



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 5, 2025

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

RE: CCN: 245422
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 29, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



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February 5, 2025

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

Re: Reinspection Results
Event ID: HF7E12

Dear Administrator:

On January 29, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 9, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 15, 2025

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

RE: CCN: 245422
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 9, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor

St. Cloud A District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by April 9, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

Milaca Elim Meadows Health Care Center

January 15, 2025

Page 4

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 01/29/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER MILACA ELIM MEADOWS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments On 01/06/25 - 01/09/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 01/06/25 - 01/09/25, 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. 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		1/25/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/27/2025

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.

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

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F 656	Continued From page 1 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656			

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F 656	Continued From page 2 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R54) reviewed for care planning. Findings include: R54's Admission Minimum Data Set (MDS), 12/09/2024; indicated R54 had diagnoses including coronary artery disease (CAD), depression, anxiety and asthma. In review of R54's Face Sheet, print date of 1/08/25, additional diagnoses included emphysema, malignant neoplasm of unspecified part of unspecified bronchus or lung and a personal history of nicotine dependence. Upon entering R54's room for an interview on 1/06/25 at 2:21 p.m., R54's person smelled of cigarette smoke. R54 stated that she had just come back from the outside resident smoking area. R54 stated that she has not smoked as much since admission due to the cold weather, and mainly smokes late afternoon / early evening when family and friends visit. A review of R54's Smoking Risk assessment, dated 12/17/24, resident's smoking frequency of smoking was dependent on R54's stress level.			F 656	A comprehensive review of Resident R54's care plan will be conducted. The care plan will be updated to accurately reflect the resident's current assessed care needs. Staff involved in the care of Resident R54 will be re-educated on the importance of maintaining an accurate and person-centered care plan. Conduct a facility-wide audit of all residents' care plans to identify any other instances where care plans may not be comprehensive, accurate, or person-centered. Any identified deficiencies will be addressed immediately, and care plans will be updated accordingly. Implement a mandatory training program for all care planning staff on the development and maintenance of comprehensive, person-centered care plans. Establish a protocol for regular review and revision of care plans to ensure they remain accurate and reflective of residents' current needs. Introduce a checklist for care planning to ensure all aspects of a resident's needs are considered and documented. The Director of Nursing or designee will		

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

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F 656	Continued From page 3 R54 agreed to allow the unit nurse to store her cigarettes and lighter during her stay when not outside smoking. The facility deemed R54 to be able to smoke independently. However, review of R54's care plan (creation date of 12/19/24) and the nursing assistant care sheet for the unit, it was noted both lack documentation that R54 was a smoker. Attempts were made throughout survey (1/06/25 - 1/09/25) to observed R54 smoking, however, do to the cold temperatures, R54 did not go outside to smoke. During an interview on 1/08/25 at 10:47 a.m., nursing assistant (NA)-A and registered nurse (RN)-A, reviewed the unit's nursing assistant care sheet (undated). Both NA-A and RN-A verified the care sheet did not identify R54 as a smoker. However, both staff members were aware of R54 being a smoker. During interview on 1/08/25 at 11:05 AM, the unit manager (LPN)-A and director or nursing (DON) were noted to be sitting in the unit managers office. The unit manager, after review of R54's care plan, verified the resident's care plan did not address R54 as a smoker and what if anything the facility staff (including agency pool staff) needed to do to monitor R54. Both staff members stated it was important to have the information available to assure resident safety and whereabouts when smoking. In review of the facility's policy, entitled: Care Plan and Baseline Care Plan (last revised 10/14/22) indicted the following:	F 656	audit 25% of resident care plans monthly for three months to ensure compliance with comprehensive, person-centered care planning. Results of these audits will be reviewed by the facility's QAPI committee, which will determine if further monitoring or audits are necessary. The Director of nursing or designee is responsible for maintaining compliance with the care planning requirements under F656.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER MILACA ELIM MEADOWS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST MILACA, MN 56353		
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F 656	Continued From page 4 "3. The interdisciplinary team, in conjunction with the resident, resident's family, significant other or resident representative, shall develop a comprehensive person-centered care plan for each resident. This comprehensive care plan will be in the [electronic health record] by day 21 of the stay or 7 days after completion of the comprehensive initial MDS, whichever comes first. 4. The resident care plan is constantly changing. It should be updated routinely in the electronic record to reflect resident's current condition. The resident care plan is reviewed for accuracy, updated with quarterly MDS review, and all other scheduled MDS assessments."	F 656			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 15, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: HF7E11

Dear Administrator:

The above facility was surveyed on January 6, 2025 through January 9, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER MILACA ELIM MEADOWS HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 01/06/25 - 01/09/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

