DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL	ID: HJY5
					E SURVEY AGENCY	Facility ID: 00374
1. MEDICARE/MEDICAID PROVIDER N (L1) 245127	NO.	3. NAME AND AD (L3) MILLE LAC	DRESS OF FACILI' C S HEALTH SYS '			4. TYPE OF ACTION: <u>7 (</u> L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) 200 NORTH				1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 190247401		(L5) ONAMIA, N	IN		(L6) 56359	3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SU	PPLIER CATEGORY	Υ.	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 09/23	3/2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:			
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of The	Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
12. Total Facility Beds	57 (L18)		Acceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNF)	7. Medical Director 8. Patient Room Size
	37 (210)				5. Life Safety Code	9. Beds/Room
13. Total Certified Beds	57 (L17)		pliance with Program ents and/or Applied V		* Code: A *	(L12)
14. LTC CERTIFIED BED BREAKDOWN	I				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
57						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARI	KS (IF APPLICABLE S	HOW LTC CANCELI	LATION DATE):			
	×		,			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY API	PROVAL Date:
	, HFE NE II		09/23/2015	(L19)	18. state survey agency approximate the survey agency agency agency agency approximate the survey agency	ogram Specialist 10/14/2015
				(L19) EGIONAI		rogram Specialist 10/14/2015 (L20)
	PART II - TO	BE COMPLETE 20. COM	D BY HCFA RH APLIANCE WITH C	EGIONAI	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi	E AGENCY 10/14/2015 (L20) al Solvency (HCFA-2572)
Austin Fry	PART II - TO	BE COMPLETE 20. COM	D BY HCFA RE	EGIONAI	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi	rogram Specialist 10/14/2015 (L20) E AGENCY
Austin Fry	PART II - TO	BE COMPLETE 20. COM	D BY HCFA RH APLIANCE WITH C	EGIONAI	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I	E AGENCY 10/14/2015 (L20) al Solvency (HCFA-2572)
Austin Fry 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Particular	PART II - TO	BE COMPLETE 20. COM	D BY HCFA RH APLIANCE WITH C	EGIONAI	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I	E AGENCY 10/14/2015 (L20) al Solvency (HCFA-2572)
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Austin Fry 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible	PART II - TO	BE COMPLETE 20. COM RIGI	D BY HCFA RH IPLIANCE WITH C HTS ACT:	EGIONAI IVIL	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above :	rogram Specialist 10/14/2015 (L20) E AGENCY al Solvency (HCFA-2572) interest Disclosure Stmt (HCFA-1513)
Austin Fry. 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE	PART II - TO Y rticipate (L21) 23. LTC AGREEMI	BE COMPLETE 20. COM RIGI	D BY HCFA RH MPLIANCE WITH C HTS ACT: 24. LTC AGREEME	EGIONAI IVIL	Kate JohnsTon, Pr COFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION:	EAGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L.30)
Austin Fry 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Pau 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION	PART II - TO Y rticipate (L21) 23. LTC AGREEMI	BE COMPLETE 20. COM RIGI	D BY HCFA RH MPLIANCE WITH C HTS ACT: 24. LTC AGREEME	EGIONAI IVIL	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	cogram Specialist 10/14/2015 (L20) E AGENCY al Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
Austin Fry. 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 03/20/1967	PART II - TO Y rticipate (L21) 23. LTC AGREEME BEGINNING I	BE COMPLETE 20. COM RIGI ENT Z DATE	D BY HCFA RH APLIANCE WITH C HTS ACT: 24. LTC AGREEME ENDING DATH	EGIONAI IVIL	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I: 3. Both of the Above : 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination	cogram Specialist 10/14/2015 (L20) E AGENCY al Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
Austin Fry. 19. DETERMINATION OF ELIGIBILITY	PART II - TO Y (L21) 23. LTC AGREEMI BEGINNING I (L41)	BE COMPLETE 20. CON RIGI ENT : DATE	D BY HCFA RH APLIANCE WITH C HTS ACT: 24. LTC AGREEME ENDING DATI (L25)	EGIONAI IVIL	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	cogram Specialist 10/14/2015 (L20) E AGENCY al Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
Austin Fry. 19. DETERMINATION OF ELIGIBILITY	PART II - TO Y (L21) 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVE A. Suspension o	BE COMPLETE 20. CON RIGI 20. CO	D BY HCFA RH APLIANCE WITH C HTS ACT: 24. LTC AGREEME ENDING DATH	EGIONAI IVIL	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I: 3. Both of the Above : 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination	cogram Specialist 10/14/2015 (L20) E AGENCY al Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513) (L30) (L30) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety nt 06-Fail to Meet Agreement OTHER
Austin Fry. 19. DETERMINATION OF ELIGIBILITY	PART II - TO Y (L21) 23. LTC AGREEME BEGINNING I (L41) 27. ALTERNATIVE	BE COMPLETE 20. CON RIGI 20. CO	D BY HCFA RH APLIANCE WITH C HTS ACT: 24. LTC AGREEME ENDING DATH (L25) (L44)	EGIONAI IVIL	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I: 3. Both of the Above : 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination	cogram Specialist 10/14/2015 (L20) E AGENCY al Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
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Austin Fry. 19. DETERMINATION OF ELIGIBILITY	PART II - TO Y (L21) 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVE A. Suspension o B. Rescind Susp	BE COMPLETE 20. CON RIGI 20. CO	D BY HCFA RH APLIANCE WITH C HTS ACT: 24. LTC AGREEME ENDING DATI (L25) (L44) (L45)	EGIONAI IVIL	Kate JohnsTon, Pr COFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above : Ovnership/Control I 3. Both of the Above : Other Reason for With Actions: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	cogram Specialist 10/14/2015 (L20) E AGENCY al Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
Austin Fry. 19. DETERMINATION OF ELIGIBILITY	PART II - TO Y (L21) 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVE A. Suspension o B. Rescind Susp	BE COMPLETE 20. COM RIGI 20. CO	D BY HCFA RH APLIANCE WITH C HTS ACT: 24. LTC AGREEME ENDING DATI (L25) (L44) (L45)	EGIONAI IVIL	Kate JohnsTon, Pr COFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above : Ovnership/Control I 3. Both of the Above : Other Reason for With Actions: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	cogram Specialist 10/14/2015 (L20) E AGENCY al Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
Austin Fry. 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 03/20/1967 (L24) 25. LTC EXTENSION DATE: (L27) 28. TERMINATION DATE:	PART II - TO Y (L21) 23. LTC AGREEME BEGINNING I (L41) 27. ALTERNATIVE A. Suspension o B. Rescind Susp 29. (L28)	BE COMPLETE 20. CON RIGI 20. CO	D BY HCFA RH APLIANCE WITH C HTS ACT: 24. LTC AGREEME ENDING DATH (L25) (L44) (L45) CARRIER NO.	EGIONAI IVIL IVIL IVIL (L31)	Kate JohnsTon, Pr OFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 30. REMARKS	EAGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) (L3
Austin Fry. 19. DETERMINATION OF ELIGIBILITY	PART II - TO Y (L21) 23. LTC AGREEME BEGINNING I (L41) 27. ALTERNATIVE A. Suspension o B. Rescind Susp 29. (L28)	BE COMPLETE 20. COM RIGI 20. CO	D BY HCFA RH APLIANCE WITH C HTS ACT: 24. LTC AGREEME ENDING DATH (L25) (L44) (L45) CARRIER NO.	EGIONAI IVIL IVIL IVIL (L31)	Kate JohnsTon, Pr COFFICE OR SINGLE STAT 21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above : Ovnership/Control I 3. Both of the Above : Other Reason for With Actions: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	EAGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) (L3



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245127 October 14, 2015

Ms. Kim Kucera, Administrator Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Ms. Kucera:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 21, 2015 the above facility is certified for or recommended for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 57 skilled nursing facility beds located in rooms .

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

Minnesota Department of Health - Health Regulation Division • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 14, 2015

Ms. Kim Kucera, Administrator Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

RE: Project Number S5127025

Dear Ms. Kucera:

On August 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on July 27, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 23, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on July 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 27, 2015, effective August 21, 2015 and therefore remedies outlined in our letter to you dated August 10, 2015, will not be imposed.

However, as we notified you in our letter of August 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 27, 2015.

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

Feel free to contact me if you have questions.

Mille Lacs Health System October 14, 2015 Page 2

Sincerely,

Kato Johnston

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245127	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/23/2015
Name of Facility		Street Address, City, State, Zip Code	
MILLE LACS HEALTH SYSTEM		200 NORTH ELM STREET ONAMIA, MN 56359	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item	ſ	(5)	Date	(Y4)	ltem		(Y5)	Date
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0176		08/13/2015		ID Prefix	F0225		08/21/2015		ID Prefix	F0226		08/21/2015
Reg. #	483.10(n)				-	483.13(c)(1)(ii)-(iii), (c)(2	2) - ((4)		0	483.13(c)		
LSC					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0241		08/14/2015		ID Prefix	F0282		08/20/2015		ID Prefix	F0314		08/20/2015
0	483.15(a)					483.20(k)(3)(ii)					483.25(c)		_
LSC					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0315		08/20/2015		ID Prefix	F0465		08/18/2015		ID Prefix			
Reg. # LSC	483.25(d)				Reg. # LSC	483.70(h)				Reg. #			
					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					190					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
Reg. # LSC					Reg. # LSC					Reg. #			_
					200								
Reviewed By	/	Reviewed E	Зу	Da	te:	Signature of Su	rve	yor:				Date:	
State Agenc	y	BE	F/KJ	1(0/14/20	015		3392	25			09/2	23/2015
Reviewed By	/	Reviewed E	Зу	Da	te:	Signature of Su	rve	yor:				Date:	
CMS RO													
Followup to	Survey Comple	eted on:					-				a Summary of		
	7/27/2	2015				Uncorre	cteo	1 Deficiencies	s (CMS	-2567) Sent	to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 14, 2015

Ms. Kim Kucera, Administrator Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Re: Reinspection Results - Project Number S5127025

Dear Ms. Kucera:

On September 23, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 27, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00374	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/23/2015
Name	of Facility		Street Address, City, State, Zip Code	
MI	LE LACS HEALTH SYSTEM		200 NORTH ELM STREET ONAMIA, MN 56359	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
		Correction			Correction				Correction
ID Prefix	20302	Completed 09/23/2015	ID Prefix	20565	Completed 08/20/2015	ID Pre	ix 20905		Completed 08/20/2015
	MN State Statute 144.650	_		MN Rule 4658.0405 Subp.			# MN Rule 4658.	0525 Sub	
LSC		-	LSC	Min Rule 4656.0405 Subp.	-	LS		0525 Sub	p. 4
		Correction			Correction				Correction
ID Prefix	20910	Completed 08/20/2015	ID Prefix	21565	Completed 08/13/2015		ix 21685		Completed 08/20/2015
	MN Rule 4658.0525 Subp.	_		MN Rule 4658.1325 Subp.	_		# MN Rule 4658.	4445 Quil	
	Min Rule 4656.0525 Subp.	_		Min Rule 4656.1325 Subp.		LS			
		Correction			Correction				Correction
ID Prefix	21805	Completed 08/13/2015	ID Prefix	21990	Completed 08/21/2015	ID Pret	ix 22000		Completed 08/21/2015
Reg. #	MN St. Statute 144.651 Su	- Ibd. {	Reg. #	MN St. Statute 626.557 Su	- Ibd. 4	Reg.	# MN St. Statute	626.557	Subd.
0		-			_		С		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Pret	ix		Completed
Reg. #		_	Reg. #		_	Reg.			
LSC		-	LSC		-	LS			
		0 "			o "				0 "
		Correction Completed			Correction Completed				Correction Completed
ID Prefix		•	ID Prefix			ID Pret	ix		•
Reg. #		_	Reg. #		_	Reg.	#		
LSC		-	LSC		-	LS	c		_
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:			Date:	
State Agency	,	BF/KJ	10/14/20	-	33925	5		09/	23/2015
Reviewed By			Date:	Signature of Surve				Date:	
CMS RO									
Followup to	Survey Completed on:			1			as a Summary of nt to the Facility?		
	7/27/2015 1: REVISIT REPORT (5/99)		Page 1 of 1	a Denciencies	(0.00-2007) 36		YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY	ID: HJY5 Facility ID: 00374
MEDICARE/MEDICAID PROVIDER N (L1) 245127 2.STATE VENDOR OR MEDICAID NO. (L2) 190247401 5. EFFECTIVE DATE CHANGE OF OWN		3. NAME AND ADD (L3) MILLE LAC (L4) 200 NORTH (L5) ONAMIA, M 7. PROVIDER/SUF	S HEALTH SYS1 ELM STREET N	TEM	(L6) 56359	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
(L9) 6. DATE OF SURVEY 07/27 .	/ 2015 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	13 PTIP 22 CLIA 14 CORF	8. Full Survey After Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 57 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	57 (L18) 57 (L17) 19 SNF (L39) S (IF APPLICABLE S	X B. Not in Com Requirement ICF (L42)	ace With equirements e Based On: acceptable POC pliance with Program ents and/or Applied V IID (L43)	Vaivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
17. SURVEYOR SIGNATURE Bruce Melcher	t, HFE NE II	Date :	08/27/2015	(L19)	18. STATE SURVEY AGENCY AP	ogram Specialist 09/14/2015
	PART II - TO	BE COMPLETE	D BY HCFA RE	. ,	OFFICE OR SINGLE STAT	C 1 (L20)
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible 			IPLIANCE WITH CI ITS ACT:	WIL	 Statement of Financi Ownership/Control I Both of the Above : 	ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEME	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 03/20/1967	BEGINNING I	DATE	ENDING DATE	1	VOLUNTARY 00 01-Merger, Closure 00	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	č
25. LTC EXTENSION DATE: (L27)	 ALTERNATIVE A. Suspension of B. Rescind Susp 	of Admissions:	(L44)		04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active
			(L45)			
28. TERMINATION DATE:	29.	INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539		DETERMINATION (jf approval dat			
	(L32)			(L33)	DETERMINATION APPRO	VAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 4, 2015

Ms. Kim Kucera, Administrator Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

This letter redacts and replaces the letter dated August 10, 2015.

RE: Project Number S5127025

Dear Ms. Kucera:

On July 27, 2015, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Substandard Quality of Care - means one or more deficiencies related to participation

requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor Minnesota Department of Health Health Regulation Division 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7338 Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 5, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 5, 2015 the following remedy will be

Mille Lacs Health System September 4, 2015 Page 3

imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mille Lacs Health System is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective July 27, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 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 <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

Mille Lacs Health System September 4, 2015 Page 4

copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@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) 565-9462

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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above.

Mille Lacs Health System September 4, 2015 Page 6

If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 27, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 27, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process

Mille Lacs Health System September 4, 2015 Page 7

> Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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,

ate Opporton

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

	-	ID HUMAN SERVICES			FORM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245127	B. WING		07/23/2015
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
	as your allegation of Department's accepta	ance. Your signature at the ge of the CMS-2567 form will			
	revisit of your facility validate that substant	cceptable POC an on-site may be conducted to ial compliance with the attained in accordance with			
F 176 SS=D	Minnesota Departme 483.10(n) RESIDENT	was conducted by the nt of Health on 7/27/2015 SELF-ADMINISTER SAFE	F 176		8/13/15
	An individual resident the interdisciplinary te §483.20(d)(2)(ii), has practice is safe.	-			
	by: Based on observatio review, the facility fail self-administration of	medications (SAM) for 1 of served for self-administration		 R-63 with the Potential to Affect all residents who have orders to receive nebulizer treatments. 1. On 7/28/15 TMA-A was coached on Self administered nebulizers vs not self administered nebulizers. She was also given the policy on Self-administered medication. 	
	was observed alone i (a drug delivery devic	n 7/20/15, at 7:28 p.m. R63 n her room with a nebulizer se used to administer rm of a mist inhaled into the		2. On 8/12/15 The MAR of all residents who have an order for Nebulizer treatment were updated to indicate if they have met the	
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE
Electroni	cally Signed				08/21/2015

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

PRINTED: 08/31/2015

							<u>D. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			1 Y /	E SURVEY PLETED
		245127	B. WING			07	/23/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 176	lungs) running, with a medication aide (TMA the medication was o dining room passing r other residents in their mask off her nose and mask on her chest wi around the back of her R63's room while R63 and into the room new made no attempted to to R63's nose and mo medication. At 7:44 p room, turned off the n mask from R63's chear R63's diagnoses inclu- behavioral disturbance chronic obstructive pu and congestive heart plan dated 6/2/15, inclu- disorientated to time a moderately impaired of The Physician's Orde Administration Record Duoneb to be adminis hand written note on not like the nebulizer in front of her face an A Self Administration effective 7/21/15, indi cognitively able to par	A)-A who had administered a)-A who had administered in the opposite side of the medications and assisting ir rooms. R63 removed the d mouth and placed the th the elastic strap still er neck. TMA-A walked past a) had the mask on her chest at to R63 twice. TMA-A b) check, or reapply the mask b) th for installation of the .m. TMA-A entered R63's hebulizer and removed the st. uded dementia with tes, depression, anxiety, ulmonary disease (COPD) failure. A cognition care licated R63 was and place and had cognition. Irs and the Medication d (MAR) for 7/15, directed stered four times a day. A the MAR indicated R63 did mask and to hold the mask d let her breathe in that way. of Medication Assessment cated R63 was not rticipate in a SAM. /20/15, at 7:50 p.m. TMA-A	F 1	176	requirements allowing to self administer their Nebulizer treatment. 3. On 8/13/13 An email was sent to all nurses regarding the administration of self-administered medication. Any Resident that is allowed to self administer their nebulizers will be noted in the MAR, If this is not noted the nurse must REMAIN with the resident during the treatment. A memo was placed on each Medication Cart. Monitoring 1. Starting 8/24/15-9/28/15 An audit will be completed on a minimum of 5 residents who have scheduled Neb. treatments every day x1 week, then every week x 4 weeks to ensure all residents who do not have an order to self administer medication are being observed during the treatment (Attachment A) Responsibility Parties: Care Coordinators or DON Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	1	
	stated she did not kno	ow if R63 could be left alone /A-A added she usually					

Facility ID: 00374

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	S FOR MEDICARE &					10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		· · · ·	TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COE	DE	
MILLE LA	CS HEALTH SYSTEM			NORTH ELM STREET AMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 176			F 176			
	busy she left R63 alo	e it had been so hectic and ne.				
	alone to SAM the net	as assessed to not to be left pulizer. In the past she would ask but now will allow staff to				
F 225 SS=E	483.13(c)(1)(ii)-(iii), (d	c)(2) - (4) DRT	F 225			8/21/15
	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowl court of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a in employee, which would service as a nurse aide or ne State nurse aide registry s.				
	involving mistreatmen including injuries of u misappropriation of re immediately to the ac to other officials in ac	nknown source and esident property are reported Iministrator of the facility and cordance with State law procedures (including to the				

Facility ID: 00374

If continuation sheet Page 3 of 65

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/31/2015 APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245127	B. WING			07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLEIA	CS HEALTH SYSTEM			20	00 NORTH ELM STREET		
	CS HEALIN STOTEM			0	NAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	The results of all investo to the administrator of representative and to with State law (includic certification agency) v incident, and if the all appropriate corrective This REQUIREMENT by: Based on observation review, the facility fai of abuse, neglect, mi unknown were imme- adminstrator and stat	estigations must be reported	F	225	Investigation and Protection: Affects residents R47, R12, R22, R39, R11, R66, R44, R8 with the Potential to affect All Residents. Injuries of Unknown Origin:		
	R12, R22, R39, R11, allegations reviewed. reference checks for	The facility failed to conduct			Affects residents R39, R11, R66, R44, R8 with the Potential to affect All Residents. Corrections support investigation, protection and injuries of unknown ori	gin	
	Findings include:				7/24/15 @ 10:35 PM: A Performance Improvement Plan was delivered and implemented effective immediately		
	Investigation and Pro				with NA-C. (Attachment B). One said measurement included		
	worker (SW) stated thas been implicated	3/15, at 5:09 p.m. with social hat nursing assistant (NA)-C in four incident reports from 2015 as the potential AP).			NO complaints regarding care action during the shift. Failure to meet this goal will result in further disciplinary action up to termination. 7/29/15 In order to ensure the protection and safety of R22 it was		
	Review of facility Inci reports indicated the	dent and Investigation following:			decided that at this time 2 staff would be required in the room when		
	R47's quarterly Minin	num Data Set (MDS) dated e was moderately cognitively			providing care. This was discussed at R22's Care Conference and was approved by both R22 and her family.		

