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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 42U4

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) **MILACA ELIM MEADOWS HEALTH CARE CENTER**
(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 **11/23/2021** (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 **70** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
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
	70			
(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 :
Karen Aldinger, Unit Supervisor 12/12/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/12/2021 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2021

CMS Certification Number (CCN): 245422

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast, PO Box 157
Milaca, MN 56353

Dear Administrator:

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 November 20, 2021 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2021

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast, PO Box 157
Milaca, MN 56353

RE: CCN: 245422
Cycle Start Date: September 16, 2021

Dear Administrator:

On November 24, 2021, we notified you a remedy was imposed. On November 23, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 20, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 16, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 24, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 16, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 20, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 42U4

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) **MILACA ELIM MEADOWS HEALTH CARE CENTER**
(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 **09/16/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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

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From (a) :
To (b) :

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

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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
	70			
(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 11/04/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/19/2021 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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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
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 10, 2021

Administrator
Elim Home - Milaca
730 Second Street Southeast, PO Box 157
Milaca, MN 56353

RE: CCN: 245422
Cycle Start Date: September 16, 2021

Dear Administrator:

On September 16, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 16, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by March 16, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 09/16/2021

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
E 000	Initial Comments On 9/13/21 to 9/16/21, a survey for compliance with CMS Appendix Z, Emergency Preparedness Requirements, was completed during a recertification survey. Elim Home - Milaca was found in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 9/13/21 to 9/16/21, a standard recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed at the time of the recertification survey. Elim Home - Milaca was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated; however, no deficiencies were cited due to actions taken by the facility prior to the recertification survey: H5422031C (MN48488) The following complaints were found to be unsubstantiated: H5422029C (MN74823) H5422030C (MN71096) 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.	F 000		

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

Electronically Signed | 10/19/2021

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 _____	C 09/16/2021

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	Continued From page 1 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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		11/20/21

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 _____	C 09/16/2021

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 561	Continued From page 2 by: Based on observation, interview, and document review, the facility failed to ensure assessed and identified preferences for rising were honored for 1 of 1 residents (R45) reviewed for choices and who voiced they were not assisted timely with rising in the morning. Findings include: R45's quarterly Minimum Data Set (MDS), dated 7/29/21, identified R45 had intact cognition and was totally dependent on staff for transfers and bed mobility. R45's care plan, last reviewed 8/11/21, identified R45 was alert and orientated and able to make her needs known outlining, "Allow choices/included in decisions about daily routine." Further, the care plan identified a section labeled, "Personal Preferences," which directed, "Wants to be up around 7:30 or 8:00 A.M." On 9/13/21, at 8:48 a.m. R45 was observed to be laying in bed in her room in a night gown. R45 was interviewed at this time and voiced she typically was not assisted with morning cares and rising, "until nine, nine thirty" every morning as the staff have, "a lot of people to get up." R45 stated her preference would be to get up at, "about eight [8:00 a.m.] or so," but reiterated remaining in bed until staff were available to care for her, "has to be" acceptable as the floor staff didn't have enough help to get to everyone timely. Immediately following this interview, two nursing assistants (NA) entered R45's room with a mechanical lift to assist her with rising and morning care.	F 561	F561 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Milaca Elim Meadows to comply with F561. To assure continued compliance, the following plan has been put into place; Regarding cited resident: R45□s personal preferences were addressed by the unit coordinator and R45□s care plan and group sheets were corrected to honor her rising wishes on 10/11/2021. Actions taken to identify other potential residents having similar occurrences: All other residents whose care plans indicated personal preferences were reviewed to ensure the Preference is still accurate and being honored. Measures put in place to ensure deficient practice does not recur: All staff was educated on 10/18/2021 and 10/19/2021 regarding the honoring of personal preferences.	

