper testing will be completed by 4-1-16 by Life Safety System and there- after as required and Pat Johnson will be responsible to ensure proper documentation is recorded and available.	4/1/16

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K 067	Continued From page 6 This deficient condition was verified by a Maintenance Supervisor.	K 067		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect 75 of 75 residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 1:30 PM to 4:30 PM on 03/01/2016, it was revealed during the review of the facility's emergency generator testing and maintenance logs that the facility did not complete 3 of 12 monthly generator inspections and 12 of 52 weekly inspections of the emergency power generator. This deficient condition was verified by a Maintenance Supervisor.	K 144	Les Jacobson, environmental services, will do weekly and monthly testing and record information on the logs. Pat Johnson, Environmental Service Director will review logs monthly to ensure testing and record keeping are up to date.	3/22/16