Facility ID: 00374

If continuation sheet Page 4 of 65

PRINTED: 08/31/2015

					0(0) 5	NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	TE SURVEY
		245127	B. WING)7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD)E	
				200 NORTH ELM STREET		
	CS HEALTH SYSTEM			ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 225	Continued From page	<u>م</u>	F 22	5		
1 220			F 22		00	
		tensive assistance in ADLs. d 2/26/15, indicated she had		8/15/15 Existing VA tracking I revised to include identity of a	-	
	dementia and needs			perpetrators to better identify	-	
		g. The care plan further		occurring, including those inc		
		ght alteration in cognition		that have been ¿unable to		
	-	nd that resident will continue		substantiate.¿		
	to be oriented to pers			The Log will be updated at th	e time	
		ion, place and time.		investigation results are subn		
	Mille Lacs Nursing Ho	ome Progress Notes dated		to OHFC and again when the		
		indicated: "This nurse		investigation is closed.	-	
		room, 5 rooms away from		Upon Closure of each incider	nt the	
		ppened, but heard a distinct		VA Log will be electronically f		
		a woman's out cry. This		by LSW to administrator to a		
		on the walkie [walkie-talkie]		administrator is kept informed		
	from the aide. The ai	de stated (in her words) On		FULL STATUS of the investi	gations	
	2 a.m. rounds, I went	to check resident in room		with regards to timeliness of	report	
	45-1 and woke up res	sident in 45 -2 [R47] in the		submissions, final disposition	and	
	process. I told [R47]	the time and said she		actions taken with regards to		
	should lay back down	and try and get some sleep		alleged perpetrator.		
	until coffee time. [R4	7] said "No, I want to sit up		Person(s) responsible: LSW		
	-	aid "No lets lay down" and		On 8/17/15: Facility wide Vulr		
		[R47's] feet to bring them in		Adult Policy (Attachment C) r		
		and hit me in the head,		delineate protections for resid		
		velled out "ow" and NA-C		This includes CMS language	defining	
		me, R47 said "I didn't, you		injuries of unknown source.		
		NA-C] walked out and		On 8/18/15: Administrator and		
		This nurse [LPN-D] asked		Medical Director sent a letter		
		ne aide. Res. [R47] stated		(Attachment D) to all resident		
	that the aide hit her."			their representatives regardin		
	An Incident Basert -	ibmitted to the state access		survey findings; how, what a		
	· ·	ubmitted to the state agency that R47 had a conflict with		often we educate staff and th		
		n 1/24/15. Following a		facility¿s commitment to prote vulnerable adults. A flier with	Soung	
	review of the related	-		information on warning signs	of abuse	
		as originally determined		and neglect, and a copy of th		
		ue to her dementia. Further		education over the last 12 m		
		47 allegedly struck a nursing		were included with the letter.	onuno	
		t [R47] also alleged the		On 8/19/15 Social Service Inc	cident	
		ck her. The report indicated			Jaon	

Facility ID: 00374

If continuation sheet Page 5 of 65

	S FOR MEDICARE &					10.0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	FE SURVEY MPLETED		
		245127	B. WING		0	7/23/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 225	Continued From page	e 5	F 22	5				
	a further investigation A follow-up Investigation the state agency on 2 the SW met with the in 1/28/15 and 1/30/15 a recall any incidents of unable to speak with after the SW learned to her work schedule SW spoke with NA-C 10:45 p.m. NA-C ack happened as describe stated she had not stit had tried to lift R47's The investigative report NA-C. This report als been implicated in a p During interview 7/23 stated the resident wa incident had happened dementia. The SW suspended during he could "not be proved" R47 continued to be o SW said NA-C was co cares for R47, and wa NA-C on how to keep Review of the facility"	in needed to be completed. tive Report was submitted to 2/2/15. The report indicated resident R47 on the a.m. of and resident was unable to f concerns. The SW was NA-C until 2/2/15 (7 days of the situation) in part due not coinciding with the SW. by phone on 2/2/15, at nowledged the incident ed by LPN-D's note. NA-C ruck R47 in any way, but legs to help her lay down. ort indicated the AP was so included that NA-C had previous submitted report. /15, at 5:10 p.m., the SW as unable to recall if the ed, and said R47 had said NA-C was not r investigation because it ' that NA-C abused R47, and on the work schedule. The ounseled on how to provide as asked for ideas from o R47 safe. s MLHS-LTC NA/R	Γ 22	revised to provide document space that clearly identifies evaluators thoughts in regard 1) Reason for submission 2) Rationale for NOT submit report beyond the facility 3) Action taken to Protect Th The revision also provides th team a means to clearly do their evaluation of the incider any ACTION that they feel no be taken on but not limited o following items: (Attachment 1)Timeliness of the report 2) Was Protection of the resi appropriate 3) Reportability decisions we appropriate The vulnerable adult reportin process/guides located at ea nurses' station will be update by 8/25/15. Responsible Person: LSW 8/19/15: 4- separate staff me scheduled for 8/25/15 where Administrator, DON and LSV jointly provide nursing staff w training regarding the up to c changes that have been put place to assist staff in identifi- potential abuse and neglect,	the initial ds to: tting ne Resident ne review cument nt and eeds to n the F) dent ere ng ach ed eting were the W will vith date t into ying			
	pending the investiga 1/28/15 and NA-C wa and 1/29/15, while the	A-C was not suspended tion of the incident dated as scheduled to work 1/28/15 e investigation was in		protecting the resident, disc reportable injuries of unknow and reporting requirements. This staff mtg will also cover revisions to policies and ava	wn origin the			
		his incident lacked timely A-C. This incident occurred		tools. All Nurses and NA-R s be strongly encouraged to at an attendance record will be	staff will ttend,			

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		MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/23/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
F 225	Continued From page	<u>ه د</u>	F 22	5	
F 229	on 1/24/15 but was no 1/27/15. The investig the R47 was actually suspend NA-C or take during the investigation that a thorough invest R47. R47 had another facill Referral Form (SSIRF R47 was involved in a a.m., of possible abus The SSIRF indicated: (electronic progress in verbal statements and resident [R47]; possible maltreatment but just resident's dementia." indicated the incident Investigative Team or reported submitted to 3/3/2015 at 12:30 p.m NA-C was a person w the situation. An initial Incident Rep state agency on 3/3/1 of R47 on 3/2/15. The progress notes from N a.m. of 3/2 that sugge	ot reported to the SA until pation did not determine if abused. The facility did not e action to protect residents, on. There was no indication tigation was completed for lity Social Service Incident F), signed by RN-C indicated an incident on "3/2/15 early se or resident aggression." CRN-C noted PCC notes notes) by LPN-B questioning d other behaviors by ole indication of t a likely symptoms of The SSIRF further t was discussed with n 3/3/15 at 8:30 a.m., and	F 22	 and those staff unable to attend be required to review materials presented and minutes of the me A signature of completion will be required at the time of the review no later than 9/1/15. Persons responsible: Administrat DON and LSW 8/20/15: Protection of the Reside After review of all final evidence in 2567 report NAR-C will be termin 8/21/15. (NAR -C has been off si 8/10/15, earliest available meetin for NAR-C prior to next schedule 8/21/15). (Attachment G) MONITORING 1. Audit (Attachment H) of each S Service Incident Report Form will reviewed for: timeliness of repor appropriateness of report, and a taken to protect residents The audit will begin with any incide occurring after 8/21/15 and will i every incident reported for the n 3 months (ending 11/21/15) Responsible person: DON and L . Audit (Attachment I) of each Investigation Report will be comp to:Ensure thoroughness of investigations. The audit will begin with any incident occurring after 8/21/15 and will include every incident appropriateness of 	eeting. but for, nts n the hated nce g date d shift is Social be ting, ctions dent nclude ext SW bleted
	staff." The report indi whether this was mal	altreatment of resident by icated uncertainty by staff on treatment, and "SW decided nit the allegation to [state		reported for the next 3 months (e 11/21/15) Person(s) responsible: DON and Both audit reports will be reported Quality Assurance Committee. (QA meets quarterly; Oct., Jan.,A	LSW d to the

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	S FOR MEDICARE &				OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETIC
F 225	Continued From page	e 7	F 22	5	
	a.m., written by LPN- "kicking at staff" and going to report 'her' to indicated R47 told sta everyone I heard" O second progress note wipe dry blood off [R4 The note continued, t stated "I am going to Facility documentatio was taken to protect I during this investigati Documentation of the did not include detern bloody lip, and there with the nursing assis R47. The SSRIF also immediate reporting of agency or administrat A final, Investigative F state agency on 3/06 The report indicated o interviewed by RN Ca this SW. Resident de happening this past w or the nighttime that u denied that anyone h her or that she has hi also indicated "SW c about progress notes shift, "indicating the N the EZ lift (mechanica bathroom per resident noticed resident's lip	B, indicated [R47] was [R47] told staff "she was the nurse" The note also aff "you go around hitting Dn 3/2/15 at 6:03 a.m., a ed indicated staff went to 47's] lip, and [R47] hit staff. hat after R47 hit staff, R47 report you for hitting me." In did not indicate any action R47 and other residents on of potential abuse. e investigation of this incident nination the cause of R47's was no evidence of interview stant who provided cares for o indicated there was no of this incident to the state tor. Report was submitted to the 6/15 regarding the incident. on 3/2/15 the "resident was are Coordinator (RN- A) and enied remembering anything veekend during the daytime upset her in any wayShe its her or has been mean to t anyone else." The report communicated with [LPN-B] from 3/2/15 during night JAR was situating resident in al lift) to help her to the tt's request and the NAR		Reference Checks: F225 (comp 8/19/15) Affects Residents R47,R12,R22 R39, R11, R66, R44, R8 and th Potential to affect all Residents 1. 8/18/15 The VA policy was u (attachment C) indicating that H would attempt to obtain informat from previous employers and /c current employers during the pre-employment screening proof including dates of employment, position held, and feedback on workplace performance 2. 8/18/19 A new Reference Ch Form was developed (attachment J) which identifies documented reference checks of employment, position held ar feedback on workplace perform 3. 8/18/15 The VP of HR provid Training to the HR recruiter on the revised VA Policy, and the new Reference Check Form. The Reference Check Form wat implemented on 8/19/15 and wit used on all new hires going for Monitoring: (attachment K) Responsible Party: VP of HR 4. Biweekly audits will be comp by the VP of HR or designee fo for all new hires. The audit will include verification that the Reference Check form was completed for all new hires priot their first day of employment.	2 e pdated IR tition or cess eck with dates nd hance. led the s ill be ward leted r

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		O. 0938-039 E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,		COM	IPLETED	
		245127	B. WING		07	7/23/2015	
NAME OF P	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		200 NORTH ELM STREET ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 225 Continued From page			F 225				
	The report indicated and assisted [R47] wi same night, the NA w attempted to lift R47's resident kicked at NA referenced the allega was slapped. The rej perpetrator in this inc R47's care plan was to were made on how to cares. The report als coached by the SW a progress note chartin have been reminded reports. The report in not resting well with the maltreatment of resid particular incident, SW and ears open for pati- conduct, etc."	NA-C re-approached later ithout incident. Later the vas doing rounds and s feet back in bed, and -C. The report then tions made by R47, that she port did not confirm a ident. The report indicated reviewed, and suggestions o approach R47 during to indicated LPN-B was and DON on more thorough g, and further, that staff to submit timely incident included: "Something is just his, and although there is no ents 'substantiated' in this <i>V</i> will continue to keep eyes tterns and/or trends in		(QA meets quarterly; Oct., Jan., April and July).			
	Schedule from Februa 2015, indicated NA-0	Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.					
	stated, in review of th "concerns with NA-C" she had really done a felt they could not sut against NA-C, and the "suspension or discip	' but again could not prove anything wrong. The facility ostantiate the allegations erefore did not warrant a line" during the vas no indication that a					

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				CONSTRUCTION		10.0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED	
		245127	B. WING		0	7/23/2015	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 225	R12's quarterly MDS was moderately cogn extensive assist with grooming. R12's care indicated she had pot related to cognitive in mobility. An initial Incident Reg agency on 2/18/15, ir was allegedly slapped person who was atter medicine. The AP or listed as unknown. A final Investigative F state agency on 2/23. The report indicated I allegations, but the or "tracked," was the on [R12] during the adm Magnesia (MOM) tha indicated the SW and more information abo administered the MO schedule, LPN-B and duty. At 10:45 p.m. c SW met with NA-C, w given MOM to R12 u NA-C said "[R12] didu took the cup and thre [NA-C] tried to clean resident's clothing an The report indicated I any way, but acknow with the wet ones. Th	dated 4/27/15 indicated she itively intact and needed dressing, bathing and e plan dated 1/31/15, tential for abuse from others inpairment and limited bort submitted to the state indicated that on 2/18/15, R12 d, on her cheek, by a staff mpting to administer in the Incident Report was Report was submitted to the /15, regarding the incident. R12 had made numerous inly allegation that could be e about someone slapping inistration of Milk of t morning. Firstly, the report d DON proceeded to seek but who would have M that morning. Per I NA-C were the persons on on 2/19/15, the DON and who freely admitted having inder direction of LPN-B. in't want the MOM, and [R12] w the MOM all over." it up off the bedding, d her face, using wet wipes." NA-C denied slapping R12 in ledged wiping R12's face off the report indicated, "It is ceived by [R12] as a slap."	F 225				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/31/2015 1 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		245127	B. WING		_	07/:	23/2015
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET			
							0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	her as the lady who s agreed to do so. [R1: however, so decided indicated "[NA-C's] wi leads SW to believe s about not slapping re- indicated the DON sp 2/23/15 at 3:20 p.m. NA-C to give MOM to occupied elsewhere that NA-C did report [slapped by a "blonde indicated staff have b persons present durin and NA-C was instruct without a colleague p During interview on 7 stated she did not sus could not prove NA-C acknowledged NA-C multiple incidents, and [NA-C], but did not fer suspend" or provide of during this investigation The investigation of th	lapped her, and NA-C 2] was sleeping soundly, not awaken her. The report illingness to go, however, she [NA-C] is being truthful sident." The report then boke to LPN-B by phone on LPN-C admitted asking 0 R12 due to LPN being LPN-C also acknowledged [R12's] claim of being lady." The report then een alerted to have two ng cares with this resident cted not to enter room resent. /23/15, at 5:20 p.m. the SW spend NA-C since they c slapped R12. The SW had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on.	F 225) DEFICIENCY)		
	follow up to have R12 nursing assistant who NA-C was instructed without a colleague p offered no indication						
	R22's admission MDS	S dated 4/24/15, indicated					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 08/31/2015 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	((X3) DATE COMP	SURVEY LETED
		245127	B. WING				07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
F 225	accident (CVA), was n impaired and needed and extensive assist v plan dated 5/3/15, ind with toileting and tran- depression and sadne care plan further indic abuse from others rel- weakness, aches and indicated "resident will needs met in a safe e During observation or lifted her pant leg and right shin measuring a (centimeters) x 2 cm fading to dark purple swelling In an interview 7/20/1 that she had been tre- and there is a staff me shift that is rough with this staff member had transferring" which ca also stated she had a bar along the bottom The facility submitted state agency on 6/27/ alleged mistreatment The report also identifi right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm, report was submitted the initial reporter, NA	In d a cerebral vascular moderately cognitively limited assist with transfers with toileting. R22's care licated she needed assist sfers, had history of ess/isolating self. R22's cated she had potential for ated to her general l pains. The care plan goal ll remain safe and have environment." n 7/20/15, at 5:54 p.m. R22 I displayed a bruise on her approximately 8 cm . R22's bruise was black, in color, with no apparent 5, at 5:54 p.m. R22 stated ated "roughly by the staff" ember who works the night n her. R22 went on to state I "grabbed her arm when iused a large bruise and Iso hit her leg into the metal	F 2	225				

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TEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	IPLETED		
		245127	B. WING		07	7/23/2015		
AME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE			
IILLE LAC	S HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 225	Continued From page	2 12	F 22	25				
		.)-C reported at 5:15 a.m.,	1 22					
	5	After being toileted, R22						
	told [NA-C] she was r	not coming back tonight,and						
		er." NA-C asked who, and						
		doesn't know who. The						
	report then indicated in (RN)-A followed up w	vith R22 in the morning and						
		vhat happened: "Resident						
		aying here again tonight and						
		ated like this anymore." R22						
		as mad at her during the						
		use the bathroom so many						
		grabbed me and threw me ed out her hand hurt, and						
		e grabbed me," noted a						
		hand measures 5.5 cm						
		circular is shape. R22 also						
		rew me into bed, "I hit my						
	•	tal;" a bruise noted on right sures 2.5 cm x 2.5 cm						
		2 could not recall who the						
	girl was, nor her name							
	-	eport further indicated NA-C						
		stant working on that wing						
		LPN-A was the nurse in						
		uries noted, resident was nain safe here, NA-C will be						
		g with resident at this time.						
		t Report was submitted to						
		7/1/15, which identified an						
		urce on R22's right forearm ple in color, and oval in						
	· · · ·	cident occurrence was						
		indicated R22 said, "It						
	happened a few days							
1	· · ·· ·· -	ort was submitted to the						

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		10. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	CON	MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI	DE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	Continued From page	e 13	F 22	5		
		nt reports. The report		5		
		nd social worker SW "have				
		is issue thoroughly and have				
		antiate who the alleged				
		r certain, but have reached a				
		asonable suspicion a crime				
	-	the form of assault, and are				
	hence submitting a re	rdance with Elder Justice				
	Act." Further, "The d					
		nits of our ability are being				
		Office of Health Facility				
	Complaints] the state	agency." The Investigative				
		ed on 7/1/15, the DON and				
		(NA-C) who stated R22 had				
		toilet 6-8 times that night then indicated [SW and				
		the AP the number of				
		nvolving this NAR, which				
		[regarding] her credibility,				
	-	newhat defensive, face				
	reddening and voice					
		gs and others don't, so I end				
		The report further listed,				
	-	ew 7/2/15 the DON and SW				
		stated she "reported having R22) on 6/30, that [R22] is				
	,	the blonde hair and bangs,				
	•	ice, etc. The blond hair with				
		tion of NA-C. The report				
		NA-C had been "implicated				
		5814, 78740, and 79433 with				
		gles" with residents, as she				
		; received coaching in these also involved in report				
		becifically named as AP."				
		scribed NA-C as the staff				
	I member who had hur	t her and NA-C was caring				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/31/2015 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	23/2015
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CS HEALTH SYSTEM				00 NORTH ELM STREET			
				0	NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page for her and received n disciplinary action was suspended pending the was no indication that was completed by the interviews with staff a During interview on 7/ DON stated she has of be doing the accusation certain. The DON said during the night shift," that do that." The DOC report if they notice ar In an interview on 7/2 stated she did not talk regarding abuse alleg stated, "I don't general hunt." The DON said, keeps coming up doe The DON also said the "data privacy and con stated when somethin allegations come up of on duty initiates the O said the nurse would find address any immedia NA-C, the SW stated several residents she	e 14 nultiple large bruises, no s taken, NA-C was not he investigation. Also, there a thorough investigation e facility to include other nd residents. (23/15, at 4:50 p.m. the concerns that NA-C might ons, but stated she was not id, "Staff monitor [NA-C] and "we have nurses on N stated the nurses were to nything and have concerns. 3/15, at 5:03 p.m. the SW with other residents or staff ations by R22. The DON ally do that, it's not a witch "Just because their name s not make them guilty." ere were issues around fidentiality." SW further	F 2	225				
	further stated, in rega allegation of abuse, "a The SW also said the "not intensive, and the	ubstantiated." The SW rd to NA-C, after the first a lot of coaching was done." coaching for NA-C was ere was no improvement documentation of education						

Facility ID: 00374

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		D HUMAN SERVICES				FORM): 08/31/2015 1 APPROVED
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245127	B. WING		_	07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
			2	00 NORTH ELM STREET			
	CS HEALTH SYSTEM		c	DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page During an interview of administrator said, "W working on nights, we enough staff." The ad feel the DON and SW During an interview of the DON stated NA-C facility policy following R22 . She stated, "If I would have had to su who would take care of During an interview of stated, "I don't work a am mandated, but I d stated, "I have heard little rough, but I can't stated one of the resid being rough and leavi the staff member as the resident and stated the threw me into the cha bathroom again." NA the nurse a lot on night During interview on 7/ stated she works part LPN-H stated she has NA-C is rough with the witnessed it directly. aware that she was to the night shift when shi indicated she had hear	e 15 n 7/23/15 at 5:10 p.m., the /e have three young people can't suspend; there is not ministrator further stated, " I did the right thing." n 07/23/15, at 5:14 p.m. was not suspended per the g the allegation made by had suspended one, I spend all three staff, then of the residents?" n 07/24/15, 5:14 a.m., NA-E a lot of overnights unless I o hear a few things." NA-E about people being super that some of the girls are a tell you who." She further dents mentioned about a girl ng bruises. NA-E described hey were described by the e resident said " the girl ir because I had to go to the -E stated she does not see nts. /24/15, at 5:25 a.m. LPN-H time on the night shift. s heard from other NAs that e residents but had not LPN-H stated she was not o monitor any staff during he works. She further ard R12 had reported that	F 225				
	works on the North wi was because of the ca	r and that NA-C no longer ing and thought the reason at; not because she can not in residents. She then					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/31/2015 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM				0 NORTH ELM STREET			
				0	NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	9 16	F 2	25				
		e night shift don't work o work on each unit alone.						
	INJURIES OF UNKN	OWN ORIGIN						
	was moderately cogn plan, dated 3/30/15, in extensive assist with	all activities of daily living, and for transfers, and was						
	dated 10/7/14, indicat purple bruise on the r buttock and that R39 bruising occurred. The been lowered to floor the bruise and indicat the injury. The incider anticoagulant medica clotting), other injurie unspecified times fram							
	DON)stated, when R3 floor it would be hard during that event but due to use of anticoas therefore the injury wa reportable. Although R39 was mo unable to recall how t was no evidence that	as not considered oderately impaired and he bruise occurred, there						