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 _____	C 09/16/2021

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 561	Continued From page 3 When interviewed on 9/15/21, at 10:48 a.m. NA-A stated R45 was often "one of the last" residents to be assisted with morning cares and rising due to the amount of assistance she required. NA-A stated she was unaware R45 had ever voiced a preference for her morning rising time but added, "If she wants to start getting up earlier, we [could] do that." R45's recently completed Care Conference Summary, dated 8/3/21, identified a quarterly care conference was held with R45 in attendance and involved in her care planning. The summary provided a section to answer and record R45's preferences for bathing, wake time, bed time, activity preferences and food(s). This recorded a checkmark next to the option which read, "Wake time," along with additional text reading, "0730 [7:30 a.m.]." On 9/15/21, at 12:04 p.m. the social services designee (SSD)-A was interviewed. She explained resident preferences and choices where entered into the care plan and reviewed routinely with residents at their respective care conferences. SSD-A reviewed R45's most recently completed Care Conference Summary and verified it recorded R45 as having a preference for a 7:30 a.m. wake-time. SSD-A stated such preferences, "should be on her [R45] group sheet" which the NA(s) use to alert them to such preferences so they can be honored and implemented. SSD-A and the surveyor then reviewed these 'group sheets' which identified R45's preference for a 7:30 a.m. wake time was not listed. At 12:16 p.m. licensed practical nurse manager (LPN)-A joined the interview. LPN-A explained the information on R45's care plan, including her preference for wake time, was still	F 561	Effective implementation of actions will be monitored by: The Social worker designee will audit residents who have personal preferences listed on their care plans weekly X 4 weeks and then monthly X 2 months to ensure that their preferences are being honored and match the care plan and group sheet. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits is recommended. Those responsible to maintain compliance will be: The Director of Nursing, is responsible for maintain compliance.	

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F 561	Continued From page 4 accessible to the NA(s) through their phone-type devices they use while on the floor. LPN-A stated the amount of assistance R45 required for morning care and rising "shouldn't matter," and they would "look at that" and address it with the staff. LPN-A voiced it was important to ensure resident preferences and choices were honored as best able as "it's her [R45] house" and doing so provides her with "some control in her life." On 9/6/21, at 11:31 a.m. the assistant director of nursing (ADON) was interviewed and voiced staff should do their best to "meet their [residents] preferences with the means available." ADON stated she felt the floor staff strived to do this on a daily basis; however, she acknowledged they could "some days" likely work to get R45 up earlier. ADON expressed it was important to honor resident preferences and choices, as best able, as the facility provided "person centered care" and it helps the resident to "make them feel like they're at home." A provided Resident Dignity, Choices and Preferences policy, dated 2/2020, identified the facility will " ... put protocols in place to honor resident's choices and preferences as able." The policy continued, "Resident's choices and preferences will be reviewed upon admission and at quarterly care conferences. These preferences will be care planned as appropriate."	F 561		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		11/20/21

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F 677	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene and grooming was provided for 2 of 3 residents (R6, R41) reviewed for activities of daily living (ADLs) and who were dependent on staff for care. Findings include: R6's admission Minimum Data Set (MDS), dated 6/14/21, identified R6 had severe cognitive impairment and required extensive assistance with personal hygiene. Further, the MDS identified R6 demonstrated no rejection-of-care type behaviors. R6's care plan, dated 9/9/21, identified R6 required total assistance to complete his grooming and listed a goal which read, "Resident will be clean and well-groomed by staff through [review date]." The care plan directed, "GROOMING: Staff to provide total assist with grooming." However, the care plan lacked any preference or statements regarding preferences R6 wished for or had pertaining to his fingernail care (i.e., he did not want long fingernails trimmed). On 9/13/21, at approximately 10:20 a.m. R6 was observed seated in his wheelchair. R6 had visibly long fingernails on both hands, with several of his nails having a visible, dark-colored substance or debris present under them adjacent to the nail bed. During subsequent observations, on 9/14/21 at 4:32 p.m., and 9/15/21 at 10:25 a.m., R6 continued to have long fingernails with a dark substance and/or debris present underneath	F 677	F677 It is the policy of Milaca Elim Meadows to comply with F677. To assure continued compliance, the following plan has been put into place; Regarding cited resident: R6□s nail care were trimmed and cleaned on 9/13/2021 and R41□s were trimmed and cleaned on 9/21/2021. Actions taken to identify other potential residents having similar occurrences: All other residents whose care plans indicated nails are to be trimmed and cleaned by nursing home staff were reviewed to ensure nail care has been completed and that care plan and group sheets reflect POC. Measures put in place to ensure deficient practice does not recur: All nursing staff was educated on 10/18/2021 and 10/19/2021 regarding routine personal hygiene and grooming cares. Effective implementation of actions will be monitored by: The Unit Coordinator will audit resident□s nails within 48 hours of resident□s scheduled bath weekly X 4 weeks and then monthly X 2 months to ensure that their nail care has been completed. Results of these audits will be reviewed by the facility QAPI committee and they will	

