DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 16, 2024

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

RE: CCN: 245422
Cycle Start Date: December 29, 2023

Dear Administrator:

On January 11, 2024, we notified you a remedy was imposed. On December 29, 2023, the Minnesota Department 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 February 1, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 29, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of January 11, 2024, 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 February 29, 2024, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 1, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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.

Correction of the Life Safety Code deficiency cited under K211 at the time of the November 29, 2023 standard survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of July 31, 2024, has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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January 11, 2024

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

RE: CCN: 245422
Cycle Start Date: November 29, 2023

Dear Administrator:

On December 12, 2023, we informed you that we may impose enforcement remedies.

On January 10, 2024, the Minnesota Department(s) of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 29, 2024.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 29, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 29, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 29, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Milaca Elim Meadows Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 29, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 May 29, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@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 **01 - MAIN BUILDING 01** B. WING _____	**11/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILACA ELIM MEADOWS HEALTH CARE CENTER	**730 SECOND STREET SOUTHEAST** **MILACA, MN 56353**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/27/2023. At the time of this survey, Milaca Elim Meadows Health Care Center was 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	K 000		

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

Electronically Signed | 12/19/2023

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 IS NOT REQUIRED. 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: Milaca Elim Meadows Health Care Center 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	K 000		

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K 000	Continued From page 2 additions are all Type II (111) constr uction. 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 capacity of 70 beds and had a census of 59 at the time of the survey.	K 000		
K 211 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain facility means of egress requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6, 7.1.6.2, 7.1.7 and 7.1.10.2.1 , and . This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 11/27/2023 between 12:28 PM and 12:57 PM, it was revealed by observation that the west exit	K 211	A waiver is being requested for this deficiency. A concrete mason will be contacted to fix the egress issues. The problem areas will be fixed no later than June 30, 2024 when the frost is out of the ground and outside concrete work can be done.	6/30/24

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K 211	Continued From page 3 door, south exit adjacent to room 234 and therapy, exhibited a change in elevation from 1 1/2 inch to 3 inches in the concrete slab, presenting a potential trip or fall hazard. An interview with the Maintenance Technician verified this deficient finding at the time of discovery.	K 211		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space	K 222		12/4/23

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	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/27/2023**

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K 222	Continued From page 4 is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the delayed egress system per NFPA 101 (2012 edition), Life Safety Code sections 7.1.10.1, 7.1.10.2.1. This deficient finding could have an patterned impact on the residents within the facility.	K 222	The blinds were removed on December 4, 2023 by Pat Johnson, environmental service director. This was verified by administrator.	

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K 222	Continued From page 5 Findings include: On 11/27/2023 at 12:46 PM, it was revealed by observation there are blinds on the door in the 300 wing obstructing the operating hardware not allowing for full instant use in the case of fire or other emergency. An interview with the Maintenance Technician verified this deficient finding at the time of discovery.	K 222		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. These deficient finding could have an patterned impact on the residents within the facility. Findings include: On 11/27/2023, at 5:45 PM, it was revealed by observation that the exterior lights for the door from therapy and the administration exit discharge was not lighting the public way. An interview with the Maintenance Tech verified	K 281	Light bulbs were replace on 12/15/23 by Pat Johnson, ESD. This was verified by administrator.	12/15/23

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K 281	Continued From page 6 thes deficient findings at the time of discovery.	K 281		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly configure illuminated exit signage per NFPA 101 (2012 edition), section(s) 19.2.10, 19.2.10.1, 7.10, 7.10.1.8, 7.10.8.1, 7.10.5, 4.5.3.3, 4.5.8. These deficient findings could have an patterned impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 3:00 PM, it was revealed by observation that emergency lighting in the TR Room and in the chapel did not illuminate when tested. 2. On 11/27/2023 at 1:00 PM, observations revealed in the door from the "Cabin" went to an enclosed courtyard and was not intended to be an emergency exit. The door did not have signage that read "NOT AN EXIT". 3. On 11/27/2023 at 5:00 PM. observations revealed there was no Exit Signage above the	K 293	#1. Monthly logs were up to date. The issue would have been found and corrected in November, 2023. The batteries were replaced on 11/29/2023. This verified by administrator. #2. A sign that reads "Not an Exit" was placed on the door in the Cabin area. This verified by administrator #3. Exit sign will be installed by 1/5/24 and will be verified by administrator.	1/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 293	Continued From page 7 employee entrance/exit. An interview with the Maintenance Tech verified thes deficient findings at the time of discovery.	K 293		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		12/12/23