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	S FOR MEDICARE &					<u>IO. 0938-03</u>		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED		
		245127	B. WING		0	7/23/2015		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	E			
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE		
	Continued From page 17 actual cause, nor was R39's injury of unknown origin reported to the state agency.		F 225					
	she was moderately of plan, dated 6/3/15, in extensive to total assi	ist for all activities of daily impaired, and at risk for						
	Report Forms indicate unknown origin. An in indicated R39 had a t hand that was dark pu 8 cm x 8 cm. The rep was unable to state h blood thinners and de "minor." Another Soci dated 11/4/14, indicat to her left temple and was unable to state th third incident report d had a bruise of unknown knee, dark purple in of (unit of measurement report further indicate the cause of the injur- medications, and the	rate Social Services Incident ed R11 had injuries of incident form dated 10/21/15, pruise to the top of her right urple in color and measured ort further indicated R11 ow the injury occurred, used escribed the injury as fal Services Report Form, ted R11 had bruising noted above her left eyebrow, and he cause of the injury. A ated 12/18/14, indicated R11 own origin to her left inner color, measuring 1 x 1 3/4. was not indicated). The d R11 was unable to report y, use of anticoagulant e injury was considered to be three bruises were reported						
	SW stated, R11 "had have ever known." Sh	n 7/24/15, at 12:54 p.m., more bruising than anyone I ne stated the bruise on R11's caused by "recent trimming						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								PRINTED: 08/31/2015 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
245127			B. WING			_	07/23/2015		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 225	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 R11's temple and forehead, SW stated that nursing felt the bruising was due to placement of R11's nebulizer mask, however, SW interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift for transfer and there were no records of any falls and indicated the bruising was likely due to placement of R11's nebulizer mask. During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 could reliably answer when asked if bruising was related to abuse, therefore, she felt the injury was not reportable. Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, and were unable to determine what happened, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified but none of these incidents were submitted to the state agency. R66's quarterly MDS, dated 1/7/15, indicated she was moderately cognitively impaired. Care plan, dated 2/915, indicated R66 required extensive assist of two staff with use of mechanical lift for transfers, at risk for delirium, and at risk for abuse related to depression. During review of a Social Service Incident Referral Form, dated 2/3/15, a facility progress noted indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 had bruising		F	225					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	08/31/2015 APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		245127	B. WING			_	07/23/2015		
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		200 NORTH ELM STREET ONAMIA, MN 56359						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 225	Continued From page 19		F	225					
	SW stated, the bruise was reviewing a progr with nursing and dete assessed to be a mine reportable to to OHFC During an interview of DON stated, R66 use lift) and did not always occasionally "flailing h stated, R66 was confu "hard to say if R66 wo talk about how the bru time had passed." Although R66 had bila hands to her shoulder unwitnessed and the identify what happene immediately reported agency nor was a tho	n 7/24/15, at 12:54 p.m., the d a Hoyer lift (mechanical s cooperate in lift, ner arms." She further used and that it would be build have been able to to uising occurred after any ateral bruising from her rs, the injury was resident was unable to ed. The facility had not the incident to the state rough investigation ne if R66 was "flailing her							
	was severely cognitive dated 7/10/15, indicat assist with activities o	ated 6/9/15, indicated she ely impaired. Care plan, red R44 required extensive f daily living, and was at risk hort term memory loss and king skills.							
	dated 6/15/15, indicat on her posterior forea	vice Incident Referral Form, ed R44 had a purple bruise rm measuring 6.3 cm x 7 ring her bath. The incident							

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						FORM	: 08/31/2015 APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		245127	B. WING	B. WING			23/2015	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE			
MILLEIA	CS HEALTH SYSTEM		20	00 NORTH ELM STREET				
	OUTEALTH OTOTEM		0	NAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 225	Continued From page 20 form indicated R66 did not state the cause of injury and that the injury was determined to be "minor."The bruise was not reported to OHFC. During an interview on 7/24/15, at 12:54 p.m., SW stated, on 8/18/14, staff reported R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of the thumb to her wrist. She stated the reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. She further stated the injury was not reportable due to staff witness of the potential cause. A Social Services Incident Referral form was requested for this injury but was not received. During an interview on 7/24/15, at 12:54 p.m., SW stated when making a determination of whether or not to report an injury to OHFC, she refers to statutes, and uses a decision tree. SW also stated that she looks at whether a resident is able to explain the injury or if someone else saw it, and if there is a history of other recent falls and/or injuries. She further stated, if the nurses indicated minor injury or njury not suspicious in nature or location, it does not need to be reported.		F 225					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/31/2015 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY PLETED
		245127	B. WING			07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	there was no charting would show evidence completed. Even though R44 was cognitively impaired, I origin, on the posterior indication the facility of investigation to deterr injury, also the incider state agency. R8's quarterly minimul her to be severely cog requiring assist of two living. CP dated 5/15/ extensive assist for ac was at risk for abuse dementia. A review of SSIRF da had a bruise measurin her thumb and forefin thumb to her wrist. Th initial evaluation and o resulted from R8 wrin wringing of her hands During an interview of SW stated, the injury staff witness of the po investigation of the inj facility administrator v a report was not made	uries. However, she stated in the clinical record that that follow up had been s assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her in was not reported to the um data set (MDS) identified gnitively impaired and o staff for activities of daily 15 indicated R8 required ctivities of daily living and related to diagnosis of ted 8/18/14, indicated R8 ng 8.5 cm in length between ger from the base of her he reporting nurse did the determined the bruising ging her hands, and the s was witnessed by staff. In 7/24/15, at 12:54 p.m., was not reportable due to otential cause. No further jury was completed. The vas notified of the injury but e to the state agency. A	F	225			

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						IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 225	Although R8 had seve and had a bruise 8.5 forefinger from the ba There was no indicati thorough investigation her injury, also the indi- the state agency. Review of the facility revised 7/15, indicate (Mille Lacs Health Sy are vulnerable to abu physical, mental psyc sexual abuse)" The "protection will include individual abuse prev reporting of all cases neglect, or financial e reporting to the Comr substantiated inciden regard to investigation the policy stated: "All thoroughly investigate further potential abus progress." Under the Patient" section, the p alleged perpetrator (A situation. If the AP is suspended until the ir and further, "Disciplin up to and including di employee/employees defined Injury of Unkr the injury was not obs suspicious." The poli	ere cognitive impairment, cm between her thumb and ase of her thumb to her wrist. ion the facility completed an in to determine the source of cident was not reported to Vulnerable Adult Policy, d: "It is the policy of MLHS stem) to protect adults who se (including verbal, chosocial/emotional, and e policy further indicated: e abuse prevention plans, ention plans, internal of suspected abuse, exploitation, and external non Entry Point (CEP) of ts of maltreatment." In n of a reportable incident, I alleged violations are ed. The facility must prevent e while the investigation is in e "Protection for Resident or policy directed that "The AP) will be removed from the an employee, they will be nvestigation is completed," iary action will be carried out ismissal of a as appropriate." The Policy nown Origin as "source of served and injury as cy did not expound on this CMS definitions. In regard	F 225			

Facility ID: 00374

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	S FOR MEDICARE &				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/23/2015
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
F 225	Continued From page	23	F 225		
F 226 SS=F	employers." 483.13(c) DEVELOP/ ABUSE/NEGLECT, E		F 226		8/21/15
	policies and procedur	t, and abuse of residents			
	by: Based on observatio review, the facility fail Vulnerable Adult Polic abuse, neglect, mistre unknown origin were administrator and star investigated, and res during the investigatio (R47, R12, R22, R39 allegations reviewed. to conduct reference policy for 4 of 5 newly NA-B, DA-A and RN- effect all 50 residents and resulted in substar resident behavior and	is not met as evidenced n, interview and document ed to implement their cy to ensure all allegations of eatment and injuries of immediately reported to the te agency, were thoroughly idents were protected ons for 8 of 15 residents' , R11, R66, R44 and R8) In addition, the facility failed checks according to their v hired employees (NA-A, -B). This had the potential to who resided in the facility, andard quality of care under a facility practices.		Investigation and Protection: Affects residents R47, R12, R22, R39, R11, R66, R44, R8 with the Potential to affect All Residents. Injuries of Unknown Origin: Affects residents R39, R11, R66, R44, R8 with the Potential to affect All Residents. Corrections support investigation, protection and injuries of unknown or 7/24/15 @ 10:15 PM: A Performance Improvement Plan was delivered an implemented effective immediately with NA-C. (Attachment B). One said measurement included NO complaints regarding care action during the shift. Failure to meet this	d
	indicated: "It is the po Health System) to pro vulnerable to abuse (e Adult Policy, revised 7/15, licy of MLHS (Mille Lacs otect adults who are including verbal, physical, emotional, and sexual		goal will result in further disciplinary action up to termination. 7/29/15 In order to ensure the protection and safety of R22 it was decided that at this time 2 staff would be required in the room when providing care. This was discussed	

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					OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/23/2015
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				200 NORTH ELM STREET	
	CS HEALTH SYSTEM			ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETIC
F 226	Continued From page	24	F 22	6	
1 220		further indicated: "protection	F 22	at R22's Care Conference and w	125
	,	evention plans, individual		approved by both R22 and her fa	
		ns, internal reporting of all		8/15/15 Existing VA tracking log	anniy.
		buse, neglect, or financial		revised to include identity of alle	aed
	exploitation, and exte			perpetrators to better identify the	-
	-	(CEP) of substantiated		occurring, including those incide	
	incidents of maltreatn			that have been ¿unable to	
		ortable incident, the policy		substantiate.	
		iolations are thoroughly		The Log will be updated at the ti	me
		ility must prevent further		investigation results are submitte	
	-	the investigation is in		to OHFC and again when the	
		"Protection for Resident or		investigation is closed.	
		oolicy directed: "The alleged		Upon Closure of each incident th	ne
	perpetrator (AP) will b			VA Log will be electronically form	
		an employee, they will be		by LSW to administrator to assu	
	suspended until the ir	nvestigation is completed,"		administrator is kept informed o	f the
	and further, "Disciplin	ary action will be carried out		FULL STATUS of the investigat	tions
	up to and including di	smissal of		with regards to timeliness of rep	ort
	employee/employees	as appropriate."		submissions, final disposition an	d
				actions taken with regards to	
	INVESTIGATION ANI	D PROTECTION		alleged perpetrator.	
				Person(s) responsible: LSW	
		/15, at 5:09 p.m. with social		On 8/17/15: Facility wide Vulner	
		nat nursing assistant (NA)-C		Adult Policy (Attachment C) rev	
		n at least four incident		delineate protections for residen	
		/ 2015 to July 2015 of		This includes CMS language de	fining
	alleged abuse, and ne	eglect.		injuries of unknown source.	
	_			On 8/18/15: Administrator and	
		dent and Investigation		Medical Director sent a letter	u el (e u
	-	5 to 7/20/2015 for NA-C		(Attachment D) to all residents a	nu/or
	identified the following	y:		their representatives regarding	how
		num data aat (NDC) datad		survey findings; how, what and	now
		num data set (MDS) dated		often we educate staff and the	20
		e was moderately cognitively		facility; s commitment to protect	ng
		tensive assistance in ADLs.		vulnerable adults. A flier with	abuaa
	-	d 2/26/15, indicated she had		information on warning signs of	
	dementia and needs	assist with dressing,		and neglect, and a copy of the	
1	arooming and hathing	 The care plan further 		education over the last 12 mont	ho

Facility ID: 00374

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					OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
F 226	Continued From page	25	F 226	3	
		nd that resident will continue		On 8/19/15 Social Service Incide	ent
	to be oriented to pers			Reporting Form (Attachment E)	
				revised to provide documentation	
	-	ce Incident Referral Form		space that clearly identifies the	
	(SSIRF) indicated lice	-		evaluators thoughts in regards to	D:
		orted to the social worker		1) Reason for submission	
		it 4 p.m., an incident that		2) Rationale for NOT submitting	
	SSIRF, dated 1/27/15	ight shift on 1/24/2015. The		report beyond the facility 3) Action taken to Protect The Re	esident
		tween res [resident] & aides		The revision also provides the re	
		lapping aide and stating 'I		team a means to clearly docum	
	didn't hit you, you hit	me you liar.'" The SSIRF		their evaluation of the incident ar	nd
		separated aide & resident,		any ACTION that they feel needs	
		escorted aide to hallway to		be taken on but not limited on the	e
	inquire what happene indicated the incident			following items: (Attachment F) 1)Timeliness of the report	
	investigation and/or r	•		2) Was Protection of the resident	•
	-	signed by the SW on		appropriate	
	1/28/15.			3) Reportability decisions were	
				appropriate	
	A review of Mille Lace	Nursing Home Progress		The vulnerable adult reporting	
		, written by LPN-D indicated:		process/guides located at each	
		res. room, 5 rooms away		nurses' station will be updated	
		ent happened, but heard a woman's out cry.		by 8/25/15. Responsible Person: LSW	
	This nurse then got a			8/19/15: 4- separate staff meetin	a were
		e aide (nursing assistant,		scheduled for 8/25/15 where the	•
		d (in her words) "On 2 a.m.		Administrator, DON and LSW w	
		ck resident in room 45-1		jointly provide nursing staff with	
		woke up resident in 45-2		training regarding the changes the	
		I told [R47] the time and		have been put into place to assi	
		ack down and try and get		staff in identifying potential abuse	
		ee time." [R47] said "No, I ting." NA said "No lets lay		and neglect, protecting the reside discerning reportable injuries of	ent,
		o pick up [R47's] feet to		unknown origin and reporting	
		d [R47] swung and hit me in		requirements.	
		I [NA] yelled out "ow" and		This staff mtg will also cover the	
		hit me, [R47] said, 'I didn't,		revisions to policies and available	e
	you hit me you liar' th		1	tools. All Nurses and NA-R staff	

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		MEDICAID SERVICES			OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	COMPLETED	
		245127	B. WING		07/23/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETIC	
F 226	Continued From page	e 26	F 226	5		
	walkie the nurse" T the res. why she hit th that the aide hit her." identify the nursing as A facility email, writte 1/28/2015, indicated informed by LPN-D o a nursing assistant. was a progress note "incident report form." SW further reviewed because the notes in allegedly struck a NA also that the resident NAR struck her, the in reported" to the state An Incident Report su on 1/28/15, indicated reported to this SW in 1/27/15" and furthe past weekend" with a Following a review of by the "Stand Up Tea Management Team", incident was due to [f symptoms" The rep progress note which i "claimed at the time t thus requiring a report	This nurse [LPN-D] asked he aide. Res. [R47] stated The nursing note did not ssistant by name. n by the SW, dated the SW had been verbally f R47 being in a conflict with The email indicated there of the incident, but no further " The email indicated the the progress notes, and dicated "the resident .R [nursing assistant] and claimed at the time that the ncident DOES need to be agency. ubmitted to the state agency : "An incident was verbally n the late afternoon r that R47 had a conflict "this nursing assistant. The related progress notes am" and "Behavior it was originally determined R47's] "dementia port referred to a nursing indicated that [R47] hat the NAR struck her," rt to the state agency, and tion done accordingly as per		be strongly encouraged to attend an attendance record will be kep and those staff unable to attend be required to review materials presented and minutes of the me A signature of completion will be required at the time of the review no later than 9/1/15. Persons responsible: Administrat DON and LSW 9/20/15: Protection of the Reside After review of all final evidence 2567 report NAR-C will be termin 8/21/15. (NAR-C has been off sin 8/10/15, earliest available meetin for NAR-C prior to next schedule 8/21/15. (Attachment G) MONITORING 1. Audit (Attachment H) of each S Service Incident Report Form will reviewed for: timeliness of repor appropriateness of report, and a taken to protect residents The audit will begin with any incide occurring after 8/21/15 and will i every incident reported for the n 3 months (ending 11/21/15) Responsible person: DON and L 2. Audit (Attachment I) of each Investigation Report will be comp to:Assure thoroughness of investigations. The audit will begin with any incident occurring after 8/21/15 and will include every	t will will setting. Social I be ting, actions dent nclude ext SW bleted	
	initial report submittee indicated an incident	F, the internal email, and the d to the state agency occurred sometime during norning hours of 1/25/14.		incident reported for the next 3 months (ending 11/21/15) Person(s) responsible: DON and Both audit reports will be reporte		

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE). 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	1 ° <i>î</i>		· · /	PLETED
		245127	B. WING		07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				200 NORTH ELM STREET		
	CS HEALTH SYSTEM			ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 226	Continued From page	27	F 22	6		
	p p p p	ated the incident was first	1 22	the Quality Assurance Committe	عم	
		nown to the SW on late		(QA meets quarterly; Oct., Jan.,		
	-	4, (two days after the		April and July).		
		d to the state agency on				
	· · ·	s after the incident allegedly		Reference Checks: F225 Correc	ted	
		s no indication this incident		8/19/15		
	was reported immedia	ately to the administrator		Affects Residents R47,R12,R22		
		ditionally, the investigation		R39, R11, R66, R44, R8 and the	9	
	of this incident: lacke	ed timely interviewing of		Potential to affect all Residents		
	NA-C, and other invo	lved staff, and potentially		1. 8/18/15 The VA policy was up	dated	
	affected residents; die	d not provide evidence R47		(Attachment C) indicating that H	R	
		tigated for injuries; and		would attempt to obtain informat		
		ction to protect residents		from previous employers and /o	r	
	during the investigation	on.		current employers during the		
				pre-employment screening proc	ess	
				including dates of employment,		
	-	Report was submitted to the		position held, and feedback on		
		5. The report indicated the		workplace performance		
		the a.m. of 1/28/15 and		2. 8/18/19 A new Reference Che	eck	
		ent unable to recall any		Form was developed		
		with any aides the previous		(Attachment J) which identifies		
		was unable to speak with		documented reference checks v		
	NA-C, (identified as the investigation of the inves			dates of employment, position h	eia	
	involved) until 2/2/15			and feedback on workplace		
		nt) "in part due to her work ng with the SW." SW spoke		performance.	od	
		ng with the SVV." SVV spoke on 2/2/15, at 10:45 p.m.		3. 8/18/15 The VP of HR provide Training to the HR recruiter on the the training to the the the the training to the the the training to the the training to the the training to the training t		
		the incident happened as		revised VA Policy, and the new		
		's note, and further, "[NA-C]		Reference Check Form.		
	-	ruck resident in any way, but		The Reference Check Form was	\$	
		t [R47's] legs to help her lay		implemented on 8/19/15 and will		
		port indicated "There is no		used on all new hires going forw		
		NAR striking resident." The		Monitoring: (attachment K)		
	investigative report in	-		Responsible Party: VP of HR		
		C. This report also included		4. Biweekly audits will be complete	eted	
		mplicated in a previous		by the VP of HR or designee for		
	submitted report.			for all new hires. The audit will		
				include verification that the		
	1	/23/15, at 5:10 p.m., the SW	1	Reference Check form was		1

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE
F 226	stated in the investiga recall if the incident h had dementia. The S suspended during he could not be proven t NA-C continued to be SW said NA-C was co cares for R47, and wa NA-C on how to keep Review of the facility! Schedule from Janua 2015, indicated NA-C	ation, R47 was unable to ad happened, and that R47 SW said NA-C was not r investigation because it hat NA-C abused R47, and e on the work schedule. The ounseled on how to provide as asked for ideas from o R47 safe. s MLHS-LTC NA/R iny 26, 2014 to February 8, c worked on the night shift on while the investigation of	F 22	26 completed for all new hires p the first day of employment. Audit reports will be reported Quality Assurance Committee (QA meets quarterly; Oct., Ja April and July).	to the e.
	Referral Form (SSIRF R47 was involved in a a.m., of possible abus The SSIRF indicated: (electronic progress r verbal statements and resident [R47]; possit maltreatment but jus resident's dementia." indicated the inciden Investigative Team or reported submitted to 3/3/2015 at 12:30 p.n NA-C was a person w the situation.	ble indication of t a likely symptoms of The SSIRF further t was discussed with n 3/3/15 at 8:30 a.m., and the state agency on n. The report also indicated with credible knowledge of			
	the situation. An initial Incident Rep state agency on 3/3/1 maltreatment of R47 referenced "two progr	port was submitted to the			

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	S FOR MEDICARE &					D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		· · /	SURVEY PLETED
		245127	B. WING		07	/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 226	some behavioral cond by resident [R47] at w maltreatment of residu indicated uncertainty maltreatment, and "S' submit the allegation A nursing progress not a.m., written by LPN-I "kicking at staff" and [going to report 'her' to indicated R47 told sta everyone I heard" O second progress note wipe dry blood off [R4 The note continued, ti stated "I am going to Facility documentation was taken to protect F during this investigation Documentation of the did not include determ bloody lip, and there w with the nursing assiss R47. The SSRIF also immediate reporting of agency or administrat A final, Investigative F state agency on 3/06 The report indicated of interviewed by RN Ca this SW. Resident de happening this past w	cerns/dementia symptoms york or possible ent by staff." The report by staff on whether this was W decided to go ahead and to [state agency]" ote, dated 3/2/215 at 4:03 B, indicated [R47] was (R47] told staff "she was o the nurse" The note also aff "you go around hitting On 3/2/15 at 6:03 a.m., a ed indicated staff went to H7's] lip, and [R47] hit staff. hat after R47 hit staff, R47 report you for hitting me." In did not indicate any action R47 and other residents on of potential abuse. Investigation of this incident hination the cause of R47's was no evidence of interview stant who provided cares for o indicated there was no of this incident to the state	F 224	6		

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					OMB NO. 093	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		245127	B. WING		07/23/20)15
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
MILLE LA	CS HEALTH SYSTEM		200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COM HE APPROPRIATE	(X5) IPLETIO DATE
F 226	about progress notes shift, "indicating the N the EZ lift (mechanica bathroom per resider noticed resident's lip apparently cracked fr winter air. [NA-C] tol- the dried blood off, b causing NA's glasses The report indicated and assisted [R47] w same night, the NA w attempted to lift R47's resident kicked at NA referenced the allega was slapped. The re perpetrator in this inc R47's care plan was were made on how to cares. The report als coached by the SW a progress note chartin have been reminded reports. The report in not resting well with t maltreatment of resid particular incident, SV and ears open for par conduct, etc." Review of the facility Schedule from Febru 2015, indicated NA-C 3/2/15 (the night of th worked on 3/3/15.	a from 3/2/15 during night NAR was situating resident in al lift) to help her to the ht's request and the NAR had been bleeding om being chapped with dry, d [R47] she was going wipe but R47 struck out at NA, a to dismount from her face." NA-C re-approached later ithout incident. Later the vas doing rounds and s feet back in bed, and A-C. The report then tions made by R47, that she port did not confirm a ident. The report indicated reviewed, and suggestions o approach R47 during so indicated LPN-B was and DON on more thorough ng, and further, that staff to submit timely incident ncluded: "Something is just his, and although there is no lents 'substantiated' in this <i>N</i> will continue to keep eyes tterns and/or trends in	F 2			
	During interview 7/23 stated, in review of th	/15, at 5:30 p.m. the SW is incident, she had " but again could not prove				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	· · ·	E SURVEY
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
MILLE LA	CS HEALTH SYSTEM					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 226	Continued From page	e 31	F 226			
	felt they could not sub against NA-C, and the "suspension or discip investigation. There v	anything wrong. The facility ostantiate the allegations erefore did not warrant a line" during the vas no indication that a n was completed for R47.				
	was moderately, cogr extensive assist with grooming. R12's care	dated 4/27/15 indicated she nitively intact and needed dressing, bathing and e plan dated 1/31/15, tential for abuse from others npairment and limited				
	(SSIRF), signed by the indicated there was a early A.M.", which alle was described as: "[I Res re some issues. want to go home, the lady with the ponytail up yesterday', and 'TI when she tried to mail 4p.m. resident [R12] concerns." The SSIR following: an internal on 2/18/15; that the re received by the SW in listed; the incident was "Investigative Team"	email report was completed eport of alleged abuse was n person, no date or time as discussed with on 2/18/15 at 0833; and that al report was submitted on				