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F 677	Continued From page 6 several of the nails. R6 was interviewed at this time at voiced "one of the girls" helps him complete his fingernail care. R6 stated he wanted his nails trimmed and added he thought the floor staff "will eventually" help him do such. R6's progress note, dated 9/8/21, identified R6 received his bath and had no new skin issues. The note lacked evidence if R6 had been offered and/or refused nail care. Further, R6's medical record lacked evidence R6 had been offered and declined nail care in the past weeks. On 9/15/21, at 10:36 a.m. nursing assistant (NA)-A was interviewed and described R6 as typically "pretty pleasant" and not usually resistive to personal hygiene and grooming cares. NA-A explained nail care should be completed "after [their] baths" and then observed R6's fingernails at the request of the surveyor. NA-A stated R6's nails were "slightly overgrown" and needed to be clipped. NA-A stated if R6 had been recently offered nail care and refused it, then R6's refusal should be recorded in the nurses' notes or their behavioral charting. When interviewed on 9/15/21, at 1:35 p.m. licensed practical nurse (LPN)-B stated R6 was not diabetic and the NA(s) should be helping him to complete personal hygiene and grooming. LPN-B explained nail care should be done "weekly with their baths," and if such care was offered and refused, then it would be recorded in the nurses notes or on the resident' "bath sheet." LPN-B stated it was important to ensure nail care was provided to promote a resident's dignity and to "have them look good." On 9/15/21, at 2:38 p.m. licensed practical nurse	F 677	make the decision if further monitoring/audits is recommended. Those responsible to maintain compliance will be: The Director of Nursing, is responsible for maintain compliance.	

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manager (LPN)-A was interviewed. LPN-A verified R6 required physical assistance to complete his grooming and personal hygiene, and any refused care(s), including nail care, should be recorded in the progress notes or bath sheet(s). LPN-A stated she no longer had the completed bath sheets to provide for review; however, acknowledged there was no recorded refusals of care for R6 in his progress notes. LPN-A expressed R6's nail care should be provided during his weekly bath and added R6 did have a history of dry skin which could cause him to itch himself. LPN-A stated nail care should be completed as long, potentially soiled nails, could cause "an infection control issue" and for R6's overall cleanliness.

When interviewed on 9/6/21, at 11:36 a.m. the assistant director of nursing (ADON) stated she was aware R6's nail care had been found not completed by the survey team and voiced the NA(s) should be offering such care on the resident's scheduled bath day. ADON expressed she was "not certain where the break down was" which caused this to get missed or overlooked. ADON stated it was important to ensure nail care was provided "for infection control clearly" as long, soiled nails could cause a skin infection if R6 scratched himself.

R41's significant change of status MDS dated 7/26/21, was scored a 99, which indicated the staff were unable to complete the cognitive status assessment, however, the admission MDS of

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5/1/21 indicated R41 had severe cognitive impairment. The MDS of 7/26/21, indicated R41 required extensive assistance with personal grooming, had diagnoses including, dementia and diabetes and did not reject cares.

R41's care plan, with a start date of 4/27/21, which was reviewed/revised 8/17/21, indicated R41 was dependent on staff for grooming, and indicated, "Staff to provide assistance with washing and nail care as resident allows d/t (due to) hand pain and prefers[sic]." The careplan goal indicated "The resident will maintain ability to participate ability to participate in grooming choices." R41's careplan, revised on 9/16/21, indicated R41 was at risk for altered comfort in arm and hand pain. R41's goal statement of that date indicated, "Resident's pain management goal is: ____" with no identified goal outlined, and the blank space left empty. Staff were directed to: Monitor for level of pain; Medicate per orders; and notify MD/NP (Medical Doctor/Nurse Practioner) if pain is not adequately managed with current interventions. The care plan additionally identified the following non-pharmacological interventions: Offer positioning, warm blanket, ice pack, warm pack, emotional support, toileting, fluids, snack, activity, music, TV show, movie as indicated for distraction. Additionally the care plan indicated staff were to administer pain medication as ordered.

The Group 5 work list for the nursing assistants, printed on 9/15/21, identified R41 received his bath on Tuesday evening. The work list did not specify who was to complete nail care for R41.

On 9/14/21, at 4:41 p.m. R41 was observed in the dining room, R41's fingernails were long,

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extending beyond his fingertips, with the edges of some nails jagged and uneven with brown/black debris under them.

On 9/15/21, at 3:54 p.m. R41 was observed sitting in his reclining chair in the commons area. Although the care sheet identified R41 received his bath routinely on Tuesday evenings, (9/14/21), R41 was observed to have his fingernails extending beyond his fingertips, with jagged edges observed and brown/black debris present under the nails.