01/27/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER MILACA ELIM MEADOWS HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST MILACA, MN 56353		
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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER MILACA ELIM MEADOWS HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R54) reviewed for care planning. Findings include: R54's Admission Minimum Data Set (MDS), 12/09/2024; indicated R54 had diagnoses including coronary artery disease (CAD), depression, anxiety and asthma. In review of R54's Face Sheet, print date of 1/08/25, additional diagnoses included emphysema, malignant neoplasm of unspecified part of unspecified bronchus or lung and a personal history of nicotine dependence. Upon entering R54's room for an interview on 1/06/25 at 2:21 p.m., R54's person smelled of cigarette smoke. R54 stated that she had just	2 565			1/25/25
			A comprehensive review of Resident R54's care plan will be conducted. The care plan will be updated to accurately reflect the resident's current assessed care needs. Staff involved in the care of Resident R54 will be re-educated on the importance of maintaining an accurate and person-centered care plan. Conduct a facility-wide audit of all residents' care plans to identify any other instances where care plans may not be comprehensive, accurate, or person-centered. Any identified deficiencies will be addressed immediately, and care plans will be updated accordingly. Implement a mandatory training program for all care planning staff on the development and maintenance of comprehensive, person-centered care		

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2 565	Continued From page 3 come back from the outside resident smoking area. R54 stated that she has not smoked as much since admission due to the cold weather, and mainly smokes late afternoon / early evening when family and friends visit. A review of R54's Smoking Risk assessment, dated 12/17/24, resident's smoking frequency of smoking was dependent on R54's stress level. R54 agreed to allow the unit nurse to store her cigarettes and lighter during her stay when not outside smoking. The facility deemed R54 to be able to smoke independently. However, review of R54's care plan (creation date of 12/19/24) and the nursing assistant care sheet for the unit, it was noted both lack documentation that R54 was a smoker. Attempts were made throughout survey (1/06/25 - 1/09/25) to observed R54 smoking, however, do to the cold temperatures, R54 did not go outside to smoke. During an interview on 1/08/25 at 10:47 a.m., nursing assistant (NA)-A and registered nurse (RN)-A, reviewed the unit's nursing assistant care sheet (undated). Both NA-A and RN-A verified the care sheet did not identify R54 as a smoker. However, both staff members were aware of R54 being a smoker. During interview on 1/08/25 at 11:05 AM, the unit manager (LPN)-A and director or nursing (DON) were noted to be sitting in the unit managers office. The unit manager, after review of R54's care plan, verified the resident's care plan did not address R54 as a smoker and what if anything the facility staff (including agency pool staff) needed to do to monitor R54. Both staff members	2 565	plans. Establish a protocol for regular review and revision of care plans to ensure they remain accurate and reflective of residents' current needs. Introduce a checklist for care planning to ensure all aspects of a resident's needs are considered and documented. The Director of Nursing or designee will audit 25% of resident care plans monthly for three months to ensure compliance with comprehensive, person-centered care planning. Results of these audits will be reviewed by the facility's QAPI committee, which will determine if further monitoring or audits are necessary. The Director of nursing or designee is responsible for maintaining compliance with the care planning requirements under F656.		

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2 565	Continued From page 4 stated it was important to have the information available to assure resident safety and whereabouts when smoking. In review of the facility's policy, entitled: Care Plan and Baseline Care Plan (last revised 10/14/22) indicted the following: "3. The interdisciplinary team, in conjunction with the resident, resident's family, significant other or resident representative, shall develop a comprehensive person-centered care plan for each resident. This comprehensive care plan will be in the [electronic health record] by day 21 of the stay or 7 days after completion of the comprehensive initial MDS, whichever comes first. 4. The resident care plan is constantly changing. It should be updated routinely in the electronic record to reflect resident's current condition. The resident care plan is reviewed for accuracy, updated with quarterly MDS review, and all other scheduled MDS assessments." Suggested Method of Correction: The DON (Director of Nursing) or designee could review/revise facility policies as needed to ensure they reflect current standards of practice for care planning (creation and revision). In addition, the DON or designee could train staff and conduct audits to ensure compliance. Also, the DON or designee could report the results to quality assurance. Time Period for Correction: Twenty-one (21) days.	2 565			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER MILACA ELIM MEADOWS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST MILACA, MN 56353		
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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 01/08/2025. At the time of this survey, Milaca Elim Meadows Health Care Center was found 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 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 additions are all Type II (111) construction. 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 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000			

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

Electronically Signed

TITLE

(X6) DATE

01/27/2025

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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