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	S FOR MEDICARE &			CONSTRUCTION		10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET NAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	was "slapped on her of this morning while sta her to take some med R12 had no apparent consistent with this cl The report also indica investigation is warran perpetrator" on the re "unknown." A review of the SSIRF State Agency indicate occurred in the early possibly earlier, no ac or staff until it was dis on 2/18/15. There was was immediately report administrator. Furthe documentation of this R12 was slapped; and have R12 positively id (possibly NA-C) who Although NA-C was in room without a colleat documentation offere were put in place for assisted by NA-C dur incident, regardless of A final Investigative R state agency on 2/23/ indicated the "Initial F agency]at 4 p.m.," was made to local law indicated R12 had ma but the only allegation	cheek by a staff person early aff person was trying to get dicine." The report indicated injuries, and "has been aim throughout the day" ated "a full internal nted." The "alleged port form was listed as F, and the initial report to the ed, that although this incident morning of 2/18/15, and ction was taken by the facility acussed later that morning as no indication the incident orted to state agency and er, the investigation a incident did not indicate if d there was no follow up to dentify the nursing assistant, provided her cares that day. Instructed not to enter R12's gue present, the d no indication protections other residents who were ing the investigation of this if its outcome.	F 226			

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	S FOR MEDICARE &			OMB NO. 0938-0			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		` '	IE SURVEY MPLETED	
		245127	B. WING		o	7/23/2015	
NAME OF P	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM) NORTH ELM STREET IAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 226	morning (the white st SW and DON procees information about wh the MOM that mornin according to the schee the persons on duty. indicated, "DON and freely admitted having direction of [LPN-B]." "[NA-C] said resident resident took the cup over." and "[NA-C] tri bedding, resident's cl wet wipes." The repor- slapping resident in a wiping R12's face off report indicated "It is by [R12] as a slap." the SW asked NA-C see if resident could of lady who slapped her "[R12] was sleeping s decided not awaken I "NA-C's willingness to believe she [NA-C] is slapping resident." T spoke to LPN-B by pl	uff)." The report indicated ded to seek more o would have administered g. The report identified, edule, LPN-B and NA-C were Further, the report SW met with [NA-C], who g given MOM upon the The report continued, didn't want the MOM, and and threw the MOM all ed to clean it up off the othing and her face, using ort indicated "[NA-C] denied iny way, but acknowledged f with the wet ones." The possible this was perceived Next, the report indicated, to go to resident's room to or would identify her as the r, and NA-C agreed to do so.	F 226				
	LPN-C also acknowle (R12's) claim of being The report then indica to having "two persor this resident and NA- room without a collea During interview on 7	/23/15, at 5:20 p.m. the SW spend NA-C since "they					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 08/31/2015 M APPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245127	B. WING			07	/23/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	acknowledged NA-C multiple incidents, and [NA-C], but did not fea suspend" or provide of during this investigation Review of the facility's Schedule from Februa 2015, indicated NA-C 2/22/2015, that is on t incident, and during th	had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on. s MLHS-LTC NA/R ary 9, 2015 to February 22, c worked on 2/17/15 through the date of the alleged he subsequent investigation. ion a thorough investigation	F	226			
	she had depression a accident (CVA), and impaired and needed and extensive assist y plan dated 5/3/15, ind with toileting and tran depression and sadne care plan further indic abuse from others rel weakness, aches and indicated "resident wi needs met in a safe e During observation or lifted her pant leg and right shin measuring a (centimeters) x 2 cm. be black, fading to da apparent swelling. In p.m. R22 stated that s "roughly by the staff"	ess/isolating self. R22's cated she had potential for lated to her general d pains. The care plan goal II remain safe and have environment." In 7/20/15 at 5:54 p.m., R22 d displayed a bruise on her approximately 8 cm R22's bruise was noted to ark purple in color, with no an interview 7/20/15, at 5:54					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED	
		245127	B. WING		0	7/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C			
				200 NORTH ELM STREET	H ELM STREET		
	CS HEALTH SYSTEM			ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 226	Continued From page	o 25					
F 220	Continued From page		F 22	26			
		this staff member had					
		en transferring" which					
		e and also stated she had ne metal bar along the					
	bottom of her bed.						
	The facility submitted	an Incident Report to the					
		7/15 regarding an incident of					
		and physical abuse of R22.					
	-	ified a bruise on R22 top					
		g 5.5 cm x 5 cm, circular in					
	-	l bruise on R22's lower right , circular in shape. The					
		by RN-D, and indicated that					
		A-C, was also the alleged					
	-	cident. The report indicated,					
	nursing assistant (NA	A)-C reported at 5:15 a.m.,					
	she had toileted R22	, after being toileted, R22					
		not coming back tonight,and					
		er." NA-C asked who, and					
		doesn't know who. The					
		that registered nurse					
		with R22 in the morning and what happened: "Resident					
		taying her again tonight and					
		ated like this anymore." R22					
		as mad at her during the					
	-	o use the bathroom so many					
	times, and that a "gir	I grabbed me and threw me					
		ed out her hand hurt, and					
		ne grabbed me," noted a					
		hand measures 5.5 cm					
		circular is shape. R22 also					
		nrew me into bed, "I hit my					
		etal" a bruise noted on right					
		sures 2.5 cm x 2.5 cm 22 could not recall who the					
	-	ie. R22 thought it was					
	gin mao, nor nor nam		1			1	

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PRINTED: 08/31/2015 FORM APPROVED

Facility ID: 00374

		ND HUMAN SERVICES MEDICAID SERVICES			FC	TED: 08/31/2015 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		245127	B. WING			07/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				200 NORTH ELM STREET		
	CS HEALTH SYSTEM			ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 226	was the nursing assist during the night, and charge. No other inj reassured she will re- removed from workin An additional Incident the state agency on T injury of unknown so "8 x 5 cm, reddish pu- shape." The date of i unknown. The report happened a few days An Investigative Rep state agency on 07/0 submitted incident re 7/1/15. The report in nursing (DON) and s tried to investigate th been unable to subst perpetrator [AP] is fo conclusion there is re may have occurred in hence submitting a re enforcement, in acco Act." Further the rep our internal investiga are being submitted to agency." The Invest indicated on 7/1/15, the the AP, (NA-C) who subst report then indicated with the AP the numb	stant working on that wing LPN-A was the nurse in juries noted, resident was main safe here, NA-C will be og with resident at this time. t Report was submitted to 7/1/15, which identified an urce on R22's right forearm urple in color and oval in ncident occurrence was t indicated R22 said "It s ago." ort was submitted to the 2/15, which combined two ports dated 6/27/15 and dicated the director of ocial worker (SW) "have is issue thoroughly and have cantiate who the alleged r certain, but have reached a easonable suspicion a crime in the form of assault, and are	F 2	226	=NCY)	
	defensive, face redde	ne became somewhat ening and voice tightening, report things and others				
L	1		1			

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PRINTED: 08/31/2015 FORM APPROVED

			0.00	00107010701			
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	· · · ·	TE SURVEY MPLETED	
		245127	B. WING		0	7/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP COD	E		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 226	don't, so I end up get further listed, that dur DON and SW meet w "reported having hear 6/30, that [R22] is afr hair and bangs, that s The blond hair with th NA-C. The report fur been "implicated in pr 78740, and 79433 wi with residents, as she received coaching in also involved in repor specifically named as Although R22 had de member who had hur for her and received r incident documentation to protect residents d included other intervie During interview on 7 DON stated she "has	ting in trouble.' " The report ring an interview 7/2/15 the vith NA-D, who stated she rd from resident (R22) on aid of the girl with the blonde she is not very nice, etc. the bangs fits description of ther included that NA-C had revious reports 75814, th possible "power struggles" these incidents. NA-C was t 79866 but was not s AP." scribed NA-C as the staff t her and NA-C was caring multiple large bruises, the poin indicated no action taken uring investigation of these was no indication that a in was completed that ews with staff and residents.	F 226				
	not certain." The DO during the night shift, on that do that." The were to report to her have concerns. In an interview on 7/2 stated she "did not ta	ions," but stated she "was N said, "staff monitor [NA-C] " and also "we have nurses DON stated the nurses if they notice anything and 23/15, at 5:03 p.m., the SW Ik with other residents or allegations by [R22]." The					

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		ID HUMAN SERVICES				FORM): 08/31/2015 /I APPROVED
	S FOR MEDICARE & DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		OMB NC (X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			-		LETED
		245127	B. WING			07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
			:	200 NORTH ELM STREET			
	CS HEALTH SYSTEM			ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226			F 226				
	around "data privacy	o said there were issues and confidentiality." SW					
	allegations come up o	something regarding abuse over the weekend, the nurse					
	said the nurse would	OHFC reporting. The SW talk to the resident, and					
	NA-C, the SW stated	te concerns. Regarding I, "At times there have been					
		is not allowed to care for,					
	-	if, during the investigation ubstantiated." The SW					
	-	rd to NA-C, after the first					
		a lot of coaching was done."					
		e coaching for NA-C was ere was no improvement					
		documentation of education					
	or mentoring done."						
		n 7/23/15 at 5:10 p.m., the Ve have three young people					
		e can't suspend; there is not					
		Iministrator further stated, " I					
	feel the DON and SW	/ did the right thing."					
	During an interview o	n 07/23/15, at 5:14 p.m.,					
		was not suspended per the					
		g the allegation made by had suspended one, I					
		spend all three staff, then					
	who would take care	•					
		n 07/24/15 5:14 a.m., NA-E					
		a lot of overnights unless I					
		o hear a few things." NA-E about people being super					
		that some of the girls are a					
	little rough, but I can't	tell you who." She further					
		sident mentioned about a girl					
	peing rough and leave	ing bruises. NA-E described					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 08/31/2015 // APPROVED
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245127	B. WING				07/	23/2015
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 226	resident and stated the threw me into the char bathroom again." NA- the nurse a lot on night During interview on 7, stated she works part LPN-H stated she has NA-C is rough with the witnessed it directly. aware that she is to me night shift when she we she had heard R12 has slapped her and also on the North wing and because of the cat not care of any certain re- aides on the night shift prefer to work on eact INJURIES OF UNKNO The facility Vulnerabled defined Injury of Unkry the injury was not obs suspicious." The polit definition to include col- interpretive guidance. R39's annual MDS, di was moderately, cogrid dated 3/30/15, indicat assist with all activitie a mechanical stand for	hey were described by the re resident said " the girl ir because I had to go to the E stated she does not see hts. /24/15, at 5:25 a.m. LPN-H time on the night shift. s heard from other NAs that e residents but had not LPN-H stated she is not nonitor any staff during the works. She further indicated ad reported that NA-C had that NA-C no longer works d thought the reason was t because she can not take sidents. She then stated the ft don't work together they h unit alone. OWN ORIGIN e Adult Policy, revised 7/15, nown Origin as "source of served and injury as cy did not expound on this riteria from the CMS ated 3/9/15, indicated she hitively impaired. The CP, red R39 required extensive s of daily living (ADLs), used	F	226				
	a mechanical stand for identified at risk for at	or transfers, and was						

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	-	ID HUMAN SERVICES				FORM	M APPROVED D. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245127	B. WING			07	/23/2015
NAME OF P	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 226	had a large, dark purp portion of her buttock injury, and R39 was " bruising occurred. Th "a few days ago had I not standing when tra Hoyer (a mechanical SSRIF further indicate that could explain bru chart contained "falls that could explain bru chart contained "falls that could likely have SSIRF indicated R39 reported to the state a investigation was con though there was no any objects or the floo ground. During an interview o DON stated, when R3 floor "it would be hard during that event." Th easily due to use of a therefore the injury wa reportable." Although R39 was mo unable to recall how t was no evidence that investigation was con actual cause, nor was origin reported to the R11's quarterly MDS, she was moderately, CP, dated 6/3/15, ind	ble bruise on the right upper , and it was an "unknown" unaware" of how the e SSIRF also indicated R39 been lowered to floor due to unsferring & then lifted with lift) Possible cause." The ed R39 used a medication ising, and also that R39's or other recent incidents produced the injury." The 's injury was "minor" and not agency. No further npleted for this incident even indication R39 had struck or as she was lowered to the to know if injury occurred he DON said R39 bruised nticoagulant medication, so as "not considered oderately impaired and he bruise occurred, there a more in-depth npleted to determine the s R39's injury of unknown state agency. dated 4/15/15, indicated cognitively impaired. The	F	226			

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PRINTED: 08/31/2015

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/31/2015
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		245127	B. WING			07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From page risk for abuse related		F	226			
	A review of SSIRF dat had a bruise to the top purple in color, and m SSIRF indicated R11 injury occurred, but R medication, and R11's "minor." The facility ar no report was made to A second SSIRF, date had bruising noted to her left eyebrow. The unable to state the ca facility administrator v was not reported to th A third SSIRF dated fa a bruise of unknown of dark purple in color, a inches. The SSIRF in "unknown", that R11 v cause of the injury was indicated the injury was the facility administration injury was not reported During an interview al unknown origin on 7/2 stated, R11 "had morn have ever known." Th R11's hand "may have trimming of [R11's] na the bruise herself. Re R11's temple and fore nursing felt the bruisir [R11's] nebulizer mas	ted 10/21/15, indicated R39 p of her right hand, dark heasured 8 cm x 8 cm. The was unable to state how the 11 used anticoagulant s bruise was described as dministrator was notified but o the state agency. ed 11/4/14, indicated R11 her left temple and above e SSIRF indicated R11 was huse of the injury. The vas notified, but the injury he state agency. 12/18/14, indicated R11 had origin to her left inner knee, and measuring 1 x 1 3/4 dicated the injury was was unable to report the sed anticoagulants; and also as considered to be "minor." ator was notified, but the ad to the state agency. bout the three injuries of 24/15, at 12:54 p.m., the SW e bruising than anyone I he SW said the bruise on e been caused by recent ails," indicating R11 caused garding the bruise noted to shead, the SW stated that ng "was due to placement of					

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MUI				FORM	D: 08/31/2015 APPROVED D: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	· <i>`</i>					LETED
		245127	B. WING			_	07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	SW further stated R11 Hoyer lift [a mechanic there were no records bruising was "likely du nebulizer mask." No f completed for this inju During an interview of DON stated R11 "cour reporting nurse asked abuse, therefore, the reportable. Although R11 was ide cognitively impaired, a different locations, the investigation complete causes of R11's bruis was notified of the inju incidents were submit R66's quarterly MDS, was moderately, cogr dated 2/9/15, indicate assist of two staff, wit for transfers. The CP risk for delirium and p depression. A review of R66's nurs 1/26/2015, there was bruises" on [R66] bott identified as bruising The SSIRF also indic	n her way back from supper. 1 did not ambulate, used a cal lift] for transferring, and s of any falls. SW added the ue to placement of [R11's] further investigation was ury. n 7/24/15, at 12:54 p.m., the ld reliably answer" when the d if bruising was related to DON felt the injury was not entified to be moderately and had multiple bruises at ere was no indepth ed to determine the actual less. The facility administrator uries but none of these tted to the state agency. dated 1/7/15, indicated she hitively impaired. The CP, ed R66 required extensive h use of a mechanical lift, P also indicated R66 was at botential abuse, related to tted 2/3/15, indicated during sing progress note dated "presence of unknown h arms, the size was "from hands to shoulder."	F	226				

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	-	D HUMAN SERVICES				FORM	0: 08/31/2015 APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	-	(X3) DATE COMP	
		245127	B. WING			07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	was an "unknown inju state the cause, and t to be "minor." The inj facility administrator, I the state agency. During an interview of SW stated, the bruise was reviewing R66's I said she "spoke with I bruising was assesse therefore not reportab agency."During an int p.m., the DON said R (mechanical lift), and cooperate in lift, occa The DON further state that it would be "hard been able to to talk at occurred after any tim Although R66 had bila hands to her shoulder unwitnessed and the identify what happene immediately reported agency nor was a tho completed to determin arms" while using the R44's annual MDS, d was severely cognitive 7/10/15, indicated R4	ry", that R66 was unable to hat the injury was assessed ury was reported to the but was not not reported to n 7/24/15, at 12:54 p.m., the s were noted while the DON progress notes. The SW nursing" and determined the d "to be a minor injury, and ble to the state erview on 7/24/15, at 12:54 66 used a Hoyer lift R66 did not always sionally "flailing her arms." ed R66 was confused, and to say if R66 would have bout how the bruising he had passed." ateral bruising from her rs, the injury was resident was unable to ed. The facility had not the incident to the state rough investigation he if R66 was "flailing her mechanical lift.	F 22	6			

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU				FORM	0: 08/31/2015 APPROVED 0: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	· <i>`</i>				· /	LETED
		245127	B. WING			-	07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	TE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 226	A review of SSIRF da had a purple bruise o forearm, measuring 6 found during her bath was an "unknown" inj the cause of injury. T be "minor". The facilit but the injury was not agency. During an interview o SW stated, "The injur nursing staff to be 'mi suspicious criteria. T a need to report" to th In an interview on 7/2 DON stated, "[R44] w you if something happ needs known." Even though R44 was cognitively impaired, I origin, on the posterior indication the facility o investigation to deterr injury, also the incider state agency. R8's quarterly minimu her to be severely cog requiring assist of two living. CP dated 5/15/ extensive assist for a	 ted 6/15/15, indicated R44 n her posterior (back side) 3 cm x 7 cm, that was The SSIRF indicated this ury, and R66 could not state The injury was determined to y administrator was notified, reported to the state In 7/24/15, at 12:54 p.m., the y was determined by inor' and did not meet any he SW said she "did not see he state agency. 4/15, at 12:54 p.m., the Yould have been able to tell bened, she could make her Is assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her nt was not reported to the um data set (MDS) identified	F	226				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/31/2015 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMPI	SURVEY
		245127	B. WING		_	07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page	e 45	F 226				
	had a bruise measuring her thumb and forefing thumb to her wrist. The initial evaluation and or resulted from R8 wring wringing of her hands During an interview of SW stated, the injury staff witness of the po- investigation of the inj facility administrator war a report was not made Social Services Incide requested for this injury Although R8 had sever and had a bruise 8.5c forefinger from the bar There was no indication thorough investigation her injury, also the ind the state agency. During an interview of SW stated, when make whether or not to report agency, she "refers to decision tree." The S looks at whether a res- injury, or if someone of a history of other record	ry but was not received. ere cognitive impairment, em between her thumb and se of her thumb to her wrist. on the facility completed an it to determine the source of cident was not reported to n 7/24/15, at 12:54 p.m., king a determination of ort an injury to the state o statutes, and uses a W also stated that she sident is able to explain the else saw it, and if there was ent falls and/or injuries. The the nurses indicated minor spicious in nature or					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/31/2015 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	_	(X3) DATE	
		245127	B. WING			07/:	23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREE ONAMIA, MN 56359	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	DON said, minor injur state agency. She fur criteria or policy" the fun- determine whether an "major." The DON also the nurses judgement injury was minor or m charge "followed up of she stated there was	e 46 n 7/24/15, at 12:54 p.m., the ries are not reportable to the ther stated, there was "no facility has to identify and n injury was "minor" versus so stated she "would use t" when determining if an ajor, and that the RN in on the injuries." However, no charting on the clinical w evidence that follow-up	F 22	26			
	7/15, indicated as its who are vulnerable to policy included: "To a everything within its c occurrence of abuse of attempt to obtain infor employers and or/curr NA-A's personnel rec hired on 7/13/15. The evidence reference cl to employment at the NA-B's personnel rec hired on 6/30/15. The evidence reference cl to employment at the Dietary Aide (DA)-A's	revention Policy, revised purpose "to protect adults abuse" Further, the assure the facility was doing ontrol to prevent the or neglectthe facility would rmation from previous rent employers." cord identified they were personnel record lacked necks were completed prior facility.					