A review of the Observation Detail List Report dated 8/31/21, completed by licensed practical nurse (LPN)-C, indicated, "Unable to cut nails d/t (due to) pain in fingernails and toenails." The documentation lacked any further follow up or interventions related to this. Observation Detail List Reports from 8/10/21, 8/17/21, 8/24/21, and 9/14/21, were reviewed and were noted to have been completed by LPN-C, and lacked documentation to reflect nail care was provided. Additionally, the documentation lacked the reason nail care was not completed, for example related to pain or because of R41's preference, and failed to identify assessments or interventions implemented to address this. The Observation Detail List Report of 8/3/21, completed by registered nurse (RN)-A indicated R41 had no complaints of pain, except to right hand when touched. RN-A indicated resident did not wish to receive any extra pain meds at that time. The Observation Detail List Report, under the section of Skin, specifically directed staff, "Observe resident nails and provide nail care as indicated."

On 9/15/21, at 3:59 p.m. after having reviewed R41's documentation, LPN-C stated they had not

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trimmed R41's fingernails or toenails with his bath last evening. LPN-C went on to state they, personally, had never trimmed R41's nails, however, stated they were aware R41 was resistive at times. After viewing R41's nails, LPN-C described R41's nails as being long and dirty. LPN-C stated this was of concern due to the potential for the "dirtiness" of the nails, and the potential for infections when he scratched himself. Additionally, LPN-C identified R41 fed himself finger foods and this was not very sanitary. LPN-C stated the nurse practitioner should have been consulted at that time regarding possible interventions with pain management or to review other ideas to perform nail care. LPN-C stated she was now planning on placing a resident concern form for the NP.

On 9/16/21, at 11:33 a.m., LPN-A stated it was difficult to communicate with R41 at times, and R41 had become angry at times with others touching his right hand due to complaints of pain. LPN-A stated if R41 had refused to have nail care performed, staff should have continued to approach at a later time. If the staff was unable to complete cares, this was to be passed on to the upcoming shifts via the 24 hour board in report. LPN-A stated even if the nails were not trimmed, R41's nails should have been cleaned and should appear free from debris. LPN-A stated lack of completion of routine nail care was an infection control concern, as R41 was known to scratch himself. Additionally, LPN stated it would be a dignity issue due to the appearance of nails.

On 9/16/21, at 1:57 p.m. the assistant director of nursing (ADON) identified it was a personal choice of R41 if he did not wish to have his nails cleaned and trimmed, however, if it was because

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F 677	Continued From page 11 of pain, it would be important to try to determine the cause of pain and implement interventions appropriately. Additionally, the ADON stated a message should have been left for the NP to evaluate and review what was occurring, what interventions were currently in place, and assess the effectiveness of the interventions. This review should have included a review of medications, as well as non-pharmaceutical interventions as well. ADON stated if R41 was experiencing pain with provision of nail care she would have anticipated follow through to evaluate interventions. A provided Bathing: Shower or Tub Bath policy, dated 12/2019, identified each resident would be provided a, at least, weekly bath or shower. The policy directed, "Trim finger and toenails as needed."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure repeated episodes of constipation were comprehensively assessed and interventions developed to provide comfort and reduce the risk of complication for 1 of 1 resident (R6) reviewed for their bowel management.	F 684	F684 It is the policy of Milaca Elim Meadows to comply with F677. To assure continued compliance, the following plan has been put into place;	11/20/21