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	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/27/2023**

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MILACA ELIM MEADOWS HEALTH CARE CENTER	**730 SECOND STREET SOUTHEAST** **MILACA, MN 56353**

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K 321	Continued From page 8 Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3,19.3.2.1.5, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 2:26 PM, it was revealed by observation that there was tape over the strike plate for the door to the chapel storage room causing the door to not positively latch. 2. On 11/27/2023 at 2:35 PM, it was revealed by observation that there was Bio-Hazard containers stored in the corridor by the maintenance shop. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 321	#1. Tape was removed on 11/27/23 and Pastor instructed not to put tape on the latch at any time. #2. Bio-hazard containers moved to a dedicated storage room on 12/12/23. This verified by administrator.	
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 331	Documentation for the acoustical panels	1/5/24

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K 331	Continued From page 9 facility failed to provided interior finish materials that meets the NFPA Life Safety Code 101 2012 edition sections 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 11/27/2023 between 12:30 PM. to 1:00 PM., it was observed that the facility has wood paneling and acoustical panels in located in the Country Lodge. At the time of the inspection it could not be verified that it was treated with a fire retardant finish. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 331	was found and forwarded to Kim Swanson, fire marshal. An approved fire coating treatment will be applied to the wood paneling by 1/5/24.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		12/29/23

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K 351	Continued From page 10 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 11/27/2023 at 5:30 PM, it was revealed by observation that the there is a lack of sprinkler protection in the Administration Corridor. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 351	Brother's, a sprinkler company, has been contacted and is scheduled to add a sprinkler head. The new sprinkler head will be installed by 12/29/23.	
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 _____	K 353		1/5/24

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K 353	Continued From page 11 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 automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, section 5.4.1.4, and 5.4.1.4.2. These deficient findings could have an widespread impact on the residents within the facility. Findings include: 1. On 11/27/2023, at 2:15 PM, it was revealed by observation that there were 13 unsecured fire sprinkler heads that were not protected from being damaged, stored loosely within the spare sprinkler head box that was not mounted located by the fire sprinkler riser room. 2. On 11/27/2023, at 2:20 PM, it was revealed by observation that the Water flow switch cover is not intact in the sprinkler riser room. 3. On 11/27/2023, at 3:00 PM, it was revealed by observation that there are IT wires on the sprinkler pipe above the ceiling in the smoke barrier into Country Meadows and above the smoke barrier doors in Little North. 4. On 11/27/2023, at 3:15 PM, it was revealed by	K 353	#1. The 13 unsecured fire sprinkler heads have been removed from the building, leaving the appropriate legal amount of secured sprinkler heads on 11/28/23. This was verified by administrator. #2. Water flow switch cover will be in place as of 12/29/23. #3. IT wire will be off the sprinkler pipes as of 1/5/24. #4. Upon inspection there was no paint on the sprinkler heads but taping mud which rubbed off with a rag. This was done on 12/12/23 and verified by administrator. #5. The escutcheon plates have were missing have been put back on. This was completed on 12/12/23 and verified by the administrator.	

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K 353	Continued From page 12 observation that there is paint on the sprinkler head by room 117 and 2 in the TR Room storage room. 5. On 11/27/2023, at 5:20 PM, it was revealed by observation that there are Escutcheon plates missing in the soiled linen are of the laundry room and the beauty shop. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363		1/5/24

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K 363	Continued From page 13 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3, 19.3.6.3.10 and 7.1.10.1 . These deficient findings could have an widespread impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 12:31 PM, it was revealed by observation that the serving kitchen door in the Country Lodge was obstructed by serving equipment door. 2. On 11/27/2023 at 12:38 PM, it was revealed by observation that the door of resident room 104 was wedged open with a towel. 3. On 11/27/2023 at 4:45 PM, it was revealed by observation a 1/4 inch gap to therapy door in Little North. 4. On 11/27/2023 at 5:30 PM, it was revealed by	K 363	#1. A stop bar, which will not allow interference with the roller door, will be installed by 12/29/23. #2. All staff have been instructed that resident doors are not to be wedged open. #3. The therapy door gap will be fixed by 1/5/24 as material has been ordered. #4. A commercial lockset was installed on 12/11/23 and holes were filled. This was verified by administrator.	