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		245127	B. WING		07/23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 226		e 47 nployment at the facility.	F 226		
	identified they were h personnel record lac	N)-B's personnel record hired on 5/11/15. The ked evidence reference ted prior to employment at			
F 241 SS=D	staff stated four of th did not have docume HR stated there was that reference check facility used the appli		F 241		8/14/15
	manner and in an en	mote care for residents in a vironment that maintains or lent's dignity and respect in or her individuality.			
	by: Based on observation review, the facility fait rising and morning ro (R50 and R12),who in assistance to complet (ADL's). R50's diagnoses, as	T is not met as evidenced on, interview and document iled to provide a dignified outines for 2 of 8 residents required extensive staff ete activities of daily living identified on the care plan 015, included hemiplegia,		F241 Affects R50 &R12. Potential to affect all residents 1. 8/11/15:Dignity & respect & it's relationship to cares was discussed at the nsg staff meeting 8/11/15. 2. 8/14/15: NAR night duty assignment sheet was revised (Attachment L) 3.8/14/15: an email to all NARs regarding dignity & respect and AM	

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	S FOR MEDICARE & DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		245127	B. WING		07/23/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO
F 241	Continued From page	e 48	F 241		
	transfers, toileting, dri hygiene. During observation or R50 was lying on her left hand positioned of blanket was at the foor resident, exposing R5 see she already had p R50 remained in bed NA-G assisted her wi already dressed, with when NA-F removed for incontinence, NA- into her wheel chair w NA-F then brushed her in placing R50's hand wheel chair armrest a During an interview o NA-G said R50 was a morning, and we "just bed." NA-G said R50 dressing, and R50 wa needs to staff.	ssistance for ADL's, assist with bed mobility, essing and personal n 7/22/2015 at 7:11 a.m., back, in her bed, with her on top of her chest. R50's ot of the bed, pulled onto the 50's left leg, and one could pants on as she lied in bed. until 8:41, when NA-F and th morning cares. R50 was pants, socks and shirt, R50's covers and checked F and NA-G assisted R50 with use of a mechanical lift. er hair, and NA-G assisted I splint and arm into the and R50 was up for the day.		"No resident should be gotten up on the noc shift for the convenience of staff. Only Residents who are awa & choose to get up or if they are rest & attempting to get out of bed and or written in their care plan that they get at a specific time". Monitoring 8/24/15- 9/28/15 An audit will be performed every day x1 week, then every week x4 weeks ensure dignity & respect of all residen with their AM cares. The day nurse/T who arrives @0600 will round on thei scheduled wing. They will observe ar document the residents who are up a or dressed and back in bed. The repo will be given to the RN Care Coordina for review if Dignity & Respect was provided. The Care Coordinator will forward the review form to the DON a their review. (Attachment M) Responsibility: Nurses/TMA, Care Coordinators & DON Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	ess it is up to nts MA r nd nd ort ator

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM): 08/31/2015 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/2	23/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	During an interview of NA-H stated she work routinely got R50 "cle not removed from bed that." NA-H stated sh on her scheduled batt residents whom she h dressed, prior to the e said "I just need to ma and ready to go. I ge them back to bed; it h NA-H said if there wa want to get up, she w someone else up." N the residents she ass and there were some night anyway." During an interview of family member (FM)-// were getting R50 dres bed. FM-A said that of was often awake late, restless, and they [sta than stated, "I would f she'd be getting out, a day." In an interview on 7/2 director of nursing (D0 "to help the day shift s someone was trying t and keep [the residen and possibly fall." In social worker (SW) sa during the night was " aide. We should look	n 7/24/2015 at 6:00 a.m., ks on the overnight shift, and aned up and dressed," but d, "the day shift would do be does not get R50 dressed h days. She has a list of helped get cleaned and end of the night shift. NA-H ake sure they are dressed t them dressed and then put helps out the morning shift." s a resident that did not	F 241				

If continuation sheet Page 50 of 65

CENTER STATEMENT (-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		FORM OMB NC (X3) DATE	0: 08/31/2015 MAPPROVED 0: 0938-0391 SURVEY LETED
		245127	B. WING	_		_	07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	impaired and required transfers, dressing an (CP), dated 8/28/13, o opportunities to make including clothing, bed also indicated R12 ha related to insomnia, w hours of sleep at nigh morning routine prefe to get up. During observation or was noted fully dresse chair. R12 was positi television in the comm asleep in her wheelch jerking movements as in chair until 8:15 a.m approached, and awa R12 if if she wanted to breakfast. R12 replied During an interview of NA-E stated she was residents up, washed the over night shift. N shower, there was an up in their place. NA-I the residents up, was back to bed."	e was severely, cognitively d extensive assist for ad grooming. The care plan directed staff to give R12 e daily preferences choices, d time and bathing. The CP ad an alteration in sleep, with a goal of at least six it. The CP did not address a rence of when R12 wanted n 7/22/15 at 7:00 a.m., R12 ed and seated in her wheel oned in front of the non area on the east wing, nair. R12 repeatedly made as she dozed. R12 remained , (75 minutes) when staff akened her. The staff asked o go back to bed, or eat d "I don't care."	F	241				

If continuation sheet Page 51 of 65

	-	D HUMAN SERVICES					FORM): 08/31/2015 // APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245127	B. WING			_	07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
MULEIA	CS HEALTH SYSTEM			20	00 NORTH ELM STREET			
	CS REALTH STSTEW			0	NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	of a mechanical lift to dressed and put back idea why they would of During an interview of director of nursing (Do people getting up and bed on the night shift. and care coordinators day shift. The DON fut this list are usually up like the night shift to h the day." She further the only nursing home that." The intent is to prevent falls. The DC if the rationale for wal- to get them washed a plan or not. During an interview of registered nurse (RN) residents for the night	transfer] get washed, in bed, I don't have any do that." In 7/24/15, at 1:16 p.m., the ON) stated, there are many I dressed and put back to She stated, The nurses is schedule them to help the inther stated, "the people on or crawling out of bed," we help day shift "get a jump on stated, "I'm sure we are not is in the world that does help day shift out and ON stated she was not sure king a resident on night shift and dressed is on the care	F	241		DEFICIENCY)		
	who are trying to get u people who want to g who are a "Hoyer lift."	We usually look at people up but if there aren't enough et up, we will pick people ' The aides will wash and						
	prefers to get up early further stated, there is	N- C stated, "If someone / it is not care planned." She s no one currently on the planned to get up early due						
	to fall risk. RN-C state	ed, The rationale for night washed and dressed is						
	sheet directed night s cares, oral cares, dre	s undated East night group hift to complete morning ssing, making bed and five residents on the unit,						

Facility ID: 00374

If continuation sheet Page 52 of 65

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245127	B. WING		07/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 241	Continued From page including R12.	e 52	F 241		
F 282 SS=D	4/15, indicated the fa promote care for [res maintains and enhan full recognition of [a r 483.20(k)(3)(ii) SERV PERSONS/PER CAP The services provide must be provided by	atients/Residents, dated cility "must, with courtesy, idents] in a manner that ces dignity and respect in esident's] individuality." /ICES BY QUALIFIED RE PLAN d or arranged by the facility	F 282	2	8/20/15
	by: Based on observatio review, the facility fail for timely repositionin for 1 of 1 residents (F incontinence, and at development. Findings include: R50's diagnoses, as (CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascul Minimum Data Set (N indicated R50 had se and was unable to wa R50 required extensi activities of daily livin	identified on the care plan 015, included hemiplegia de, dementia, and aphasia ar disease. The quarterly MDS), dated 5/27/2015, verely impaired cognition, alk. The MDS also identified ve, physical assistance for		 F282: Affects R50 with the Potential to Affect All Residents requiring reposition and toileting. 1. On 7/23/15: an email was sent to all LTC staff, including Activity staff, by the Care Coordinator. indicating the following: "Make sure resident's are be toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted the care plan. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NA three ring binder @ each nurses' statio Staff will document each time that they assist the resident with repositioning an or toileting. Monitoring 	ning of in NR n. nd

Event ID: HJY511

Facility ID: 00374

If continuation sheet Page 53 of 65

					CONSTRUCTION		<u>10. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		245127	B. WING				7/23/2015
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET NAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 282	Continued From page	• 53	F 28	32			
	toileting, and persona				worksheet will be completed by nursin	a	
	teneting, and percent				1x/shift for 1 week then weekly x4 wee	•	
	R50's care plan (CP)	identified the potential for			(8/26/15-9/30/15)		
	alteration in skin integ			(Attachment O)			
	alteration in elimination/toileting. The CP directed staff to follow the mobility plan of care, and assist				Responsibility: DON, Care Coordinato	ors,	
		sition every 2 hours and			Nursing Staff. Audit reports will be reported to the		
		dditionally, the CP directed			Quality Assurance Committee.		
		check and change every 2			(QA meets quarterly; Oct., Jan.,		
	hours and PRN" [as r	U			April and July).		
	-	servation on 7/23/2015 from					
		n. (3 hours and 7 minutes) be dressed and seated					
		hair. At 7:55 a.m., R50 was					
		hair in the living area across					
		rsing station and watching a					
		At 8:33 a.m., R50 was					
		ig room and assisted with					
		9:36 a.m. Following the					
		in the wheel chair, R50 was where food was served to					
	the activity area in the						
		rning activity, and stayed in					
	• •	just after 10:00 a.m., when a					
	staff member wheeled	d her into the main entryway					
		mained there, still seated in					
		10:19 a.m., when a staff					
	-	outside of the building,					
		s to get fresh air. At 10:37 ed into the building near the					
		bached by nursing assistant					
		eting R50, took her vital					
	signs. More than 2 1	2 hours had elapsed since					
	R50 was last toileted	-					
		er wheel chair near the					
	-	., when NA-F assisted her					
	back to her room. In registered nurse (RN)						

Facility ID: 00374

If continuation sheet Page 54 of 65

	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MEILTIDI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		245127	B. WING		07/23/2015
IAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP C	ODE
IILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 282	Continued From pag	e 54	F 28	2	
	lift, assisted R50 into		0.	-	
	, ,	and NA-F provided perineal			
		d R50's skin, which was pink			
		inusual warmth or swelling, ned areas, and her skin was			
		so said R50 was incontinent			
		t toileted or repositioned			
		12 a.m., a total of 3 hours			
	and 7 minutes.				
	During an interview o	on 7/23/2015 at 11:16 a.m.,			
		A)-F stated R50 was last			
	repositioned when sh	ne was put in her wheel chair			
	-	eight." NA-F then stated R50			
	-	o hour repo [repositioning] R50 should also be checked			
		nce." NA-F said R50 "Was			
	definitely ready to be				
	In an interview on 7/2				
		I)-A said she "trusted the			
		oor to get toileting and ted," but what happened			
		fluke." RN-A also stated, "I'll			
		uld have been turned."			
	During an interview o	on 7/27/2015 at 1:19 p.m.,			
	-	g (DON) said resident			
		are planned, and the facility			
		, residents' needs for timely			
	assistance."				
	A facility policy regar	ding the implementation of			
		ested, but none provided.			
F 314		-	F 314	4	8/20/15
SS=D	PREVENT/HEAL PR	ESSURE SORES			

Facility ID: 00374

If continuation sheet Page 55 of 65

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/31/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/23/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
	CS HEALTH SYSTEM			200 NORTH ELM STREET	
	CO HEALIN STOTEM			ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 314	10		F 31	4	
		nust ensure that a resident			
		y without pressure sores essure sores unless the			
		ondition demonstrates that			
		le; and a resident having			
		ves necessary treatment and			
		healing, prevent infection and			
	prevent new sores fr	om developing.			
	This REQUIREMEN [®] by:	T is not met as evidenced			
		on, interview and document		F314 affects R50 and has the	
	review, the facility fai			potential to affect all residents	
		2 residents (R50) reviewed ed at risk for development of		ADL's and are at a risk for dev	
	pressure ulcers.			pressure ulcers.	
	Findings include:			1. On 7/23/15: an email was s LTC	ent to all
	•	identified on the care plan		staff, including Activity staff, b	-
		015, included hemiplegia		Care Coordinator. indicating th	
		de, dementia, and aphasia lar disease. The quarterly		following: "Make sure resident toileted and repositioned @ m	-
		MDS), dated 5/27/2015,		every 2 hrs. or more frequently	
		everely impaired cognition,		the care plan.	,
		alk. The MDS also identified		2. A toileting/reposition/skin w	orksheet
		ive, physical assistance for		(Attachment N) will be placed	
	activities of daily livin			three ring binder @ each nurs	
		th bed mobility, transfers,		Staff will document each time	-
	Pressure Sore Risk A	al hygiene. A Braden		assist the resident with reposition or toileting.	
		R50 was at moderate risk		Monitoring	
	for development of p			An audit of the toileting/reposi	tioning/skin
		assessment summary, dated		worksheet will be completed b	y nursing
		R50 required extensive to		1x/shift for 1 week then week	y x4 weeks
		s, that she was unable to		(8/26/15-9/30/15)	
		urn-and-reposition schedule		(Attachment O)	ordinatora
	every 2 nours. The C	care area assessment (CAA)		Responsibility: DON, Care Co	orumators,

Facility ID: 00374

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		MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	、 <i>'</i>	G		MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE	
				200 NORTH ELM STREET		
	CS HEALTH SYSTEM			ONAMIA, MN 56359		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO DATE
F 314	Continued From page	e 56	F 3	14		
	10	lated 2/25/2015, identified	10	Nursing Staff.		
	· ·	lcer risk factors for R50		Audit reports will be repo	rted to the	
		incontinence, cognitive loss		Quality Assurance Comm		
	and functional limitati	ion in range of motion.		(QA meets quarterly; Oct.	, Jan.,	
				April and July).		
		ne potential for alteration in				
		P directed staff to follow the and assist R50 "to turn and				
		urs and PRN" [as needed].				
		t care sheet "North" unit,				
	-	R50: T & R q 2 hrs [turn				
	and reposition every	2 hours].				
		oservation on 7/23/2015 from				
		m. (3 hours and 7 minutes)				
		chair, with her right hand and				
		nt device, and her right arm				
		trapped into the arm rest. At				
	7:55 a.m., R50 was s	seated in her wheel chair in				
		s from the north unit nursing				
	•	a news program on TV. At				
		wheeled into the dining room				
		eakfast, finishing at 9:36 a.m. and still seated in the wheel				
	-	d from the table where food				
		tivity area in the same room.				
		ne morning activity, and				
		area until just after 10 a.m.,				
		wheeled her into the main				
		ty. R50 remained there, still				
		chair, until 10:19 a.m., when				
		ed R50 outside of the r residents to get fresh air.				
		as returned into the building				
		approached by nursing				
	-	o after greeting R50, took				
		than 2 1/2 hours had				
	elansed since the init	tial observation, and still R50				

Facility ID: 00374

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PRINTED: 08/31/2015 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/31/2015 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY
		245127	B. WING		_	07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	wheel chair. R50 rem chair near the aviary of assisted her back to h NA-F and registered n mechanical lift, assist was incontinent of uri- cleansing cares for he surveyor, RN-B inspe skin. R50's skin was any unusual warmth of reddened areas, and RN-B also said R50 w had not been reposition 11:12 a.m., a total of 3 During an interview of nursing assistant (NA- repositioned when sh "at about quarter to ei was on an "every two schedule," and R50, ' repositioned." A review of nursing an progress notes from 3 indicated R50 did not for a current pressure R50 did not develop a In an interview on 7/2 registered nurse (RN) consider any resident risk for pressure sore would "look at everyth resident was at risk to RN stated R50 scored measure for predicting	r repositioned out of her hained seated in her wheel until 11:12 a.m., when NA-F her room. In her room, hurse (RN)-B, using the ed R50 into her bed. R50 ne, and NA-F provided er. In the presence of the cted and assessed R50's normal pink in color, free of or swelling, there were no her skin was fully intact. vas incontinent of urine. R50 oned from 7:55 a.m. to 3 hours and 7 minutes. n 7/23/2015 at 11:16 a.m.,)-F stated R50 was last e was put in her wheel chair ight." NA-F then stated R50 hour repo [repositioning] 'Was definitely ready to be and physician long-term care B/26/2015 to 7/14/2015, have, nor was being treated e ulcer. During this time, a pressure ulcer. 3/2015 at 4:00 p.m.)-A stated she would "who had a stroke to be at s." RN-A also said she	F 314				

Facility ID: 00374

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	MENT OF HEALTH AN					FORM	D: 08/31/2015 APPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314 F 315 SS=D	other risk factors" and RN-A said she trusted to get toileting and rep what happened today also stated, "I'll be hor turned." During an interview or the director of nursing manager had already when a resident is on and checked for incor this instance, "[R50] s breakfast into other ac The DON said resider planned, and the facili residents' needs for til A facility policy, Treath Breakdown and Ulcer "It is the policy to prop residents whose clinic risk for impaired skin i preventive measures. directed, to "establish individualized turning if the resident is immo 483.25(d) NO CATHE RESTORE BLADDEF Based on the resident assessment, the facili resident's clinical core catheterization was ne who is incontinent of t	d was "at risk for pressure." d the work group on the floor positioning completed, but y, "I'll say was a fluke." RN-A nest, she should have been n 7/27/2015 at 1:19 p.m., g (DON) said the nurse taken steps to avoid issues a schedule to be turned ntinence. The DON said in should not go right from ctivities, that is too long." nt interventions were care ity takes "very seriously, mely assistance." ment and Prevention of Skin rs, reviewed 3/14, indicated berly identify and assess cal conditions increase the integrity" and "implement " Further, the policy and record an and repositioning schedule obile." ETER, PREVENT UTI, a t's comprehensive ity must ensure that a	F 314				8/20/15

Facility ID: 00374

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _		COMF	LETED
		245127	B. WING			07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		200 NORTH ELM STREET ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 315	Continued From page	e 59	F	315			
	infections and to rest function as possible.	ore as much normal bladder					
	by: Based on observation review, the facility fail assistance for 1 or 1 urinary incontinence. Findings include: R50's diagnoses, as (CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascul Minimum Data Set (Mindicated R50 had set and was unable to wa R50 required extensisi activities of daily livin two-person assist with toileting, and persona bladder assessment, R50 was incontinent also was not safe to ut to poor trunk control. indicated R50 would q 2hr [every 2 hours] each incontinence ep assessment (CAA) for 3/11/2015, indicated history of cardio-vasi right-sided hemiplegia R50 was not a candio	h bed mobility, transfers, al hygiene. A bowel and dated 2/25/2015, indicated of bowel and bladder, and use a commode or toilet due Further, the assessment "be checked for incontinence and peri care given after bisode." The care area or urinary incontinence, dated R50 had dementia, and past cular accident (stroke), with a. The CAA also indicated date for retraining.			 315: Affects R50 with the Potential to Affect All Residents who have urinary incontinence & require assistance with toileting 1. On 7/23/15: an email was sent to all LTC staff, including Activity staff, by the Care Coordinator. indicating the following: "Make sure resident's are be toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted the care plan. 2. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NA three ring binder @ each nurses' static Staff will document each time that they assist the resident with repositioning an or toileting. Monitoring An audit of the toileting/repositioning/sl worksheet will be completed by nursing 1x/shift for 1 week then weekly x4 wee (8/26/15-9/30/15) (Attachment O) Responsibility: DON, Care Coordinator Nursing Staff. Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July). 	ng of I in AR on. , nd kin g ks	
	right-sided hemiplegi R50 was not a candio R50's CP identified a	 The CAA also indicated late for retraining. 			(QA meets quarterly; Oct., Jan.,		

Facility ID: 00374

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	S FOR MEDICARE &			CONSTRUCTION		10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	FE SURVEY MPLETED
		245127	B. WING		o	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 315	bowel and bladder, al using the bathroom d directed staff to assis every 2 hours and PF nursing assistant care undated, also directed change q 2hrs and PF needed]. During continuous ob 7:55 a.m. to 11:12 a.r R50 was observed to upright in her wheel c wrist fitted with a splin was supported and st 7:55 a.m., R50 was s the living area across station and watching 8:33 a.m., R50 was w and assisted with bre Following the meal, a chair, R50 was move was served to the act R50 participated in th stayed in the activity a when a staff member entryway of the facilit seated in her wheel c a staff member pushe building, joining other At 10:37 a.m., R50 w near the aviary, and a assistant (NA)-F, who her vital signs. More elapsed since the init was not off loaded, on	nd also that R50 was not ue to safety. The CP t R50 "to check and change RN" [as needed]. The e sheet "North" unit, d for R50: Check and RN [every 2 hours and as servation on 7/23/2015 from m. (3 hours and 7 minutes) be dressed and seated thair, with her right hand and nt device, and her right arm trapped into the arm rest. At eated in her wheel chair in from the north unit nursing a news program on TV. At <i>v</i> heeled into the dining room akfast, finishing at 9:36 a.m. ind still seated in the wheel d from the table where food civity area in the same room. ie morning activity, and area until just after 10 a.m., wheeled her into the main y. R50 remained there, still thair, until 10:19 a.m., when ed R50 outside of the residents to get fresh air. as returned into the building approached by nursing o after greeting R50, took	F 315			

Facility ID: 00374

If continuation sheet Page 61 of 65

						O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
		245127	B. WING		07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 315	1.0		F 315	5		
	mechanical lift, assist	nurse (RN)-B, using the ted R50 into her bed. R50 ine, and NA-F provided				
cleansing surveyor, l skin, and a R50 was r	cleansing cares for he surveyor, RN-B inspe	er. In the presence of the ected and assessed R50's				
	R50 was not assisted	50 was incontinent of urine. I for toileting from 7:55 a.m. of 3 hours and 7 minutes.				
	nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and that F	n 7/23/2015 at 11:16 a.m., A)-F stated R50 was last was put in her wheel chair ight." NA-F then stated R50 hour repo [repositioning] 850 should also be checked				
	for pressure sores." on the Braden" (a me pressure ulcer risk), t immobility, incontiner and was "at risk for p trusted the work grou	23/2015 at 4:00 p.m.)-A stated she would no had a stroke to be at risk RN stated R50 scored "a 13				
	the director of nursing manager had already when a resident is on and checked for inco this instance, "[R50] s breakfast into other a The DON said reside	n 7/27/2015 at 1:19 p.m., g (DON) said the nurse r taken steps to avoid issues a schedule to be turned ntinence. The DON said in should not go right from ctivities, that is too long." nt interventions were care lity takes "very seriously,				

Facility ID: 00374

If continuation sheet Page 62 of 65

		MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/23/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIO
F 315	Continued From page	e 62	F 31	5	
F 465 SS=C	Policy, revised 3/14, i "Maintain resident's of continence and maint indicated individual ca to toilet based on indi checking for incontine 483.70(h)	/SANITARY/COMFORTABL ide a safe, functional, able environment for	F 46	5	8/18/15
	by: Based on observatio review, the facility fail duct work, lights above kitchen were clean of potential to affect all re who consumed food to Findings include: During the initial tour registered dietician (F six metal caged lights food is cooked, were thick dust and debris addition there was a window screen above	of the facility kitchen with RD) on 7/20/15, at 1:15 p.m.; above the grill where the covered with 1/4 inch visible from the light fixtures. In		Potential to Affect All Residents, Staff, and Visitors who consume food from the Kitchen 1. Small window was cleaned on 7/21/15 2. Light in hood system was cleaned on 7/21/15 3. Nutrition Services staff was notified of POC at department meeting on 8/18/15 4. Cleaning of hood box will occur monthly. 5. Cleaning of small window will occur monthly. 6. Cleaning procedure for hood box was developed. (Attachment P) Nutrition services staff will be in-serviced on this	

Facility ID: 00374

If continuation sheet Page 63 of 65

	S FOR MEDICARE &					<u>D. 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY PLETED
		245127	B. WING		07	/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VIILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 465	Continued From page	e 63	F 465	5		
	7:30 a.m. the lights an observed to be covered debris. During interview 7/21, manager (DM) stated dust along with the so department was in ch items. The DM stated staff of 5 and 3 of the just are not getting do During interview 7/21, maintenance manage a contracted service t hood vent two times a director did inspect th stated "That doesn't of the expectation to cor Review of the facility of document form Fire P After Service Follow U indicated the kitchen cleaned but not to coo inaccessible. The reco "replacing box-style fa better access duct wo again on 3/2/15 and t Equipment Co. After S recommended "replace fan with upblast fan to Replace damaged filt During interview 7/22, stated the "fan blows	nd screen were still ed with visible dust and /15, at 8:15 a.m. dietary the lights were covered in creen; the maintenance arge of cleaning these 1 the maintenance has a m are on light duty so things one. /15, at 8:30 a.m. the er (MM)-A stated they have that cleans the overhead a year. The maintenance is lights and the screen and cut it" and expressed it is still mplete needed tasks. contracted cleaning service Protection Equipment Co. Jp Report dated 9/22/14, exhaust system hood was de due to them being ommendations indicated to an with upblast style to ork." The company was out he Fire Protection Service Follow Up Report cing box-style down blast o access fan and duct work.		Department Meeting help on 8/18 Monitoring Nutrition Services Manager will conduct an audit on the 4th Mond starting in Aug. & for next six mor to ensure this system is being followed and is adequate for keep the equipment clean. (Attachmer Responsibility: Dietary Manager Audit reports will be reported to th Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	lay hths bing ht Q)	

If continuation sheet Page 64 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 08/31/2015 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE	
		245127	B. WING				07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				0 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 465	grandfathered until we some uncertain time. During phone intervie representative from the Equipment Co. stated inaccessible because down to the bare met which was probably n 70's, and recommend The facilities Nutrition Procedure Equipmen indicated 1. the inside and outs clean the inside an 3. clean the light fixtu Remove the light fixtu 4. use a brush or clott grease and/or dust 5. wash hood with sou	e remodel the kitchen at w 7/22/15, at 2:15 p.m. with he Fire Protection If the fan and ducts are they were unable to see al. The system was very old, nanufactured in 1960's or led a new unit. The Services Cleaning t Hood policy undated side of the hood will be nth d outside of the hood res within the hood. ures and clean with soap h as needed to remove ap and water of the hood that extends to emi annually by a	F 4	65				

If continuation sheet Page 65 of 65

	MENT OF HEALTH		ices F5	1270		FORM	07/24/2015 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1. 7	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPLE	
		245127		B. WING		07/2	2/2015
	ROVIDER OR SUPPLIER ACS HEALTH SYST	FM		RESS, CITY, S RTH ELM	STATE, ZIP CODE		
				A, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000	X		
	Minnesota Departm	Survey was conduct ent of Public Safety. Mille Lacs Health Sy	At the				
	NC was found in su requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	ubstantial compliance rticipation in at 42 CFR, Subpart ity from Fire, and the Fire Protection Assoc 01, Life Safety Code	e with the 2000 siation				
	no basement. The constructed in 1961 in 1971. The 1961 construction and the construction. There inspected as one built facility under went a	with an addition cor building is of type II(a 1971 building is type fore, the nursing hou uilding. From 2002-2	nstructed 111) pe II(111) me was 2004 the n. A				
	The building is fully facility has a comple smoke detection in open to the corridor automatic fire depar has a licensed capa census of 50 at the	ete fire alarm system the corridors and spa , that is monitored for tment notification. T noity of 57 beds and l	with aces or he facility				
	The requirement at MET.			NATURE	TITLE		(X6) DATE

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted September 4, 2015

Ms. Kim Kucera, Administrator Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

This letter redacts and replaces the letter dated August 10, 2015.