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F 684	Continued From page 12 Findings include: R6's admission Minimum Data Set (MDS), dated 6/14/21, identified R6 had severe cognitive impairment and required extensive assistance with toilet use. Further, the MDS recorded R6 as having constipation. R6's most recent Quarterly Nursing Observation, dated 9/9/21, identified a section labeled, "BOWEL and BLADDER," which outlined there had been no changes "to [R6's] bowel or bladder related needs since the last comprehensive observation," and recorded R6's current bowel toileting plan as effective. Further, the assessment included a question which read, "Indicate any changes from the last comprehensive bowel and bladder observation ..." which was answered only with, "scp [see care plan]." The completed assessment lacked any evidence or dictation which identified R6 to have constipation or subsequent issue(s) with his bowels despite his most recent MDS recording him as having constipation. Further, R6's care plan, revised 9/9/21, identified R6 as being frequently incontinent of bowel and bladder along with his specific toileting plan. However, the care plan lacked any specific outlined problem statement or interventions to address R6's constipation despite being marked as present on his MDS completed 6/14/21. On 9/15/21, at 10:25 a.m. R6 was seated in a wheelchair by the dining room and voiced he had "a gut ache." R6 was questioned on his bowels and expressed they were "not too good" which he described "as usual." Further, R6 stated he would be open to more intervention to help promote	F 684	Regarding cited resident: R6□s orders related to his DX of constipation were corrected on 9/15/2021. Actions taken to identify other potential residents having similar occurrences: All other residents whose DX list indicated constipation were reviewed to ensure they have orders/ and orders are accurate in reflecting their constipation DX. Measures put in place to ensure deficient practice does not recur: Licensed staff was educated on 10/18/20201 and 10/19/2021 on the DX of constipation and importance of ensuring that each resident POC indicates an intervention for comfort and to reduce the risk of complications. Effective implementation of actions will be monitored by: The Unit coordinator will audit resident□s bowel and bladder records weekly X 4 weeks and then monthly X 2 months to ensure that their bowels are moving and that their orders are being followed. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits is recommended. Those responsible to maintain compliance will be: The Director of Nursing, is responsible for maintain compliance.	

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more regular bowel movements.

R6's Search Vitals Results, dated 8/16/21 to 9/16/21, identified R6's recorded bowel movements (BM) in his EMR completed every shift. This identified R6 had no BM(s) recorded on 8/16/21 or 8/17/21; however, had large-sized BM(s) recorded on 8/18/21 and 8/19/21. There were no further BM(s) recorded until 8/21/21 (two days later); and then R6 was identified as having no further BM(s) recorded until 8/26/21 (five days later). The next BM(s) for R6 were recorded on 8/29/21 (three days later), 9/1/21 (three days later), and 9/3/21 (two days later). However, R6 then had no recorded BM(s) until 9/7/21 (four days later), and then 9/10/21 (three days later). R6 then was recorded as going from 9/11/21 to 9/14/21 (three days) without a BM. The remainder of days and shift entries all recorded, "None," to indicate there was no BM had by R6.

R6's corresponding progress note(s), dated 8/15/21 to 9/15/21, identified the following:

On 8/25/21, R6 was recorded as being constipated. The note outlined, "Prune juice and Senna plus [a stool softener with laxative] given per orders ... No results noted as of yet, will pass information onto oncoming staff." A corresponding Physician's Orders sheet, dated 8/25/21, identified an order which read, "PRN [as-needed] Senna S I tab[let] PO BID [by mouth twice daily] constipation ...".

On 8/28/21 (four days later), R6 was recorded as having constipation. The note outlined prune juice was given with no results as of the note being completed.

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On 9/1/21 (four days later), R6 was recorded as having constipation. The note outlined prune juice was given with no results as of the note being completed.

On 9/6/21 (five days later), R6 was record as having constipation. The note outlined prune juice was given with no results as of the note being completed.

On 9/10/21 (four days later), R6 was recorded as having constipation. The note outlined prune juice was given with no results as of the note being completed.

Further, on 9/15/21 (five days later), R6 was again record as having constipation. R6 was given prune juice and Senna Plus; however, there were no results as of the note being completed.

R6's Medication Administration Record (MAR), dated August 2021, identified R6 was provided two Senna S (a medication used to treat constipation) 8.6 milligram (mg) tablets twice a day for constipation. Further, the MAR recorded a two as-needed administrations of one additional tablet on 8/10/21 and 8/25/21 for constipation with the results being recorded as, "Effective," and "Not Effective," respectively. R6's subsequent MAR, dated September 2021, identified R6 had an order entered for, "Bran 30 ml [by mouth] daily," on 9/2/21; however, this was recorded as being refused by R6 for several doses including on 9/2/21, 9/10/21, 9/13/21. R6 continued to receive the physician-ordered two Senna S 8.6 mg tablets twice a day, along with multiple recorded administrations of the as-needed one additional Senna S tablet (in addition to the scheduled doses) being given on 9/2/21, and

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	245422	A. BUILDING _____ B. WING _____	C 09/16/2021

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 684	Continued From page 15	F 684		

9/15/21.