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K 363	Continued From page 14 observation there are 2 holes in the door by the door handle in the East Conference Room. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 363		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 5 smoke barrier walls in accordance with the requirements of NFPA 101 "Life Safety Code" 2012 edition, sections 19.3.7.3 and 8.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/27/2023 at 3:05 PM, observation revealed that the facility used a non-fire-rated penetration sealant above ceiling in multiple places in the smoke barrier wall above the ceiling tile over cross-corridor doors located the smoke barrier by	K 372	The non-fire related penetration sealant will be removed and replaced by an approved fire rated sealant. This will be completed by 1/5/24.	1/5/24

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K 372	Continued From page 15 the resident room 203. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 372		
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not restrict the use of flammable decorations, including candles, in accordance with the requirements of NFPA 101 Life Safety Code, 2012 edition, section 19.7.5.6. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 12:19 PM, it was revealed by observation that 4 candles with intact wicks in the	K 753	All candles in the building were removed on 11/27/23. Staff re-educated that candles can not have wicks. This was verified by administrator.	11/27/23

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K 753	Continued From page 16 gift shop. 2. On 11/27/2023 at 12:23 PM, it was revealed by observation in the Unit Coordinator's office two candles with intact wicks. 3. On 11/27/2023 at 2:36 PM, it was revealed by observation in the East Conference Room one candles with intact wicks. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 753		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically	K 918		1/4/24

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K 918	Continued From page 17 exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 1:45 PM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 918	Lighthouse power has been contacted and are scheduled to come, no later than 1/4/24 to do a 4 hour load bank test. Pat Johnson, ESD, will schedule on his calendar that a 4 hour test will be done every 36 months.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used	K 920		12/14/23

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K 920	Continued From page 18 for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 3:04 PM, it was revealed by observation in room 316, there was a refrigerator plugged into a power strip.	K 920	Power strips for the refrigerators have been removed on 12/14/23 and this observation will be added to our monthly room inspection.	

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K 920	Continued From page 19 2. On 11/27/2023 at 3:15 PM, it was revealed by observation in room 205, there was a refrigerator plugged into a power strip. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 920		
K 930 SS=E	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an patterned impact on the residents within the facility. Findings include: On 11/27/2023 at 2:10 PM, it was revealed by observation that were two liquid oxygen containers located in resident room 303, one was being used and the other was not in use and being stored. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 930	Nursing staff will be re-educated that only one tank is allowed in a resident's room.	12/22/23

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	245422	A. BUILDING _____ B. WING _____	11/29/2023

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E 000	Initial Comments On 11/27/23-11/29/23 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		1/4/24

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

Electronically Signed | 12/19/2023

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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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/27/2023 at 1:45 PM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	E 041	Lighthouse Power has been contacted and scheduled to come by January 4th, 2024 to do the required 4 hour load bank test. Pat Johnson, environmental service director, has this required test on his calendar and will be completed every 36 months.	
F 000	INITIAL COMMENTS On 11/27/23-11/29/23, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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		

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F 000	Continued From page 4 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman	F 583		12/22/23

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F 583	Continued From page 5 to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure confidential information was not readily available for all residents, staff, and visitors to view for 1 of 1 resident (R24) observed to have private information visible on an open computer screen in a common area. Findings include: R24's quarterly Minimum Data Set (MDS) dated 10/18/23, indicated R24 was cognitively intact, was able to clearly communicate her needs and wishes and required substantial to maximal assistance with activities of daily living (ADL). On 11/27/23, from 5:26 p.m. to 5:41 p.m., R24's picture and medications were displayed on an open computer screen that was left unattended on the nurse's medication cart in the common hallway by the nurse's station. At 5:30 p.m., a visitor walked past the medication cart and looked in the direction of the open computer screen where R24's personal information was visible on screen. At 5:31 p.m., co-resident, R46 who was cognitively intact, walked past medication cart and looked in the direction of the open computer screen where R24's personal information was visible on screen. At 5:33 p.m.,a visitor walked past the med cart and looked in the direction of the open computer screen where R24's personal information was visible on screen. At 5:36 p.m., R46 walked up to medication cart and stood at cart looking around the top of cart. At 5:39 p.m.,	F 583	Regarding cited resident: (R24) Discussion with RN A to review the facilities protocol and expectations about leaving lap top screen open and unattended with R24 s medical information visible for other residents and visitor to see. Actions taken to identify other potential residents having similar occurrences: Management did spot checking of laptops to ensure they are locking them when unattended. Measures put in place to ensure deficient practice does not recur: All nursing staff were educated on 12/18/2023 regarding Notice of Privacy Practices Policy: We are required by law to maintain the privacy and security of the resident s protected health information. All nursing staff must ensure that all iPhone, desktop, and laptop computers are locked, closed, or logged out of prior to walking away from the device for any reason to avoid potential for breaches in resident protected health information. Effective implementation of actions will be monitored by: The clinical managers will audit staff computers and work sites for possible HIPPA concerns weekly X 4 weeks and then monthly X 2 months to ensure HIPPA compliance. The facility QAPI committee	