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5127025

Dear Ms. Kucera:

The above facility was surveyed on July 20, 2015 through July 27, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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

Mille Lacs Health System September 4, 2015 Page 2

Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

ate Comston

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
		200 NOR	TH ELM STREET			
	CS HEALTH SYSTEM	ONAMIA,	MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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		2 000			
	*****ATTEN	ITION*****				
	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.					
	that may result from a orders provided that	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.				
	receipt of State licens the Minnesota Depar Informational Bulletin	participate in the electronic sure orders consistent with tment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf licensing orders are				
BORATORY	partment of Health DIRECTOR'S OR PROVIDER/ Cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATURI	, <u> </u>	TITLE		(X6) DATE 08/21/15

HJY511

If continuation sheet 1 of 70

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	//23/2015
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From page	e 1	2 000			
	you electronically. Al is necessary for State enter the word "corre- text. You must then in State licensure proce completion date, the corrected prior to elec- Minnesota Departme On July 20-24 and Ju this Department's sta and the following corr Please indicate in you correction that you ha and identify the date Minnesota Departme the State Licensing O federal software. Tag	aly 27th, 2015 surveyors of aff, visited the above provider rection orders are issued. ur electronic plan of ave reviewed these orders, when they will be completed. ent of Health is documenting Correction Orders using				
	column entitled "ID F statute/rule out of cor "Summary Statement and replaces the "To correction order. This findings which are in after the statement, " evidence by." Followi are the Suggested M Time period for Correct PLEASE DISREGAR FOURTH COLUMN V "PROVIDER'S PLAN	D THE HEADING OF THE				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		00374	B. WING		07/23/2015		
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
ILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From page	2	2 000				
		IIREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.					
2 302	MN State Statute 144 or related disorder tra	.6503 Alzheimer's disease in	2 302			8/18/15	
	ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503						
	care staff						
	related disorders; (2) assistance with ac	Alzheimer's disease and ctivities of daily living; ith challenging behaviors;					
	(c) The facility shall p written or electronic for training program, the trained, the frequency topics covered.	rovide to consumers in form a description of the categories of employees of training, and the basic ocument compliance with					
	This MN Requiremen	t is not met as evidenced					

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
		00374	B. WING		07	/23/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST. TH ELM STREE			
MILLE LA	CS HEALTH SYSTEM		, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 302	Continued From page	e 3	2 302			
	facility failed to ensur information regarding dementia training, ind training program, the trained, the frequency topics covered in the	nd document review, the re consumers were provided a Alzheimer's disease and cluding a description of the categories of employees y of training and the basic training in a written or had the potential to affect r families.		Corrected 8/18/15		
	training program, the documentation that ir (resident families) we Alzheimer's training p	e facility's Alzheimer's re was no information or ndicated the consumers ere provided a description of program, categories of requency of training and the				
	social worker stated, completed through ea sure how resident far information. The dire no family education v	on 7/21/15, at 4:07 p.m., the dementia training was ducare. She stated she not milies received this ctor of nursing (DON) stated, vas provided regarding and she was unaware that it				
	DON or designee coustaff training to the reconsumers were awa	IOD OF CORRECTION: The uld add information regarding esident admission packet so are of this information. The uld educate staff about this duct audits to ensure				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION (>	(3) DATE SURVEY COMPLETED
		00374	B. WING		07/23/2015
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
IILLE LA	CS HEALTH SYSTEM		TH ELM STREE , MN 56359	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 565	MN Rule 4658.0405 Plan of Care; Use	Subp. 3 Comprehensive	2 565		8/20/15
		nprehensive plan of care personnel involved in the			
	by: Based on observation review, the facility fail for timely repositionin for 1 of 1 residents (F	t is not met as evidenced n, interview and document led to follow the plan of care og and toileting assistance R50) with urinary risk for pressure ulcer		corrected 8/20/15	
	(CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascul Minimum Data Set (M indicated R50 had se and was unable to wa R50 required extension activities of daily livin	h bed mobility, transfers,			
	alteration in skin integ alteration in elimination staff to follow the mol R50 "to turn and repo PRN" [as needed]. A	identified the potential for grity, and also R50's on/toileting. The CP directed bility plan of care, and assist osition every 2 hours and additionally, the CP directed o check and change every 2			

2 565 Continued From hours and PRN' During continuo 7:55 a.m. to 11: R50 was observ upright in her wh from the north u news program of wheeled into the	EM 200 NOF ONAMIA ARY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	A. BUILDING: B. WING ADDRESS, CITY, STATE RTH ELM STREET A, MN 56359 PREFIX TAG 2 565		DRRECTION N SHOULD BE E APPROPRIATE	/23/2015 (X5) COMPLET DATE
(X4) ID PREFIX TAG SUMMA (EACH DEFI REGULATOF 2 565 Continued From hours and PRN' During continuo 7:55 a.m. to 11: R50 was observ upright in her wh seated in her wh from the north u news program of wheeled into the	EM 200 NOR ONAMIA ARY STATEMENT OF DEFICIENCIES (CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) a page 5 ' [as needed]. us observation on 7/23/2015 from 12 a.m. (3 hours and 7 minutes) red to be dressed and seated neel chair. At 7:55 a.m., R50 was neel chair in the living area across nit nursing station and watching a on TV. At 8:33 a.m., R50 was	RTH ELM STREET A, MN 56359	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE	DRRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLET
(X4) ID SUMMA PREFIX (EACH DEFINR TAG Continued From 2 565 Continued From hours and PRN' During continuo 7:55 a.m. to 11: R50 was observuly wpright in her white seated in her white from the north und News program of wheeled into the seated in the seated in the seated in the the seated in the seate	EM ONAMIA ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) a page 5 ' [as needed]. us observation on 7/23/2015 from 12 a.m. (3 hours and 7 minutes) red to be dressed and seated neel chair. At 7:55 a.m., R50 was neel chair in the living area across nit nursing station and watching a on TV. At 8:33 a.m., R50 was	A, MN 56359	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLET
2 565 Continued From hours and PRN' During continuo 7:55 a.m. to 11: R50 was observ upright in her wh from the north u news program of wheeled into the	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) a page 5 ' [as needed]. us observation on 7/23/2015 from 12 a.m. (3 hours and 7 minutes) red to be dressed and seated neel chair. At 7:55 a.m., R50 was neel chair in the living area across nit nursing station and watching a on TV. At 8:33 a.m., R50 was	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLET
2 565 Continued From hours and PRN' During continuo 7:55 a.m. to 11: R50 was observ upright in her wh from the north u news program of wheeled into the	a page 5 ' [as needed]. us observation on 7/23/2015 from 12 a.m. (3 hours and 7 minutes) red to be dressed and seated neel chair. At 7:55 a.m., R50 was neel chair in the living area across nit nursing station and watching a on TV. At 8:33 a.m., R50 was	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLET
hours and PRN' During continuo 7:55 a.m. to 11: R50 was observ upright in her wh seated in her wh from the north u news program of wheeled into the	' [as needed]. us observation on 7/23/2015 from 12 a.m. (3 hours and 7 minutes) red to be dressed and seated neel chair. At 7:55 a.m., R50 was neel chair in the living area across nit nursing station and watching a on TV. At 8:33 a.m., R50 was	2 565			
During continuo 7:55 a.m. to 11: R50 was observ upright in her wh seated in her wh from the north u news program of wheeled into the	us observation on 7/23/2015 from 12 a.m. (3 hours and 7 minutes) red to be dressed and seated neel chair. At 7:55 a.m., R50 was neel chair in the living area across nit nursing station and watching a on TV. At 8:33 a.m., R50 was				
7:55 a.m. to 11: R50 was observ upright in her wh seated in her wh from the north u news program of wheeled into the	12 a.m. (3 hours and 7 minutes) red to be dressed and seated neel chair. At 7:55 a.m., R50 was neel chair in the living area across nit nursing station and watching a on TV. At 8:33 a.m., R50 was				
meal, and still se moved from the the activity area participated in th the activity area staff member wh of the facility. R her wheel chair, member pushed joining other res a.m., R50 was r aviary, and was (NA)-F, who afte signs. More tha R50 was last toi remained seated aviary until 11:12 back to her roor registered nurse lift, assisted R50 incontinent of ur care. RN-B asse in color, free of a there were no re fully intact. RN-	ing at 9:36 a.m. Following the eated in the wheel chair, R50 was table where food was served to in the same room. R50 he morning activity, and stayed in until just after 10:00 a.m., when a heeled her into the main entryway 50 remained there, still seated in until 10:19 a.m., when a staff d R50 outside of the building, idents to get fresh air. At 10:37 eturned into the building near the approached by nursing assistant er greeting R50, took her vital in 2 1/2 hours had elapsed since leted or repositioned. R50 d in her wheel chair near the 2 a.m., when NA-F assisted her n. In her room, NA-F and e (RN)-B, using the mechanical 0 into her bed. R50 was rine, and NA-F provided perineal essed R50's skin, which was pink any unusual warmth or swelling, eddened areas, and her skin was B also said R50 was incontinent as not toileted or repositioned				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	B. WING		07	//23/2015	
ME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE			
LLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
X4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE	
2 565	Continued From page	9 6	2 565				
	nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and that R for "urinary incontiner definitely ready to be In an interview on 7/2 registered nurse (RN work group on the flo repositioning complet today, "I'll say was a be honest, [R50] shou During an interview o the director of nursing interventions were ca	: 3/2015 at 4:00 p.m.)-A said she "trusted the					
		ding the implementation of steed, but none provided.					
	The Director of Nursin review the importance	OD OF CORRECTION: ng and / or designee could e of implementing all es, to assure resident needs					
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one					
2 905	MN Rule 4658.0525	Subp. 4 Rehab - Positioning	2 905			8/20/15	
		Residents must be dy alignment. The position change their own position					

STATE FORM

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING		
		00374			07/23/2015
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA		
MILLE LA	CS HEALTH SYSTEM		, MN 56359	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
2 905	Continued From page	e 7	2 905		
	including periods of t been put to bed for th has documented that hours during this time	east every two hours, ime after the resident has ne night, unless the physician t repositioning every two e period is unnecessary or dered a different interval.			
	by: Based on observatio review, the facility fai repositioning for 1 of	nt is not met as evidenced n, interview and document led to provide timely 2 residents (R50) reviewed ed at risk for development of		corrected 8/20/15	
	Findings include:				
	(CP), reviewed 6/6/2 affecting dominant si due to cerebrovascul Minimum Data Set (M indicated R50 had se and was unable to w R50 required extensi activities of daily livin two-person assist wit toileting, and person Pressure Sore Risk A 5/26/2015, indicated for development of p comprehensive skin	h bed mobility, transfers, al hygiene. A Braden Assessment, dated R50 was at moderate risk			
	total assist with ADLs walk, and was on a to every 2 hours. The c for pressure ulcers, c additional pressure u	s, that she was unable to urn-and-reposition schedule care area assessment (CAA) lated 2/25/2015, identified lcer risk factors for R50 incontinence, cognitive loss			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00374	B. WING		07	/23/2015
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 905	Continued From pag	e 8	2 905			
	and functional limitat	ion in range of motion.				
	skin integrity. The C mobility plan of care, reposition every 2 ho The nursing assistant	he potential for alteration in P directed staff to follow the and assist R50 "to turn and burs and PRN" [as needed]. It care sheet "North" unit, R50: T & R q 2 hrs [turn 2 hours].				
	7:55 a.m. to 11:12 a. R50 was observed to upright in her wheel wrist fitted with a spl was supported and s 7:55 a.m., R50 was the living area across	bservation on 7/23/2015 from m. (3 hours and 7 minutes) b be dressed and seated chair, with her right hand and int device, and her right arm strapped into the arm rest. At seated in her wheel chair in s from the north unit nursing				
	8:33 a.m., R50 was and assisted with bre Following the meal, a chair, R50 was move was served to the ac R50 participated in the	a news program on TV. At wheeled into the dining room eakfast, finishing at 9:36 a.m. and still seated in the wheel ed from the table where food stivity area in the same room. The morning activity, and area until just after 10 a.m.,				
	entryway of the facili seated in her wheel a staff member push building, joining othe	r wheeled her into the main ty. R50 remained there, still chair, until 10:19 a.m., when ed R50 outside of the r residents to get fresh air. vas returned into the building				
	assistant (NA)-F, wh her vital signs. More elapsed since the ini	approached by nursing o after greeting R50, took e than 2 1/2 hours had tial observation, and still R50 or repositioned out of her				
	chair near the aviary	mained seated in her wheel until 11:12 a.m., when NA-F her room. In her room,				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	//23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM					
	CLIMMADY ST		A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From page	e 9	2 905			
	mechanical lift, assist was incontinent of uri- cleansing cares for h surveyor, RN-B inspe- skin. R50's skin was any unusual warmth- reddened areas, and RN-B also said R50 w had not been repositi 11:12 a.m., a total of During an interview of nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and R50, repositioned." A review of nursing a progress notes from a	nurse (RN)-B, using the ted R50 into her bed. R50 ine, and NA-F provided er. In the presence of the ected and assessed R50's normal pink in color, free of or swelling, there were no her skin was fully intact. was incontinent of urine. R50 ioned from 7:55 a.m. to 3 hours and 7 minutes. on 7/23/2015 at 11:16 a.m., A)-F stated R50 was last he was put in her wheel chair eight." NA-F then stated R50 o hour repo [repositioning] "Was definitely ready to be and physician long-term care 3/26/2015 to 7/14/2015, t have, nor was being treated				
		e ulcer. During this time, a pressure ulcer.				
	registered nurse (RN consider any residen risk for pressure sore would "look at everyt	•				
	RN stated R50 score measure for predictin that also R50 "had im	d "a 13 on the Braden" (a ng pressure ulcer risk), but mobility, incontinence, and d was "at risk for pressure."				
	RN-A said she truster to get toileting and re what happened today	d the work group on the floor positioning completed, but y, "I'll say was a fluke." RN-A pnest, she should have been				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		00374	B. WING		07	//23/2015
ME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
LLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 905	Continued From page	e 10	2 905			
	turned."					
	the director of nursing manager had already when a resident is or and checked for inco this instance, "[R50] s breakfast into other a The DON said reside planned, and the faci residents' needs for t A facility policy, Treat Breakdown and Ulce "It is the policy to pro residents whose clini risk for impaired skin preventive measures directed, to "establish	ment and Prevention of Skin rs, reviewed 3/14, indicated perly identify and assess cal conditions increase the integrity" and "implement " Further, the policy and record an and repositioning schedule				
	The Director of Nursi review with care staff repositioning for pres healing, and monitor	sure ulcer preventing and for compliance.				
	TIME PERIOD FOR (14) days.	CORRECTION: Fourteen				
2 910	MN Rule 4658.0525 Incontinence	Subp. 5 A.B Rehab -	2 910			8/20/15
	have a continuous pr	e. A nursing home must ogram of bowel and bladder ce incontinence and the				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00074				
AME OF P	ROVIDER OR SUPPLIER	00374	ADDRESS, CITY, STA		07/23/2015	
			RTH ELM STREE			
AILLE LA	CS HEALTH SYSTEM	ONAMIA	A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET	
2 910	Continued From page	e 11	2 910			
	comprehensive resid home must ensure th A. a resident who without an indwelling unless the resident's that catheterization w B. a resident who receives appropriate prevent urinary tract	o enters a nursing home catheter is not catheterized clinical condition indicates				
	by: Based on observation review, the facility fai assistance for 1 or 1 urinary incontinence.	nt is not met as evidenced n, interview and document led to provide timely toileting residents (R50) who had		corrected 8/20/15		
	(CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascul Minimum Data Set (M indicated R50 had set and was unable to wa R50 required extensi activities of daily livin two-person assist wit toileting, and persona bladder assessment, R50 was incontinent also was not safe to o to poor trunk control.	identified on the care plan 015, included hemiplegia de, dementia, and aphasia ar disease. The quarterly MDS), dated 5/27/2015, everely impaired cognition, alk. The MDS also identified ve, physical assistance for g (ADLs), including h bed mobility, transfers, al hygiene. A bowel and dated 2/25/2015, indicated of bowel and bladder, and use a commode or toilet due Further, the assessment "be checked for incontinence				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	/23/2015
AME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED T				(X5) COMPLE DATE
2 910	Continued From pag	e 12	2 910			
	each incontinence eg assessment (CAA) fo 3/11/2015, indicated history of cardio-vas right-sided hemiplegi R50 was not a candio R50's CP identified a elimination/toileting, bowel and bladder, a using the bathroom of directed staff to assis every 2 hours and PI nursing assistant car undated, also directed	alteration in that she was incontinent of and also that R50 was not due to safety. The CP st R50 "to check and change RN" [as needed]. The				
	7:55 a.m. to 11:12 a. R50 was observed to upright in her wheel of wrist fitted with a spli was supported and s 7:55 a.m., R50 was s the living area across station and watching 8:33 a.m., R50 was of and assisted with bre Following the meal, a chair, R50 was move was served to the ac R50 participated in the stayed in the activity when a staff member entryway of the facility	bservation on 7/23/2015 from m. (3 hours and 7 minutes) b be dressed and seated chair, with her right hand and int device, and her right arm strapped into the arm rest. At seated in her wheel chair in s from the north unit nursing a news program on TV. At wheeled into the dining room eakfast, finishing at 9:36 a.m. and still seated in the wheel ed from the table where food tivity area in the same room. ne morning activity, and area until just after 10 a.m., r wheeled her into the main ty. R50 remained there, still chair, until 10:19 a.m., when				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/02/00	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	. ZIP CODE	07	/23/2015
	CS HEALTH SYSTEM		TH ELM STREET			
	CS REALTH STSTEM	ONAMIA	, MN 56359			
(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 ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From page 13		2 910			
	near the aviary, and a assistant (NA)-F, who her vital signs. More elapsed since the init was not off loaded, ou wheel chair. R50 rem chair near the aviary assisted her back to H NA-F and registered f mechanical lift, assist was incontinent of uri cleansing cares for he surveyor, RN-B inspe- skin, and also said R R50 was not assisted to 11:12 a.m., a total During an interview o nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and that R for "urinary incontiner In an interview on 7/2 registered nurse (RN consider resident "wh for pressure sores." I on the Braden" (a me pressure ulcer risk), b immobility, incontiner	ial observation, and still R50 r repositioned out of her ained seated in her wheel until 11:12 a.m., when NA-F her room. In her room, nurse (RN)-B, using the ted R50 into her bed. R50 ne, and NA-F provided er. In the presence of the ected and assessed R50's 50 was incontinent of urine. I for toileting from 7:55 a.m. of 3 hours and 7 minutes. n 7/23/2015 at 11:16 a.m., A)-F stated R50 was last the was put in her wheel chair ight." NA-F then stated R50 thour repo [repositioning] 250 should also be checked ince."				
	trusted the work grou be completed, but wh was a fluke."	p on the floor to get toileting hat happened today, "I'll say n 7/27/2015 at 1:19 p.m.,				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00374	B. WING		0	7/23/2015
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		12012010
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 910	manager had already when a resident is or and checked for inco this instance, "[R50] s breakfast into other a The DON said reside planned, and the faci residents' needs for t A facility policy, Bowe Policy, revised 3/14, "Maintain resident's of continence and main indicated individual c to toilet based on ind checking for incontine SUGGESTED METH	A taken steps to avoid issues a a schedule to be turned intinence. The DON said in should not go right from ctivities, that is too long." int interventions were care lity takes "very seriously, imely assistance." A and bladder Program indicated as its purpose to optimal bowel and bladder tain skin integrity The policy are plan will address "Times ividual schedule and/or ence." OD OF CORRECTION: ing and / designee could residents requiring	2 910			
21565	(21) days.	CORRECTION: Twenty-one Subp. 4 Administration of	21565			8/13/15
	Subp. 4. Self-admin self-administer medic resident assessment care as required in pa 4658.0405 indicate th is a written order from	istration. A resident may cations if the comprehensive and comprehensive plan of arts 4658.0400 and his practice is safe and there in the attending physician.				
	This MN Requirement by:	it is not met as evidenced				