On 9/15/21, at 10:36 a.m. nursing assistant (NA)-A was interviewed. NA-A explained R6 was typically continent of his bowels and able to verbalize a need to defecate to staff. NA-A stated she had noticed R6 "doesn't go [have a BM] very often" and added she felt R6's stool appeared formed and normal; however, there was just never "large amounts of it." NA-A expressed R6's poor cognition potentially caused him to just not understand he was supposed "to push" while seated on the toilet to have an adequate bowel movement, and she reiterated R6 appeared on their daily bowel list (used to communicate who's gone several days without a bowel movement) "pretty regularly."

R6's medical record was reviewed and lacked evidence R6's bowel management had been comprehensively reassessed to ensure efficacy and no further intervention was needed for his bowel management despite adjusting his bowel-related medication regimen on 8/25/21, and repeated progress note(s) outlining R6 as having ongoing constipation issues, at times requiring dietary and/or pharmaceutical intervention, and his recorded BM(s) routinely demonstrating several days in between bowel movements.

When interviewed on 9/15/21, at 1:35 p.m. licensed practical nurse (LPN)-B explained a "laxative sheet" was printed every morning which outlined residents' who are various days without having a bowel movement; then based off the list and days gone past, various interventions from their standing orders, such as prune juice or Senna, could be given to them. LPN-B stated she

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F 684	Continued From page 16	F 684		

had noticed R6's name had "been on my list more lately" and explained if the floor staff noticed any concerns with ongoing constipation, a nursing concern could be developed and placed in the mailbox for the nurse practitioner (NP) to address. At approximately 1:40 p.m. R6's hospice nurse (RN)-D joined the interview. LPN-B reviewed R6's recorded progress notes and bowel movements and herself and RN-D expressed R6 could likely be reviewed to see if more intervention, such as a daily prune juice serving and not just as-needed, could be given.

On 9/15/21, at 2:29 p.m. licensed practical nurse manager (LPN)-A was interviewed. LPN-A explained a resident's bowel function and management program was assessed by the "nurse on the floor" and if concerns were being noticed, then they should place a nursing concern to the NP to have it addressed. LPN-A explained R6 had an as-needed dosing of Senna added to his regimen on 8/25/21, to help address his constipation; however, she acknowledged the medical record lacked evidence R6's bowel management program, including his medication use and continued documented episodes of constipation since then, had been re-assessed since to ensure the intervention was effective and more was not needed adding, "It makes sense [to assess him]." Further, LPN-A stated it was important to assess a resident's bowel management program to help ensure the resident's needs are balanced and to reduce the risk of impaction or ileus (the inability of the intestine to contract normally and move waste out of the body).

When interviewed on 9/6/21, at 11:36 a.m. the assistant director of nursing (ADON) stated a

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F 684	Continued From page 17 resident' bowel function is monitored through daily "bowel reports" which then directs the staff to implement an intervention (i.e., prune juice) if they have gone "three or more days" since having a recorded BM. ADON explained a comprehensive bowel assessment would include a review of the resident's abdomen for distention along with listening to their bowel sounds; and added doing this process would help the staff know then interventions had been effective. The ADON expressed if concerns with a resident's bowel management were noted, then a "nursing concern" could be completed for the physician to address. Further, ADON stated she felt the facility had policies and procedures in place to address constipation; however, added a "more person centered approach" could have been reviewed and assessed for R6. A provided Bowel Management Program policy, dated 2/2020, identified all residents would be monitored for bowel movements each shift and any bowel movements would be recorded in the EMR. The policy continued, "Nursing staff will monitor for lack of bowel movements using the bowel management report ... This will help identify resident who may be having small bowel movements daily and may need to be evaluated." Further, the policy outlined, "For residents with chronic constipation, update provider as indicated for potential changes in medication and work with dietician to develop appropriate nutritional interventions for constipation."	F 684		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining	F 791		11/20/21

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F 791	Continued From page 18 routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred	F 791		