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F 583	Continued From page 6 registered nurse (RN)-A walked up to the medication cart, placed paper on medication cart, acknowledged R46 and walked away to put medications in medication room. RN-A did not redirect R46 away from cart and did not close computer screen. At 5:41 p.m., RN-A walked up to the medication cart, acknowledged R46 and started viewing R24's information that was present on screen. On 11/27/23, at 5:41 p.m., RN-A stated that when leaving the medication cart she makes sure the screen is locked with no resident information visible. RN-A confirmed she did not close the screen and R24's personal information was visible on screen. On 11/28/23, at 4:29 p.m., licensed practical nurse care coordinator (LPN)-A stated she expected the nurse to ensure that the Electronic Mediation Admission Record (EMAR) was closed and no resident personal information was visible before walking away from cart. LPN-A stated this was important due to HIPPA laws and protecting resident's privacy. On 11/28/23, at 4:24 p.m., director of nursing (DON) stated she expected staff to close the computer screen down so no personal information can be seen by others when leaving the medication cart. DON stated it was important so the resident's personal information can not be seen by others due to HIPPA. The "Notice of Privacy Practices" policy dated 2/23/2020 indicated "we are required by law to maintain the privacy and security of your protected health information." Additional policies were requested with none received.	F 583	will review results of these audits; the committee will then make the decision if further monitoring/audits need to be completed. Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance.	

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 690	Regarding cited resident:	12/22/23

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F 690	Continued From page 8 review, the facility failed to ensure residents received appropriate catheter care as ordered by the provider to maintain urinary catheter function for 1 of 1 residents (R37) who was reviewed for indwelling urinary catheter use. This had the potential to impact R37's catheter function and cause an increase risk of infection. Findings include: R37's quarterly Minimum Data Set (MDS) dated 9/26/23, indicated he was cognitively intake, had an indwelling urinary catheter and required extensive assist with toileting and personal hygiene. R37's Resident Face Sheet, printed 11/29/23, identified R37 had benign prostatic hyperplasia (an enlarged prostate which can block the flow of urine out of the bladder), with lower urinary tract symptoms. R37's diagnoses also included bladder neck obstruction and urinary tract infection, site not specified. R33's care plan dated 10/26/23, indicated the R37 had an indwelling catheter related to neuromuscular dysfunction of the bladder (a bladder malfunction caused by an injury or disorder of the brain, spinal cord, or nerves). The care plan directed staff to assess the drainage (urine) every shift and as indicated. Staff were directed to record the amount, type, color and odor of the urine. The care plan directed staff to change catheter per the provider order. The care plan directed staff to avoid obstructions in the drainage and to not allow tubing or any part of the drainage system to touch the floor. The care plan did not include information regarding orders for catheter irrigation.	F 690	R37 orders related to catheter irrigation were D/C on 11/29/2023. Actions taken to identify other potential residents having similar occurrences: The facility reviewed all residents orders to ensure residents who receive catheter care as ordered by the provider to maintain catheter function. All future orders with parameters must be entered as a special instruction within the area, which is being, assessed i.e. outputs. Measures put in place to ensure deficient practice does not recur: On 12/18/2023, all licensed staff were educated transcription of orders for catheter irrigation parameters. Effective implementation of actions will be monitored by: The clinical managers will audit residents with orders to irrigate catheter weekly X 4 weeks and then monthly X 2 months to ensure that orders are being followed. The facility QAPI committee will review results of these audits; the committee will then make the decision if further monitoring/audits need to be completed. Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance.	