STATE FORM

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If continuation sheet 15 of 70

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00374	B. WING		07/23/2015			
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST					
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREE ., MN 56359	1				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE		
21565	Continued From page	e 15	21565					
	review, the facility fail self-administration of	medications (SAM) for 1 of served for self-administration		corrected 8/13/15				
	Findings include:							
	During observation on 7/20/15, at 7:28 p.m. R63 was observed alone in her room with a nebulizer (a drug delivery device used to administer medications in the form of a mist inhaled into the lungs) running, with a face mask. The trained medication aide (TMA)-A who had administered the medicaiton was on the opposite side of the dining room passing medications and assisting other residents in their rooms. R63 remove the mask off her nose and mouth and placed the mask on her chest with the elastic strap still around the back of her neck. The TMA-A walked past R63's room while R63 had the mask on her chest and into the room next to R63 twice. TMA-A made no attempted to check, or reapply the mask to R63's nose and mouth for installation of the medication. At 7:44 p.m. TMA-A entered R63's room turned off the nebulizer and removed the mask from R63's chest.							
	chronic obstructive per and congestive heart plan dated 6/2/15, ind disorientated to time moderately impaired	ces, depression, anxiety, ulmonary disease (COPD) failure. A cognition care dicated R63 was and place and had cognition.						
	Administration Recor Duoneb to be admini	ers and the Medication d (MAR) for 7/15, directed stered four times a day. A the MAR indicated R63 did						

HJY511

If continuation sheet 16 of 70

STATEMEN	a Department of Healt T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
		00374	B. WING		07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21565	not like the nebulizer in front of her face ar A Self Administration effective 7/21/15, ind cognitively able to pa During interview on 7 stated she did not kn with the nebulizer. SI residents alone with the had been so hectic a On 7/23/15, at 11:20 (RN)-A stated R63 w alone to SAM the neb	mask and to hold the mask ad let her breathe in that way. of Medication Assessment icated R63 was not irrticipate in a SAM. 7/20/15, at 7:50 p.m. TMA-A ow if R63 could be left alone he usually does not leave their nebulizer but because it nd busy she left R63 alone. a.m. registered nurse as assessed to not to be left bulizer. In the past she would ask but now will allow staff to	21565			
21685	The Director of Nursi review the facility's p residents for the abili medications, with the TIME PERIOD FOR (14) days. MN Rule 4658.1415 Housekeeping, Oper Subp. 2. Physical pla including walls, floors systems, and equipm continuous state of g with regard to the heat	IOD OF CORRECTION: ng and/or designee could olicy for assessment of ty for self administration of e facility staff responsible. CORRECTION: Fourteen Subp. 2 Plant ation, & Maintenance ant. The physical plant, s, ceilings, all furnishings, nent must be kept in a ood repair and operation alth, comfort, safety, and idents according to a written	21685			8/18/15

Minnesota Department of Health STATE FORM

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HJY511

If continuation sheet 17 of 70

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
		00374	B. WING		07	/23/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE	1 0/120/201	
AILLE LA	CS HEALTH SYSTEM		RTH ELM STREE	т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21685	Continued From page	e 17	21685			
	routine maintenance	and repair program.				
	by:	it is not met as evidenced				
	review, the facility fail duct work, lights above kitchen were clean of	n, interview, and document led to ensure exhaust fan ve grill and screen in the f dust and debris. This had residents, staff and visitors from the kitchen.		corrected areas cited were cl 7/21/15	eaned on	
	Findings include:					
	registered dietician (F six metal caged lights food is cooked, were thick dust and debris addition there was a window screen above	of the facility kitchen with RD) on 7/20/15, at 1:15 p.m.; s above the grill where the covered with 1/4 inch visible from the light fixtures. In 12 inch long by 6 inch e the kitchen sink was n a black dust and debris.				
	7:30 a.m. the lights a	is completed on 7/21/15, at nd screen were still red with visible dust and				
	manager (DM) stated dust along with the so department was in ch DM stated the mainter	/15, at 8:15 a.m. dietary d the lights were covered in creen and the maintenance harge of cleaning those. The enance has a staff of 5 and 3 luty so things just are not				
	a contracted service	/15, at 8:30 a.m. the er (MM)-A stated they have that cleans the overhead a year. The maintenance				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				B. WING		
	ROVIDER OR SUPPLIER	00374	DDRESS, CITY, STATE,		07	//23/2015
	CS HEALTH SYSTEM		RTH ELM STREET			
	CO REALTH STOTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21685	Continued From page	e 18	21685			
	director did inspect the lights and the screen and stated "That doesn't cut it" and expressed it is still the expectation to complete needed tasks.					
	document form Fire F After Service Follow I indicated the kitchen cleaned but not to co inaccessible. The rec "replacing box-style f better access duct we again on 3/2/15 and t Equipment Co. After recommended "repla fan with upblast fan te Replace damaged filt During interview 7/22 stated the "fan blows	Service Follow Up Report cing box-style down blast o access fan and duct work.				
	The MM then stated to but that is how this st	the fans should be cleaned, yle exhaust fan works and it we remodel the kitchen at				
	representative from the Equipment Co. stated inaccessible because down to the bare met	d the fan and ducts are they were unable to see tal. The system was very old, nanufactured in 1960's or				
	Procedure Equipmen indicated	nal Services Cleaning It Hood policy undated side of the hood will be nth				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00374	B. WING		07/23/20	
	ROVIDER OR SUPPLIER	200 NOF	ADDRESS, CITY, STAT			
0(0)15			A, MN 56359	PROVIDER'S PLAN OF C		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
21685	-		21685			
	grease and/or dust 5. wash hood with so 7. the interior section the roof is cleansed s commercial hood-clea	of the hood that extends to emi annually by a				
	The Administrator and the cleaning schedule	OD OF CORRECTION: d / or designee could review e within food service and ncy that high areas should				
	TIME PERIOD FOR (days.	CORRECTION: Seven (7)				
21805	MN St. Statute 144.6 Residents of HC Fac.		21805			8/14/15
	residents have the rig courtesy and respect	treatment. Patients and to be treated with for their individuality by ons providing service in a				
	by: Based on observatior review, the facility fail rising and morning ro (R50 and R12),who re	t is not met as evidenced n, interview and document led to provide a dignified utines for 2 of 8 residents equired extensive staff te activities of daily living		corrected 8/14/15		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
	00374		B. WING			
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		07/23/201	
			TH ELM STREET	,		
	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21805	Continued From pag	e 20	21805			
	R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia, dementia, and aphasia. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, required extensive, physical assistance for ADL's, including two-person assist with bed mobility, transfers, toileting, dressing and personal hygiene.					
	R50 was lying on her left hand positioned of blanket was at the for resident, exposing R see she already had R50 remained in bed NA-G assisted her w already dressed, with when NA-F removed for incontinence, NA- into her wheel chair w NA-F then brushed h in placing R50's hand wheel chair armrest a During an interview of	n 7/22/2015 at 7:11 a.m., r back, in her bed, with her on top of her chest. R50's ot of the bed, pulled onto the 50's left leg, and one could pants on as she lied in bed. I until 8:41, when NA-F and ith morning cares. R50 was n pants, socks and shirt, R50's covers and checked -F and NA-G assisted R50 with use of a mechanical lift. her hair, and NA-G assisted d splint and arm into the and R50 was up for the day.				
	NA-G said R50 was morning, and we "jus bed." NA-G said R50					
	acknowledged R50 w when she assisted R NA-F did not know w "someone on nights dressed," and that w	22/2015 at 9:18 a.m., NA-F vas dressed this morning 50 to get up for the day. ho worked with R50, but said [the night shift] got her as typical for R50's routine. would not be dressed early				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING		07	//23/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM					
			A, MN 56359	PROVIDER'S PLAN C		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page	e 21	21805			
	on Tuesdays, "becau day."	ise she gets a bath on that				
	NA-H stated she wor routinely got R50 "cle not removed from be that." NA-H stated si on her scheduled bat residents whom she dressed, prior to the said "I just need to m and ready to go. I ge them back to bed; it I NA-H said if there wa want to get up, she w someone else up." N the residents she ass and there were some night anyway." During an interview of family member (FM)- were getting R50 dre bed. FM-A said that was often awake late restless, and they [st	on 7/24/2015 at 6:00 a.m., its on the overnight shift, and eaned up and dressed," but id, "the day shift would do he does not get R50 dressed th days. She has a list of helped get cleaned and end of the night shift. NA-H take sure they are dressed et them dressed and then put helps out the morning shift." as a resident that did not vas instructed "to get NA-H did add that some of sisted "liked to get up early," e who simply "were up all on 7/24/2015 at 1:06 p.m., A said he was unaware staff essed, then having her stay in depending on the night, R50 e, or was "up at 3:00 a.m. and aff] will get her up." FM-A think if [R50] got dressed,				
	day." In an interview on 7/2	and up to breakfast for the 24/2015 at 1:17 p.m., the 0ON) stated the night shift try				
	"to help the day shift someone was trying and keep [the resider and possibly fall." In	staff." The DON said "If to get up, then get them up, nt] from getting out of bed the same interview, the				
	during the night was	aid getting a resident up "not just a decision for the k into this some more."				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	07/23/2015	
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
	CS HEALTH STSTEM	ONAMIA	A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page	e 22	21805			
	5/18/15, indicated shi impaired and required transfers, dressing ar (CP), dated 8/28/13, opportunities to make including clothing, be also indicated R12 ha related to insomnia, w hours of sleep at nigh	num data set (MDS), dated e was severely, cognitively d extensive assist for nd grooming. The care plan directed staff to give R12 e daily preferences choices, d time and bathing. The CP ad an alteration in sleep, with a goal of at least six nt. The CP did not address a erence of when R12 wanted				
	was noted fully dress chair. R12 was posit television in the comr asleep in her wheelch jerking movements as in chair until 8:15 a.m approached, and awa R12 if if she wanted t breakfast. R12 replier During an interview o NA-E stated she was	non area on the east wing, nair. R12 repeatedly made s she dozed. R12 remained n., (75 minutes) when staff akened her. The staff asked o go back to bed, or eat d "I don't care." n 7/24/15, at 5:59 a.m., instructed to get four				
	residents up, washed the over night shift. N shower, there was ar up in their place. NA-	I and dressed when working A-E stated if a resident had nother one assigned to get E stated she will usually "get shed, dressed and put them				
	licensed practical nur the over night shift is she stated they are n	on 7/24/15 12:24 p.m., se (LPN)-C stated, " usually getting up the early risers, ot getting up anyone that in. LPN-C further stated,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				B. WING		
		00374			07	//23/2015
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page	e 23	21805			
	of a mechanical lift to dressed and put back	"Some of the Hoyers [residents who require use of a mechanical lift to transfer] get washed, dressed and put back in bed, I don't have any idea why they would do that."				
	director of nursing (D people getting up and bed on the night shift and care coordinators day shift. The DON for this list are usually up like the night shift to l the day." She further the only nursing hom that." The intent is to prevent falls. The DO if the rationale for wa	on 7/24/15, at 1:16 p.m., the PON) stated, there are many d dressed and put back to the stated, The nurses s schedule them to help the urther stated, "the people on the or crawling out of bed," we help day shift "get a jump on the stated, "I'm sure we are not the in the world that does to help day shift out and DN stated she was not sure king a resident on night shift and dressed is on the care				
	registered nurse (RN residents for the nigh dressed. She stated, who are trying to get people who want to g who are a "Hoyer lift. dress them in bed. R prefers to get up earl further stated, there i East unit that is care to fall risk. RN-C state	on 7/24/15, at 2:07 p.m.,)-C stated, We schedule it shift to get up, washed and We usually look at people up but if there aren't enough get up, we will pick people " The aides will wash and N- C stated, "If someone y it is not care planned." She s no one currently on the planned to get up early due ed, The rationale for night s washed and dressed is n the morning.				
	sheet directed night s	's undated East night group shift to complete morning essing, making bed and five regidents on the unit				

STATEMEN	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY IPLETED
		00374	B. WING		07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	4/15, indicated the fa promote care for [res maintains and enhan full recognition of [a r SUGGESTED METH The Administrator an inservice facility staff care in a dignified ma auditing system to en treated with dignity.	y policy, Rights and atients/Residents, dated cility "must, with courtesy, idents] in a manner that ces dignity and respect in esident's] individuality." OD OF CORRECTION:	21805			
21990	Maltreatment of Vuln Subd. 4. Reporting immediately make an entry point. Use of a for the deaf or other s considered an oral re point may not require extent possible, the r content to identify the caregiver, the nature maltreatment, any ev maltreatment, the native reporter, the time, da incident, and any oth reporter believes mig the suspected maltre	A mandated reporter shall oral report to the common telecommunications device similar device shall be port. The common entry written reports. To the eport must be of sufficient vulnerable adult, the and extent of the suspected idence of previous me and address of the te, and location of the er information that the ht be helpful in investigating	21990			8/21/15

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		SURVEY PLETED
		00374	B. WING		07/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	CS HEALTH SYSTEM		RTH ELM STREE A, MN 56359	т		
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21990	in section 13.02, and section 144.335, to the comply with this sub- This MN Requirement by: Based on observation review, the facility fail of abuse, neglect, minunknown were immer adminstrator and station investigated, and rest their investigations for R12, R22, R39, R11, allegations reviewed reference checks for	I medical records under he extent necessary to division. Int is not met as evidenced n, interview and document iled to ensure all allegations istreatment and injuries of rediately reported to the te agency, were thoroughly sidents were protected during or 8 of 15 residents' (R47, , R66, R44 and R8) . The facility failed to conduct	21990	corrected8/21/15		
	Findings include: Investigation and Pro	otection				
	worker (SW) stated t has been implicated January 2015 to July alleged perpetrator (a	ident and Investigation				
	R47's quarterly Minir 2/17/15, indicated sh intact and needed ex R47's care plan date dementia and needs grooming and bathin indicated she had sli	num Data Set (MDS) dated the was moderately cognitively tensive assistance in ADLs. d 2/26/15, indicated she had assist with dressing, g. The care plan further ght alteration in cognition and that resident will continue				

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NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21990	Continued From page	e 26	21990			
	Mille Lacs Nursing Home Progress Notes dated 1/24/15, at 3:49 a.m. indicated: "This nurse [LPN-D] was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide. The aide stated (in her words) On 2 a.m. rounds, I went to check resident in room 45-1 and woke up resident in 45 -2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time. [R47] said "No, I want to sit up I'm waiting." NA-C said "No lets lay down" and NA-C went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA-C] yelled out "ow" and NA-C said "Why did you hit me, R47 said "I didn't, you hit me you liar" then [NA-C] walked out and walkie the nurse" This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her."					
	on 1/28/15, indicated a nursing assistant o review of the related supervisory staff, it w R47's incident was d study revealed that F assistant, but resider nursing assistant stru	ubmitted to the state agency that R47 had a conflict with n 1/24/15. Following a progress notes, and vas originally determined ue to her dementia. Further R47 allegedly struck a nursing nt [R47] also alleged the uck her. The report indicated n needed to be completed.				
	the state agency on 2 the SW met with the 1/28/15 and 1/30/15 recall any incidents of	tive Report was submitted to 2/2/15. The report indicated resident R47 on the a.m. of and resident was unable to of concerns. The SW was NA-C until 2/2/15 (7 days				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00374	B. WING		07	//23/2015
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	• •	
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
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TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	DATE
21990	Continued From page	e 27	21990			
	after the SW learned of the situation) in part due					
		not coinciding with the SW.				
		by phone on 2/2/15, at nowledged the incident				
	happened as described by LPN-D's note. NA-C					
	stated she had not struck R47 in any way, but had tried to lift R47's legs to help her lay down.					
	The investigative report indicated the AP was					
	•	so included that NA-C had				
	been implicated in a	previous submitted report.				
	During interview 7/23	8/15, at 5:10 p.m., the SW				
	•	as unable to recall if the				
	incident had happened, and said R47 had					
	dementia. The SW said NA-C was not suspended during her investigation because it					
	could "not be proved" that NA-C abused R47, and					
		on the work schedule. The				
		counseled on how to provide				
	NA-C on how to keep	as asked for ideas from 0 R47 safe.				
	Review of the facility					
		IA-C was not suspended				
		ation of the incident dated as scheduled to work 1/28/15				
		e investigation was in				
	progress.					
	The investigation of t	his incident lacked timely				
	interviewing of the N	A-C. This incident occurred				
		ot reported to the SA until				
		gation did not determine if abused. The facility did not				
		e action to protect residents,				
		on. There was no indication				
	that a thorough inves R47.	tigation was completed for				
	(X + I).					

STATEMEN	ta Department of Healt T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00374	B. WING			
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	07	/23/2015
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
			A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21990	Continued From page	e 28	21990			
	Referral Form (SSIRI R47 was involved in a a.m., of possible abu The SSIRF indicated (electronic progress r verbal statements an resident [R47]; possil maltreatment but jus resident's dementia." indicated the incident Investigative Team of reported submitted to 3/3/2015 at 12:30 p.m NA-C was a person v the situation. An initial Incident Rep state agency on 3/3/ of R47 on 3/2/15. Th progress notes from a.m. of 3/2 that sugge concerns/dementia s at work or possible m staff." The report ind whether this was mal to go ahead and sub- agency]" A nursing progress n a.m., written by LPN- "kicking at staff" and going to report 'her' to indicated R47 told sta everyone I heard" O second progress note wipe dry blood off [R- The note continued, f	ble indication of t a likely symptoms of The SSIRF further at was discussed with n 3/3/15 at 8:30 a.m., and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING		07	/23/2015
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
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21990	Continued From pag	e 29	21990			
	Facility documentation did not indicate any action					
	was taken to protect	R47 and other residents				
	during this investigat	ion of potential abuse.				
	Documentation of the	e investigation of this incident				
		mination the cause of R47's				
	bloody lip, and there was no evidence of interview					
	with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no					
		of this incident to the state				
	agency or administra	itor.				
	A final Investigative	Report was submitted to the				
	÷	6/15 regarding the incident.				
	The report indicated on 3/2/15 the "resident was					
		are Coordinator (RN- A) and				
		enied remembering anything				
		weekend during the daytime				
	or the nighttime that	upset her in any wayShe				
	denied that anyone h	nits her or has been mean to				
	her or that she has h	it anyone else." The report				
		communicated with [LPN-B]				
		s from 3/2/15 during night				
	-	NAR was situating resident in				
	`	al lift) to help her to the				
		nt's request and the NAR				
	noticed resident's lip	•				
		rom being chapped with dry,				
		ld [R47] she was going wipe out R47 struck out at NA,				
		s to dismount from her face."				
		NA-C re-approached later				
		vithout incident. Later the				
		vas doing rounds and				
	0	s feet back in bed, and				
	resident kicked at NA					
		ations made by R47, that she				
	-	port did not confirm a				
		cident. The report indicated				
		reviewed, and suggestions				
	were made on how to	a anaraa ah D47 during	1			1