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F 791	Continued From page 19 medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure recommended dental services were provided for 1 of 1 residents (R22) who required follow up visits for dental. Findings include: R22's admission Minimum Data Set (MDS) dated 1/26/21, identified R22 was cognitively intact, had mouth or facial pain and discomfort and difficulty with chewing. R22's MDS 3.0 Oral/Dental Assessment Form of 1/27/21 identified R22 had none of the following present; broken or loosely fitted full or partial denture, no natural teeth or tooth fragment, abnormal mouth tissue, obvious or likely cavity or broken natural teeth, inflamed or bleeding gums, mouth or facial pain, or discomfort or difficulty with chewing. Additionally, R22's Assessment Notes indicated denture was old and worn, but stable and functional. The recommendation at this time was for follow up to be done at the facility. A review of the Chart Progress Notes, Apple Tree Coon Rapids, dated 6/30/21 indicated R22 was seen for a limited oral evaluation which was problem focused. R22 was seen for extraction of a erupted tooth requiring removal of bone and/or sectioning of tooth. A subsequent Chart Progress Notes, Apple Tree Coon Rapids, dated 8/17/21, indicated R22 was seen for a comprehensive oral evaluation with radiographic exam (x-rays). At this time, findings	F 791	F791 It is the policy of Milaca Elim Meadows to comply with F677. To assure continued compliance, the following plan has been put into place; Regarding cited resident: R22 was seen by the Smile clinic on 10/6/2021 for missing crown and will be seen on 10/26/2021 for further dental work. Actions taken to identify other potential residents having similar occurrences: All other residents who were seen on 8/17/2021 and have recommendations for dental work by Apple tree dental were reviewed to ensure follow up care for any recommendations. Measures put in place to ensure deficient practice does not recur: Social services, Unit Coordinator, and Health Information Coordinator were educated on 10/18/2021 and 10/19/2021 on the process of dental services to ensure that resident□s dental needs are taken care of. Effective implementation of actions will be monitored by: Social service and Health information coordinator will audit dental service recommendations monthly X 2 months to ensure residents dental needs have been	

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F 791	Continued From page 20 included dental caries (cavities), with extensive caries under #30. The recommendation was made for conservative treatment on the lower jaw line (dental fillings), with the possibility of need for extraction and a partial on the lower jaw. An additional recommendation was made for a new, full, upper denture. A review of Resident Progress Notes, dated 9/11/21 identified R22 had a crown from the right lower jaw in the back which had fallen off. R22 stated the remaining tooth was sensitive but not painful. The note identified a note was left for medical records to follow up on Monday (9/13/21). The document lacked any further A document titled Apple Tree Dental, Dental Concern Information, dated 9/13/21 indicated staff were advised R22 had lost a crown over the weekend. The document indicated the pain R22 was experiencing was described as aching. On 9/13/21, at 8:58 a.m. R22 stated, "When the dentist comes to the facility, they (the dentist) do x-rays and exams, and they tell you the need, but the work doesn't get done, I need my plate fixed. It's gotten worn down, and it's difficult to chew." R22 stated she had been seen in August and a treatment plan was developed, however, no appointment has been scheduled. R22 stated the crown, which had been identified as having decay and needing restoration, has now broken off. R22 stated the dentist had discussed the possibility of using that tooth to anchor her lower partials if they were needed, and now will be unable to do so. On 9/16/21, at 10:50 a.m. health unit coordinator (HUC)-A reviewed documentation from 8/17/21	F 791	followed up on. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits is recommended. Those responsible to maintain compliance will be: The Director of Nursing, is responsible for maintain compliance.	

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F 791	Continued From page 21	F 791		

and stated recommendations were made by AppleTree Referrals with this visit. Upon receipt of the documentation, this information was referred to health information (HI)-A. HI-A was responsible to coordinate services as needed. If HI-A was unable to complete the coordination, the task was delegated to HUC-A, who then completed the task. HUC-A stated after recommendations were made, the staff (HI/HUC) conferred with the resident/responsible part to determine if they wished to go outside of the facility to complete treatment, or wait until AppleTree returned to the facility. HUC-A stated R22 was able to make decisions independently regarding treatment so had she been assigned, she would have coordinated follow up appointment as directed by R22. HUC-A stated this coordination of both the dental visit, transportation, and coordination of record submission may take a couple of days, to a week or longer. Upon review of the dates, HUC-A felt this coordination would have been scheduled by the end of August, even if unable to get in immediately. HUC-A stated she had received the notification regarding the broken crown, however, had not yet addressed it as had not been in on 9/13/21 and was unaware of follow up by HI-A. HUC-A stated it was important to follow up on dental recommendations as there was the potential for food to get caught within the decayed areas. HUC-A stated there was the potential for infection, pain, and headaches if the residents did not have follow up in a timely manner. HUC-A stated AppleTree provided all visit notes to medical records, and these records are uploaded to the electronic chart. HUC-A was unsure as to who reviewed the visit notes.