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F 690	Continued From page 9 A review of the Treatments Administrative History was completed for the dates of 11/1/23 to 11/29/23, and identified R37 was to receive Foley flushes with 40 cc's (cubic centimeters-a unit of measurement) of saline every hour to irrigate cath (catheter) if (output was) less than 300 cc's every shift per provider order of 5/30/23. R37's record indicated R37 received a Foley flush on 11/26/23, at 1:43 p.m. for "other" reasons. The document also identified R37's catheter was changed on 11/26/23 at 1:42 p.m. for "other" reasons, which was noted "he felt like he had to continue to void. On this same document, Treatments Administrative History, R37's Catheter Output was to be monitored every shift. A review of this information recorded on the following dates and shifts, R37's output was less than 300 ml (milliliters-a unit of measurement-equal to cc's): 11/1/23 Days 200 ml output; 11/2/23 Days 200 ml output, and Evenings 250 ml output; 11/5/23 Days 250 ml output; 11/7/23 Days 100 ml output; 11/8/23 Days 200 ml output; 11/10/23 Days 200 ml output; 11/11/23 Days 200 ml output; 11/12/23 Days 200 ml output. 11/15/23 Days 200 ml output, and Evenings 250 ml output; 11/16/23 Days 200 ml output; 11/17/23 Days output 250 ml and Evenings 200 ml output; 11/18/23 Days 200 ml output; 11/20/23 Days 200 ml output; 11/21/23 Days 200 ml output, Evenings 250 ml output, and Nights 250 ml; 11/22/23 Days 200 ml output;	F 690		

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F 690	Continued From page 10 11/23/23 Days 200 ml output and Nights 150 ml output; 11/24/23 Days 200 ml output and Evenings 250 ml; 11/25/23 Days 200 ml output and Evenings 250 ml; and 11/26/23 Days 200 ml output. During interview on 11/28/23, at 4:30 p.m. licensed practical nurse (LPN)-A/Clinical Coordinator, stated the information relayed on the Treatments Administrative History were not reflective of a complete complete record for outputs. LPN-A stated this information was documented in a different area, and stated she would provide it to me for review. During interview on 11/29/23, at 10:30 a.m. licensed practical nurse (LPN)-A-Clinical Coordinator provided me with a document titled Vitals Report. A brief review of the information was completed during interview with LPN-A at which time it was noted on multiple occasions, there were shifts when R37 had less than 300 ml of urine output. In clarification, LPN-A stated the entries after 7:00 a.m. were for the output total for the day shift. Upon immediate review of the information, LPN-A stated a catheter flush should have been done on multiple occasions based on the shift outputs, however, LPN-A verified the documentation indicated it had only been done on one occasion in the month of November. A full review was completed of the document labeled Vitals Report indicated urinary outputs of less than 300 ml, with some descriptive entries, on the following occasion: 11/2/23 at 2014 (8:14 p.m.) was an output of	F 690		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 11 250 ml described as straw yellow. 11/5/23 at 1348 (1:48 p.m.) urine output was 250 ml and characteristics of blood tinged. 11/17/23 at 1:19 p.m. the output was 250 ml and was not described. 11/17/23 at 8:27 p.m. urine output was 200 ml and was described as brown and dark. 11/21/23 at 8:51 p.m. urine output was 250 ml and was described as straw yellow. 11/22/23 at 4:40 a.m. the urine output was 250 ml and was described as brown and dark. 11/24/23 at 4:36 a.m. urine output was 150 ml and lacked description of urine appearance. 11/24/23 at 8:22 p.m. urine output was 250 ml and urine was described as brown and dark. 11/26/23 at 10:23 p.m. urinary output was 250 ml and lacked description of urine appearance. 11/27/23 at 8:22 p.m. urinary output was 250 ml and was described as brown/dark. 11/25/23 8:23 p.m. urinary output of 250 ml, with description not provided. Upon review of the above listed entries, it was noted there were 11 occasions documented where the criteria was met for the orders to flush the catheter, however, it was only done on 1/11 occasions. A review of the facility policy, Catheter Irrigation, reviewed 4/13/23, identified catheter irrigation was to be completed as ordered by the provider, and directed the licensed nurse to verify the order for irrigation and solution to be used. Once the procedure was completed, the policy directs the staff to document the procedure in the electronic health record.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		12/22/23

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	245422	A. BUILDING _____ B. WING _____	11/29/2023

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F 758	Continued From page 12 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 13 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assure the use of PRN (as needed) psychotropic medications (a drug which affects mood/behavior) were limited to 14 days, or had a physician specified, time limited, order for 1 of 1 resident, R57, reviewed for Hospice. Findings include: R57's Admission Minimum Data Set (MDS) of 11/4/23 identified R57 had moderate cognitive impairment. R57's diagnoses listing included both anxiety and major depression. The PHQ-9 completed with this assessment identified R57 had mild depression, based on answers provided on the Patient Health Questionnaire (PHQ-9). R57's Resident Face Sheet, dated 11/29/23, included multiple diagnoses which included encounter for palliative care (specialized medical care for people living with a serious illness), history of falling, major depression (single episode), and anxiety disorder. R57's Care Plan identified R57 had enrolled into hospice services prior to admission to the facility. The care plan identified R57 had an order for	F 758	Regarding cited resident: Resident # R57 Actions taken to identify other potential residents having similar occurrences: All residents with PRN Psychotropic medications were review to ensure there are end dates. Measures put in place to ensure deficient practice does not recur: Nurses and TMA s will look for an end date on all psychotropic medication orders received to ensure that there is an end date documented. Psychotropic nurse reviews psychotropic medication orders quarterly. Education presented to all nurses and TMAs on 12/18/2023 regarding the 14 day limited for PRN psychotropic drug. If staff believes, the medication needs to continue they will need to have the attending physician extend the order beyond 14 days if he or she believes it is appropriate. Effective implementation of actions will be monitored by:	

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F 758	Continued From page 14 Lorazepam 0.25 mg PRN every four hours as needed for anxiety. R57 was also identified as having orders in place for routine dosing of an antidepressant medication. The care plan directed staff to attempt dose reductions per regulatory guidelines, as condition warranted, and per provider order. The care plan also directed staff to monitor behavior symptoms and to offer one to one interactions and activities during periods of anxiousness. The care plan indicated the facility worked with resident, hospice, and staff to meet resident needs. During interview on 11/27/23, at 6:42 p.m. R57 stated he received pain medication routinely and also had a medication for anxiety. R57 stated he had been taking them prior to his admission to the facility. A review of the PRN Medications Administration History indicated client had lorazepam 0.5 mg ordered every four hours as needed. This order was initiated on 10/31/23 and was open-ended. The documentation did not reflect use of this medication since his admission. On 11/28/23, at 3:51 p.m. licensed practical nurse (LPN)-A/Clinical Coordinator stated R57 had the lorazepam ordered PRN for anxiety, however, he had not used it at the facility. LPN-A stated antianxiety medications were to have a stop date, and this should have been identified upon initial receipt of order, as well as when the record was prepped for provider visit for the provider visit. On 11/29/23, at 11:45 a.m. and interview was completed with the director of nursing (DON) and the lack of stop date was reviewed. The DON stated the antianxiety medication should have a	F 758	Jamie Houtsma RN, MDS nurse will audit all residents with PRN Psychotropic medication weekly X 4 weeks and then monthly X2 months to ensure PRN Psychotropic medication have an end date. The facility QAPI committee will review results of these audits; the committee will then make the decision if further monitoring/audits need to be completed. Those responsible to maintain compliance will be: The DON or designee is responsible for maintaining compliance.	

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F 758	Continued From page 15 stop date of 14 days, unless there was a different end date specified. A review of the facility policy, titled Medication Management, reviewed 5/24/22, indicated the consulting pharmacist reviewed all psychotropic medication for appropriate indications of use, monitoring for efficacy, potential adverse effects and potential for dose reduction. The policy identified target behavior symptoms were to be identified as soon as possible after admission of resident, and were to be documented in the electronic health record. The policy lacked definition as to the required time limiting component of 14 days with PRN usage of psychotropic medications, unless otherwise identified by the provider with time limits outlined and documented within the medical record.	F 758		

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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 on 11/27/2023. At the time of this survey, Milaca Elim Meadows Health Care Center was 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	K 000		

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

Electronically Signed | 12/19/2023

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 IS NOT REQUIRED. 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: Milaca Elim Meadows Health Care Center 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	K 000		

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K 000	Continued From page 2 additions are all Type II (111) constr uction. 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 capacity of 70 beds and had a census of 59 at the time of the survey.	K 000		
K 211 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain facility means of egress requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6, 7.1.6.2, 7.1.7 and 7.1.10.2.1 , and . This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 11/27/2023 between 12:28 PM and 12:57 PM, it was revealed by observation that the west exit	K 211	A waiver is being requested for this deficiency. A concrete mason will be contacted to fix the egress issues. The problem areas will be fixed no later than June 30, 2024 when the frost is out of the ground and outside concrete work can be done.	6/30/24

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K 211	Continued From page 3 door, south exit adjacent to room 234 and therapy, exhibited a change in elevation from 1 1/2 inch to 3 inches in the concrete slab, presenting a potential trip or fall hazard. An interview with the Maintenance Technician verified this deficient finding at the time of discovery.	K 211		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space	K 222		12/4/23

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K 222	Continued From page 4 is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the delayed egress system per NFPA 101 (2012 edition), Life Safety Code sections 7.1.10.1, 7.1.10.2.1. This deficient finding could have an patterned impact on the residents within the facility.	K 222	The blinds were removed on December 4, 2023 by Pat Johnson, environmental service director. This was verified by administrator.	