On 9/16/21, at 11:44 a.m. licensed practical nurse

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F 791	Continued From page 22	F 791		

(LPN)-A/Unit Coordinator stated medical records reviewed the progress notes from the dental visits and they then route to nursing/HI/or HUC as indicated. LPN-A stated AppleTree generally coordinated follow up and assumed upon review of the notes, AppleTree would have been contacted by HI/HUC. LPN-A did review the documentation regarding R22's loss of a crown, however, did not find any follow up documented either for the recommendations of 8/17/21, or 9/11/21. LPN-A stated when dental recommendations were not followed up on, there was the potential for things to get worse, adding there could be the potential for a significantly larger cavity, pain, and potential abscess. LPN-A stated R22 was cognitively able to determine the follow up desired and identified staff should consult with her to see what was desired.

On 9/16/21, and 2:05 p.m. the assistant director of nursing (ADON) stated that she was aware the information was provided to medical records following the visits with the AppleTree Dental. The ADON stated the orders were to be transcribed and appointments coordinated as identified. ADON stated if appointments and recommendations were not followed there there would be potential for pain, and identified staff was to monitor for pain and make sure follow up appointments are made as recommended.

A facility policy, Dental Services, dated 5/23/19, identified the facility was responsible for assisting resident/representative in making dental appointments and arranging transportation to and from dentistry as necessary. Additionally, the policy identified a referral was to be made within 3 days for residents who had dentures who were lost or broken during their stay. The policy

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F 791	Continued From page 23 indicated if a referral was not made within 3 days, there was to be documentation in the resident record to identify what interventions were put into place to ensure the resident could still eat and drink adequately while awaiting dental service. The policy lacked direction as to follow through for other dental concerns, such as loss of tooth, filling, or crowns.	F 791		

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	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual 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 Milacawas found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/19/2021

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as one facility: Elim Home Milaca is a 1-story building with a 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. The building is fully fire sprinkler protected. The	K 000		

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K 000	Continued From page 2 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 capacity of 70 beds and had a census of 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life	K 353	1. Kitchen sprinkler head located by dishwashing area replaced on 10/13/21 2. All kitchen sprinkler heads have been	11/20/21

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ELIM HOME - MILACA	**730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353**

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K 353	Continued From page 3 Safety Code, section 9.7.5 and NFPA 25, 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems sections 5.2.1.1.1 and 5.2.1.1.2. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1) On 09/13/2021, between 10:00 AM to 2:00 PM, it was revealed in the kitchen there is a sprinkler head in the dish-washing area that has started leaking. 2) On 09/13/2021, between 10:00 AM to 2:00 PM, it was revealed in the kitchen there were five dust-covered sprinkler heads. 3) On 09/13/2021, between 10:00 AM to 2:00 PM, it was revealed that in the walk-in cooler, there is a rusted/leaking sprinkler head. 4) On 09/13/2021, between 10:00 AM to 2:00 PM, it was revealed in the storage room by room 316 there is a missing escutcheon plate. These deficient conditions were verified by the Maintenance Director.	K 353	cleaned on 10/13/21 3. The walk-in cooler sprinkler head has on leak after an attic inspection and several days of observation by maintenance could find no leak. I has been determined it was condensation from the humid weather conditions and a small hole was discovered in the cooler. The hole was sealed on 10/13/21 and no water has been observed since. 4. The escutcheon plate was installed on 10/14/21	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel.	K 901		11/20/21

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 _____	**09/13/2021**

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K 901	Continued From page 4 Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to ensure the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99, 2012 Edition, Health Care Facilities Code Chapter 4 and per NFPA 101 (2012 edition), Life Safety Code. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/13/2021, between 10:00 AM to 2:00 PM, it was revealed that the required risk assessment was not completed in its entirety per NFPA 99; Chapters 10 and 11 were missing. This deficient condition was verified by the Maintenance Director.	K 901	K901 Risk Assessment Chapters 10 and 11 have now been added to the facility's NFPA-99 Form which will be implemented immediately, reviewed annually and at any time there are room ore equipment changes in the facility.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		11/20/21

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 _____	**09/13/2021**

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K 914	Continued From page 5 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the electrical testing and maintenance were not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 and 6.3.4.1.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/13/2021 between 10:00 AM to 2:00 PM, it was revealed that the required annual receptacle inspection in resident rooms was last completed on 03/03/2020. This deficient condition was verified by the Maintenance Director.	K 914	K914 Electrical Testing The annual receptacle inspection was completed on 9/28, 9/29, 9/30/21. Repairs were completed on 10/01/21. Maintenance Director will be responsible for all repairs inspections and timely and accurate documentation.	