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K 222	Continued From page 5 Findings include: On 11/27/2023 at 12:46 PM, it was revealed by observation there are blinds on the door in the 300 wing obstructing the operating hardware not allowing for full instant use in the case of fire or other emergency. An interview with the Maintenance Technician verified this deficient finding at the time of discovery.	K 222		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. These deficient finding could have an patterned impact on the residents within the facility. Findings include: On 11/27/2023, at 5:45 PM, it was revealed by observation that the exterior lights for the door from therapy and the administration exit discharge was not lighting the public way. An interview with the Maintenance Tech verified	K 281	Light bulbs were replace on 12/15/23 by Pat Johnson, ESD. This was verified by administrator.	12/15/23

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K 281	Continued From page 6 thes deficient findings at the time of discovery.	K 281		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly configure illuminated exit signage per NFPA 101 (2012 edition), section(s) 19.2.10, 19.2.10.1, 7.10, 7.10.1.8, 7.10.8.1, 7.10.5, 4.5.3.3, 4.5.8. These deficient findings could have an patterned impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 3:00 PM, it was revealed by observation that emergency lighting in the TR Room and in the chapel did not illuminate when tested. 2. On 11/27/2023 at 1:00 PM, observations revealed in the door from the "Cabin" went to an enclosed courtyard and was not intended to be an emergency exit. The door did not have signage that read "NOT AN EXIT". 3. On 11/27/2023 at 5:00 PM. observations revealed there was no Exit Signage above the	K 293	#1. Monthly logs were up to date. The issue would have been found and corrected in November, 2023. The batteries were replaced on 11/29/2023. This verified by administrator. #2. A sign that reads "Not an Exit" was placed on the door in the Cabin area. This verified by administrator #3. Exit sign will be installed by 1/5/24 and will be verified by administrator.	1/5/24

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K 293	Continued From page 7 employee entrance/exit. An interview with the Maintenance Tech verified thes deficient findings at the time of discovery.	K 293		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		12/12/23

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	245422	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/27/2023**

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MILACA ELIM MEADOWS HEALTH CARE CENTER	**730 SECOND STREET SOUTHEAST** **MILACA, MN 56353**

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K 321	Continued From page 8 Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3,19.3.2.1.5, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 2:26 PM, it was revealed by observation that there was tape over the strike plate for the door to the chapel storage room causing the door to not positively latch. 2. On 11/27/2023 at 2:35 PM, it was revealed by observation that there was Bio-Hazard containers stored in the corridor by the maintenance shop. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 321	#1. Tape was removed on 11/27/23 and Pastor instructed not to put tape on the latch at any time. #2. Bio-hazard containers moved to a dedicated storage room on 12/12/23. This verified by administrator.	
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 331	Documentation for the acoustical panels	1/5/24

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K 331	Continued From page 9 facility failed to provided interior finish materials that meets the NFPA Life Safety Code 101 2012 edition sections 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 11/27/2023 between 12:30 PM. to 1:00 PM., it was observed that the facility has wood paneling and acoustical panels in located in the Country Lodge. At the time of the inspection it could not be verified that it was treated with a fire retardant finish. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 331	was found and forwarded to Kim Swanson, fire marshal. An approved fire coating treatment will be applied to the wood paneling by 1/5/24.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		12/29/23

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K 351	Continued From page 10 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 11/27/2023 at 5:30 PM, it was revealed by observation that the there is a lack of sprinkler protection in the Administration Corridor. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 351	Brother's, a sprinkler company, has been contacted and is scheduled to add a sprinkler head. The new sprinkler head will be installed by 12/29/23.	
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 _____	K 353		1/5/24

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K 353	Continued From page 11 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 automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, section 5.4.1.4, and 5.4.1.4.2. These deficient findings could have an widespread impact on the residents within the facility. Findings include: 1. On 11/27/2023, at 2:15 PM, it was revealed by observation that there were 13 unsecured fire sprinkler heads that were not protected from being damaged, stored loosely within the spare sprinkler head box that was not mounted located by the fire sprinkler riser room. 2. On 11/27/2023, at 2:20 PM, it was revealed by observation that the Water flow switch cover is not intact in the sprinkler riser room. 3. On 11/27/2023, at 3:00 PM, it was revealed by observation that there are IT wires on the sprinkler pipe above the ceiling in the smoke barrier into Country Meadows and above the smoke barrier doors in Little North. 4. On 11/27/2023, at 3:15 PM, it was revealed by	K 353	#1. The 13 unsecured fire sprinkler heads have been removed from the building, leaving the appropriate legal amount of secured sprinkler heads on 11/28/23. This was verified by administrator. #2. Water flow switch cover will be in place as of 12/29/23. #3. IT wire will be off the sprinkler pipes as of 1/5/24. #4. Upon inspection there was no paint on the sprinkler heads but taping mud which rubbed off with a rag. This was done on 12/12/23 and verified by administrator. #5. The escutcheon plates have were missing have been put back on. This was completed on 12/12/23 and verified by the administrator.	

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K 353	Continued From page 12 observation that there is paint on the sprinkler head by room 117 and 2 in the TR Room storage room. 5. On 11/27/2023, at 5:20 PM, it was revealed by observation that there are Escutcheon plates missing in the soiled linen are of the laundry room and the beauty shop. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363		1/5/24

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K 363	Continued From page 13 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3, 19.3.6.3.10 and 7.1.10.1 . These deficient findings could have an widespread impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 12:31 PM, it was revealed by observation that the serving kitchen door in the Country Lodge was obstructed by serving equipment door. 2. On 11/27/2023 at 12:38 PM, it was revealed by observation that the door of resident room 104 was wedged open with a towel. 3. On 11/27/2023 at 4:45 PM, it was revealed by observation a 1/4 inch gap to therapy door in Little North. 4. On 11/27/2023 at 5:30 PM, it was revealed by	K 363	#1. A stop bar, which will not allow interference with the roller door, will be installed by 12/29/23. #2. All staff have been instructed that resident doors are not to be wedged open. #3. The therapy door gap will be fixed by 1/5/24 as material has been ordered. #4. A commercial lockset was installed on 12/11/23 and holes were filled. This was verified by administrator.	

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K 363	Continued From page 14 observation there are 2 holes in the door by the door handle in the East Conference Room. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 363		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 5 smoke barrier walls in accordance with the requirements of NFPA 101 "Life Safety Code" 2012 edition, sections 19.3.7.3 and 8.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/27/2023 at 3:05 PM, observation revealed that the facility used a non-fire-rated penetration sealant above ceiling in multiple places in the smoke barrier wall above the ceiling tile over cross-corridor doors located the smoke barrier by	K 372	The non-fire related penetration sealant will be removed and replaced by an approved fire rated sealant. This will be completed by 1/5/24.	1/5/24

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K 372	Continued From page 15 the resident room 203. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 372		
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not restrict the use of flammable decorations, including candles, in accordance with the requirements of NFPA 101 Life Safety Code, 2012 edition, section 19.7.5.6. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 12:19 PM, it was revealed by observation that 4 candles with intact wicks in the	K 753	All candles in the building were removed on 11/27/23. Staff re-educated that candles can not have wicks. This was verified by administrator.	11/27/23

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K 753	Continued From page 16 gift shop. 2. On 11/27/2023 at 12:23 PM, it was revealed by observation in the Unit Coordinator's office two candles with intact wicks. 3. On 11/27/2023 at 2:36 PM, it was revealed by observation in the East Conference Room one candles with intact wicks. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 753		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically	K 918		1/4/24

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K 918	Continued From page 17 exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 1:45 PM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 918	Lighthouse power has been contacted and are scheduled to come, no later than 1/4/24 to do a 4 hour load bank test. Pat Johnson, ESD, will schedule on his calendar that a 4 hour test will be done every 36 months.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used	K 920		12/14/23

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K 920	Continued From page 18 for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/27/2023 at 3:04 PM, it was revealed by observation in room 316, there was a refrigerator plugged into a power strip.	K 920	Power strips for the refrigerators have been removed on 12/14/23 and this observation will be added to our monthly room inspection.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 19 2. On 11/27/2023 at 3:15 PM, it was revealed by observation in room 205, there was a refrigerator plugged into a power strip. An interview with the Maintenance Tech verified these deficient findings at the time of discovery.	K 920		
K 930 SS=E	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an patterned impact on the residents within the facility. Findings include: On 11/27/2023 at 2:10 PM, it was revealed by observation that were two liquid oxygen containers located in resident room 303, one was being used and the other was not in use and being stored. An interview with the Maintenance Tech verified this deficient finding at the time of discovery.	K 930	Nursing staff will be re-educated that only one tank is allowed in a resident's room.	12/22/23