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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	ROVIDER OR SUPPLIER	00374	DDRESS, CITY, STATE		07	//23/2015
			RTH ELM STREET			
MILLE LA	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21990	Continued From page	e 30	21990			
	cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."					
	2015, indicated NA-0	r's MLHS-LTC NA/R ary 23, 2015 to March 8, C was assigned to work he alleged incident) and also				
	stated, in review of th "concerns with NA-C" she had really done a felt they could not sul against NA-C, and th "suspension or discip investigation. There w	" but again could not prove anything wrong. The facility bstantiate the allegations erefore did not warrant a				
	was moderately cogn extensive assist with grooming. R12's carr indicated she had po	dated 4/27/15 indicated she itively intact and needed dressing, bathing and e plan dated 1/31/15, tential for abuse from others npairment and limited				
	agency on 2/18/15, ir	port submitted to the state ndicated that on 2/18/15, R12 d, on her cheek, by a staff mpting to administer				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
		00374	B. WING		07	/23/2015
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21990	Continued From pag	e 31	21990			
	medicine. The AP on the Incident Report was listed as unknown.					
	state agency on 2/23 The report indicated allegations, but the or "tracked," was the or [R12] during the adm Magnesia (MOM) that indicated the SW and more information about administered the MC schedule, LPN-B and duty. At 10:45 p.m. of SW met with NA-C, given MOM to R12 of NA-C said "[R12] did took the cup and thre [NA-C] tried to clean resident's clothing an The report indicated any way, but acknow with the wet ones. T possible this was per The SW asked NA-C see if resident could/ her as the lady who agreed to do so. [R ⁻¹ however, so decided indicated "[NA-C's] w leads SW to believe about not slapping re- indicated the DON sp	at morning. Firstly, the report d DON proceeded to seek but who would have OM that morning. Per d NA-C were the persons on on 2/19/15, the DON and who freely admitted having under direction of LPN-B. In't want the MOM, and [R12] ew the MOM all over." it up off the bedding, nd her face, using wet wipes." NA-C denied slapping R12 in vledged wiping R12's face off the report indicated, "It is received by [R12] as a slap." C to go to resident's room to vould or would not identify slapped her, and NA-C 12] was sleeping soundly, I not awaken her. The report villingness to go, however, she [NA-C] is being truthful esident." The report then poke to LPN-B by phone on LPN-C admitted asking				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00374					
	ROVIDER OR SUPPLIER	00374 STREET A	B. WING 07/23/2015 ET ADDRESS, CITY, STATE, ZIP CODE				
	CS HEALTH SYSTEM		RTH ELM STREET				
	CO NEALIN STOTEM	ONAMIA	A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page	e 32	21990				
		ng cares with this resident cted not to enter room resent.					
	stated she did not su could not prove NA-C acknowledged NA-C multiple incidents, an [NA-C], but did not fe	d had "suspicions" with el "there was a reason to disciplinary action to her					
	not determine if R12 follow up to have R12 nursing assistant who NA-C was instructed without a colleague p offered no indication						
	she had depression a accident (CVA), was impaired and needed and extensive assist plan dated 5/3/15, ind with toileting and tran depression and sadn care plan further indic abuse from others rei weakness, aches and	ess/isolating self. R22's cated she had potential for lated to her general d pains. The care plan goal ill remain safe and have					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	B. WING		07	/23/2015	
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLE DATE	
21990	Continued From page	e 33	21990				
	lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm R22's bruise was black, fading to dark purple in color, with no apparent swelling						
	that she had been tre and there is a staff m shift that is rough wit this staff member had transferring" which ca	15, at 5:54 p.m. R22 stated eated "roughly by the staff" nember who works the night h her. R22 went on to state d "grabbed her arm when aused a large bruise and also hit her leg into the metal of her bed.					
	state agency on 6/27 alleged mistreatment The report also ident right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm report was submitted the initial reporter, N/ perpetrator in this inconursing assistant (N/ she had toileted R22 told [NA-C] she was that "some girl hurt h she [R22] stated she report then indicated (RN)-A, followed up y asked her to tell her reported she is not st is not going to be treat	an Incident Report to the (15, regarding an incident of t and physical abuse of R22. ified a bruise on R22's top g 5.5 cm x 5 cm, circular in I bruise on R22's lower right , circular in shape. The I by RN-D, and indicated that A-A, was also the alleged cident. The report indicated, A)-C reported at 5:15 a.m., , After being toileted, R22 not coming back tonight, and er." NA-C asked who, and doesn't know who. The that registered nurse with R22 in the morning and what happened: "Resident taying here again tonight and ated like this anymore." R22					
	night for getting up to times, and that a "gir into bed." R22 pointe	vas mad at her during the o use the bathroom so many I grabbed me and threw me ed out her hand hurt, and ne grabbed me," noted a					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
			A. BUILDING:			
		00374	B. WING		07	/23/2015
AME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
AILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21990	Continued From pag	e 34	21990			
	 21990 Continued From page 34 bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 a reported when she threw me into bed, "I hit m leg on something metal;" a bruise noted on mouter lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who t girl was, nor her name. R22 thought it was around 0400. The report further indicated N was the nursing assistant working on that winduring the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C w removed from working with resident at this time. An additional Incident Report was submitted the state agency on 7/1/15, which identified a injury of unknown source on R22's right fore 8 x 5 cm, reddish purple in color, and oval in shape. The date of incident occurrence was unknown. The report indicated R22 said, "It happened a few days ago." 					
	state agency on 07/0 two submitted incide indicated the DON at tried to investigate the been unable to subsi- perpetrator [AP] is for conclusion there is re- may have occurred in hence submitting a re- enforcement, in accor Act." Further, "The o- investigation to the li submitted to OHFC [Complaints] the state Report further indica	ordance with Elder Justice				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
			B. WING				
		00374			07	7/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page	e 35	21990				
	21990 Continued From page 35 (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re [regarding] her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble." The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."						
	member who had hur for her and received r disciplinary action wa suspended pending t was no indication tha	scribed NA-C as the staff t her and NA-C was caring multiple large bruises, no s taken, NA-C was not he investigation. Also, there t a thorough investigation e facility to include other and residents.					
	DON stated she has be doing the accusati certain. The DON sa during the night shift, that do that." The DO	/23/15, at 4:50 p.m. the concerns that NA-C might ions, but stated she was not id, "Staff monitor [NA-C] " and "we have nurses on DN stated the nurses were to nything and have concerns.					
		23/15, at 5:03 p.m. the SW k with other residents or staff					

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED		
		00074	B. WING		07/00/0045			
NAME OF PI	ROVIDER OR SUPPLIER	00374	ADDRESS, CITY, STATE	01/25/2015				
	CS HEALTH SYSTEM		RTH ELM STREET	, 0002				
		ONAMIA	A, MN 56359					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE		
21990	Continued From page	e 36	21990					
	Continued From page 36 regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."							
	administrator said, "W working on nights, we	on 7/23/15 at 5:10 p.m., the We have three young people e can't suspend; there is not dministrator further stated, " I V did the right thing."						
	the DON stated NA-0 facility policy followin R22 . She stated, "If	on 07/23/15, at 5:14 p.m. C was not suspended per the g the allegation made by I had suspended one, I uspend all three staff, then of the residents?"						
	stated, " I don't work am mandated, but I c stated, "I have heard	on 07/24/15, 5:14 a.m., NA-E a lot of overnights unless I do hear a few things." NA-E about people being super I that some of the girls are a						

STATE FORM

STATEMENT	a Department of Healt OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL		
		00374	B. WING		07/2	23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From pag	e 37	21990				
	stated one of the res being rough and leave the staff member as resident and stated to threw me into the cha- bathroom again." NA the nurse a lot on nig During interview on 7 stated she works par LPN-H stated she ha NA-C is rough with the witnessed it directly. aware that she was to the night shift when so indicated she had he NA-C had slapped how works on the North we was because of the of take care of any certors stated the aides on the	t tell you who." She further idents mentioned about a girl ying bruises. NA-E described they were described by the he resident said " the girl air because I had to go to the A-E stated she does not see ghts. 7/24/15, at 5:25 a.m. LPN-H t time on the night shift. Is heard from other NAs that he residents but had not LPN-H stated she was not o monitor any staff during she works. She further ard R12 had reported that er and that NA-C no longer ying and thought the reason cat; not because she can not ain residents. She then he night shift don't work to work on each unit alone.					
	INJURIES OF UNKN	IOWN ORIGIN					
	was moderately cogr plan, dated 3/30/15, extensive assist with	dated 3/9/15, indicated she nitively impaired. Her care indicated she required all activities of daily living, tand for transfers, and was ted to dementia.					
mesota Der	dated 10/7/14, indica purple bruise on the buttock and that R39 bruising occurred. Th	vice Incident Report Form, ited R39 had a large, dark right upper portion of her was unaware of how the he report indicated R39 had or by staff a few days prior to					

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	B. WING	IG		07/23/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			123/2013	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page	e 38	21990				
	the injury. The incide anticoagulant medica clotting), other injurie unspecified times frai "minor." The injury wa During an interview of DON)stated, when R floor it would be hard during that event but due to use of anticoa therefore the injury w reportable. Although R39 was m unable to recall how t was no evidence that investigation was cor	me, and listed the injury as as not reported to OHFC. on 7/24/15, at 12:54 p.m., the 39 had been lowered to the to know if injury occurred stated, R39 bruised easily gulant medication so as not considered oderately impaired and the bruise occurred, there t a more in-depth npleted to determine the s R39's injury of unknown					
	she was moderately plan, dated 6/3/15, in extensive to total ass living, was cognitively abuse related to depu	ist for all activities of daily / impaired, and at risk for ression.					
	Report Forms indicat unknown origin. An ir indicated R39 had a hand that was dark p 8 cm x 8 cm. The rep was unable to state h blood thinners and de	rate Social Services Incident ed R11 had injuries of incident form dated 10/21/15, bruise to the top of her right urple in color and measured out further indicated R11 now the injury occurred, used escribed the injury as ial Services Report Form,					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00374	B. WING		07	//23/2015	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page	e 39	21990				
	dated 11/4/14, indicat to her left temple and was unable to state th third incident report d had a bruise of unkno knee, dark purple in o (unit of measurement report further indicate the cause of the injur medications, and the " minor." None of the to OHFC. During an interview o SW stated, R11 "had have ever known." SI hand may have been of [R11's] nails." Reg R11's temple and for nursing felt the bruisi R11's nebulizer mask R11 who reported that way back from supper not ambulate, used a there were no record the bruising was likely nebulizer mask. During an interview o DON stated R11 coul asked if bruising was she felt the injury was	ted R11 had bruising noted above her left eyebrow, and he cause of the injury. A lated 12/18/14, indicated R11 own origin to her left inner color, measuring 1 x 1 3/4. t was not indicated). The ed R11 was unable to report y, use of anticoagulant e injury was considered to be three bruises were reported on 7/24/15, at 12:54 p.m., more bruising than anyone I he stated the bruise on R11's caused by "recent trimming arding the bruise noted to ehead, SW stated that ng was due to placement of k, however, SW interviewed at she slipped and fell on her er. SW further stated R11 did Hoyer lift for transfer and s of any falls and indicated y due to placement of R11's					
	cognitively impaired, different locations, ar what happened, there investigation complet	and had multiple bruises at nd were unable to determine e was no indepth red to determine the actual ses. The facility administrator					

Minnesota Department STATE FORM

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	123/2013
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21990	Continued From page submitted to the state		21990			
	was moderately cogr dated 2/9/15, indicate assist of two staff wit transfers, at risk for or related to depression During review of a So Referral Form, dated noted indicated R66 from her hands to he indicated R66 was un the injury and that the "minor." The injury w During an interview of SW stated, the bruise was reviewing a prog with nursing and dete assessed to be a min reportable to to OHF	bcial Service Incident 2/3/15, a facility progress had bruising along both arms r shoulders. The form further hable to state the cause of e injury was assessed to be vas not reported to OHFC. In 7/24/15, at 12:54 p.m., es were noted while the DON gress note and she spoke ermined the bruising was nor injury and therefore not				
	DON stated, R66 use lift) and did not alway occasionally "flailing stated, R66 was cont "hard to say if R66 w	ed a Hoyer lift (mechanical				
	hands to her shoulde unwitnessed and the identify what happen	resident was unable to ed. The facility had not the incident to the state				

STATEMEN	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00074	00374 B. WING			07/00/0045	
NAME OF P	ROVIDER OR SUPPLIER	00374	ADDRESS, CITY, STATE	ZIP CODE	07	//23/2015	
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET	,			
(X4) ID		ATEMENT OF DEFICIENCIES	A, MN 56359	PROVIDER'S PLAN C		(X5)	
PREFIX TAG	``	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE	COMPLET DATE	
21990	Continued From page	e 41	21990				
	completed to determinarms" while using the	ine if R66 was "flailing her e mechanical lift.					
	R44's annual MDS, dated 6/9/15, indicated she						
	dated 7/10/15, indica assist with activities of	vely impaired. Care plan, ted R44 required extensive of daily living, and was at risk short term memory loss and aking skills					
		vice Incident Referral Form.					
	on her posterior forea cm that was found du form indicated R66 d	ted R44 had a purple bruise arm measuring 6.3 cm x 7 uring her bath. The incident id not state the cause of ury was determined to be					
		as not reported to OHFC.					
	SW stated, on 8/18/1 bruise measuring 8.5	on 7/24/15, at 12:54 p.m., 4, staff reported R8 had a 5 cm in length between her 6 from the base of the thumb					
	the initial evaluation a resulted from R8 wrir	ed the reporting nurse did and determined the bruising nging her hands, and the					
	She further stated the due to staff witness of	s was witnessed by staff. e injury was not reportable of the potential cause. A					
		ent Referral form was ury but was not received.					
	SW stated when mak whether or not to rep	on 7/24/15, at 12:54 p.m., king a determination of ort an injury to OHFC, she					
	also stated that she l	d uses a decision tree. SW ooks at whether a resident is jury or if someone else saw					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00074	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	00374 STREET A	B. WING 07/23/2015 EET ADDRESS, CITY, STATE, ZIP CODE 07/23/2015				
	CS HEALTH SYSTEM		RTH ELM STREET				
	CO TIERETTI OTOTEM	ONAMIA	, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page	e 42	21990				
	it, and if there is a history of other recent falls and/or injuries. She further stated, if the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported. During an interview on 7/24/15, at 12:54 p.m., the DON stated, there was no criteria for determining whether an injury was minor vs major. She further stated, the nurse finding the injuries did initial evaluation to determine the above injuries to be minor. The DON stated she would use the nurses judgement when determining if an injury was minor or major and that the RN in charge followed up on the injuries. However, she stated there was no charting in the clinical record that would show evidence that follow up had been completed.						
	cognitively impaired, origin, on the posterio indication the facility investigation to deter	s assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her ent was not reported to the					
	her to be severely co requiring assist of two living. CP dated 5/15 extensive assist for a	um data set (MDS) identified gnitively impaired and o staff for activities of daily /15 indicated R8 required activities of daily living and related to diagnosis of					
	had a bruise measuri	ated 8/18/14, indicated R8 ing 8.5 cm in length between nger from the base of her					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00374	B. WING 07/23/20				
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE	
21990	Continued From pag	e 43	21990				
	initial evaluation and resulted from R8 with wringing of her hand During an interview of SW stated, the injury staff witness of the p investigation of the in facility administrator a report was not mad Social Services Incid requested for this inj Although R8 had sev and had a bruise 8.5 forefinger from the b There was no indicat thorough investigation	he reporting nurse did the determined the bruising nging her hands, and the s was witnessed by staff. on 7/24/15, at 12:54 p.m., was not reportable due to otential cause. No further njury was completed. The was notified of the injury but de to the state agency. A lent Referral form was ury but was not received. were cognitive impairment, cm between her thumb and ase of her thumb to her wrist. tion the facility completed an on to determine the source of acident was not reported to					
	revised 7/15, indicate (Mille Lacs Health Sy are vulnerable to abu physical, mental psy sexual abuse)" Th "protection will include individual abuse prev reporting of all cases neglect, or financial of reporting to the Com substantiated incider	Vulnerable Adult Policy, ed: "It is the policy of MLHS ystem) to protect adults who use (including verbal, chosocial/emotional, and e policy further indicated: de abuse prevention plans, vention plans, internal of suspected abuse, exploitation, and external mon Entry Point (CEP) of nts of maltreatment." In on of a reportable incident,					

STATE FORM

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE	•	
MILLE LA	CS HEALTH SYSTEM		TH ELM STREET , MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21990	thoroughly investigate further potential abus progress." Under the Patient" section, the alleged perpetrator (<i>I</i> situation. If the AP is suspended until the in and further, "Disciplir up to and including d employee/employees defined Injury of Unk the injury was not ob suspicious." The pol definition top include to screening of poten	I alleged violations are ed. The facility must prevent se while the investigation is in a "Protection for Resident or policy directed that "The AP) will be removed from the s an employee, they will be nvestigation is completed," hary action will be carried out ismissal of s as appropriate." The Policy nown Origin as "source of served and injury as icy did not expound on this CMS definitions. In regard tial employees, the policy attempt to obtain information	21990			
22000	The Administrator an and inservice the faci investigation of allega to the State rules and TIME PERIOD FOR (14) days. MN St. Statute 626.5 Reporting - Maltreatm Subd. 14. Abuse pr facility, except home personal care attenda establish and enforce	CORRECTION: Fourteen 557 Subd. 14 (a)-(c) nent of Vulnerable Adults revention plans. (a) Each health agencies and ant services providers, shall e an ongoing written abuse e plan shall contain an	22000			8/21/15

Minnesota Department of Health STATE FORM

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If continuation sheet 45 of 70

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 07/23/2015	
		00374				
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, Z	IP CODE		123/2013
MILLE LA	CS HEALTH SYSTEM		TH ELM STREET , MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	and a statement of sp to minimize the risk of comply with any rules promulgated by the li (b) Each facility, in agency and personal providers, shall devel prevention plan for ea residing there or rece The plan shall contain assessment of: (1) th abuse by other indivity vulnerable adults; (2) other vulnerable adults; (2) other vulnerable; (3) other vulnerable; (3) other vulnerable; (3	population identifying courage or permit abuse, becific measures to be taken if abuse. The plan shall is governing the plan censing agency. cluding a home health care care attendant services op an individual abuse ach vulnerable adult tiving services from them. In an individualized the person's susceptibility to duals, including other the person's risk of abusing ts; and (3) statements of the be taken to minimize the bess of this paragraph, the s self-abuse.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00374	B. WING		07/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	re, zip code	1 07	12312013
	CS HEALTH SYSTEM	200 NOF	TH ELM STREET			
	CS REALTH STSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	2 46	22000			
	by: Based on observatior review, the facility fail	t is not met as evidenced n, interview and document ed to implement their cy to ensure all allegations of		corrected 8/21/15		
	abuse, neglect, mistre unknown origin were administrator and sta investigated, and res during the investigatio (R47, R12, R22, R39 allegations reviewed. to conduct reference policy for 4 of 5 newly NA-B, DA-A and RN- effect all 50 residents	eatment and injuries of immediately reported to the te agency, were thoroughly idents were protected ons for 8 of 15 residents' , R11, R66, R44 and R8) In addition, the facility failed checks according to their hired employees (NA-A, B). This had the potential to who resided in the facility, andard quality of care under				
	Findings include:					
	indicated: "It is the po Health System) to pro vulnerable to abuse (mental psychosocial/	including verbal, physical, emotional, and sexual				
	will include abuse pre abuse prevention pla	further indicated: "protection evention plans, individual ns, internal reporting of all buse, neglect, or financial rnal reporting to the				
	Common Entry Point incidents of maltreath investigation of a repo	(CEP) of substantiated				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	B. WING		07	/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, RTH ELM STREET	, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
22000	Continued From page	e 47	22000				
	potential abuse while progress." Under the Patient" section, the p perpetrator (AP) will b situation. If the AP is suspended until the ir and further, "Disciplin up to and including di employee/employees INVESTIGATION ANI During interview 7/23 worker (SW) stated th has been implicated i reports from February alleged abuse, and m	an employee, they will be nvestigation is completed," ary action will be carried out smissal of as appropriate." D PROTECTION /15, at 5:09 p.m. with social nat nursing assistant (NA)-C n at least four incident / 2015 to July 2015 of eglect. dent and Investigation 5 to 7/20/2015 for NA-C					
	2/17/15, indicated she intact and needed ext R47's care plan dated dementia and needs grooming and bathing indicated she had slig related to dementia a to be oriented to pers A facility Social Servic (SSIRF) indicated lice (LPN)-D verbally repo	g. The care plan further ght alteration in cognition nd that resident will continue on, place and time. ce Incident Referral Form					
	occurred during the n SSIRF, dated 1/27/15 altercation/conflict be	ight shift on 1/24/2015. The					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
NAME OF P	ROVIDER OR SUPPLIER	00374 STREET A	ADDRESS, CITY, STATE,		07	//23/2015
	CS HEALTH SYSTEM		RTH ELM STREET	, 0002		
	CONERCINOTOTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 48	22000			
	also indicated, "LPN assisted res to bed, e inquire what happene indicated the incident investigation and/or r	required "further				
	Notes, dated 1/28/15 "This nurse was in a from where the incide distinct smack. Follo This nurse then got a [walkie-talkie] from th NA)." The [NA] state rounds, I went to che (room 45, bed 1) and [R47] in the process. said she should lay b some sleep until coff want to sit up I'm wai down" and NA went to bring them in bed and the head, fairly hard. NA said "why did you you hit me you liar' th walkie the nurse"	e aide (nursing assistant, d (in her words) "On 2 a.m. ck resident in room 45-1 woke up resident in 45-2 I told [R47] the time and ack down and try and get ee time." [R47] said "No, I ting." NA said "No lets lay o pick up [R47's] feet to d [R47] swung and hit me in I [NA] yelled out "ow" and hit me, [R47] said, 'I didn't, nen [NA] walked out and This nurse [LPN-D] asked he aide. Res. [R47] stated The nursing note did not				
	informed by LPN-D o a nursing assistant. was a progress note "incident report form.	n by the SW, dated the SW had been verbally f R47 being in a conflict with The email indicated there of the incident, but no further " The email indicated the the progress notes, and				

STATE FORM

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00374	B. WING		07/23/20 [/]	
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1 -	
CS HEALTH SYSTEM					
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
22000 Continued From page 49		22000			
allegedly struck a NA also that the resident NAR struck her, the i	AR [nursing assistant] and t claimed at the time that the incident DOES need to be				
on 1/28/15, indicated reported to this SW in 1/27/15" and further past weekend" with a Following a review of by the "Stand Up Te Management Team", incident was due to [symptoms" The re progress note which "claimed at the time to thus requiring a repo "an internal investigat	 an incident was verbally an the late afternoon br that R47 had a conflict "this a nursing assistant. an ursing assistant. f the related progress notes am" and "Behavior it was originally determined R47's] "dementia port referred to a nursing indicated that [R47] that the NAR struck her," rt to the state agency, and tion done accordingly as per 				
initial report submitter indicated an incident the night shift/early in The report also indicated reported, and made for afternoon of 1/27/207 incident) and reporter 1/28/2015 (three day occurred). There wa was reported immediated and state agency. A	d to the state agency occurred sometime during norning hours of 1/25/14. ated the incident was first known to the SW on late 14, (two days after the d to the state agency on rs after the incident allegedly is no indication this incident iately to the administrator dditionally, the investigation				
	OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER CS HEALTH SYSTEM SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag because the notes in allegedly struck a NA also that the resident NAR struck her, the i reported" to the state An Incident Report s on 1/28/15, indicated reported to this SW i 1/27/15" and furthe past weekend" with a Following a review o by the "Stand Up Te Management Team", incident was due to [symptoms" The re progress note which "claimed at the time" thus requiring a repo "an internal investiga policy." The alleged unidentified. A review of the SSIR initial report submitte indicated an incident the night shift/early n The report also indic reported, and made afternoon of 1/27/20 incident) and reporte 1/28/2015 (three day occurred). There wa was reported immed and state agency. A	F CORRECTION IDENTIFICATION NUMBER: 00374 00374 ROVIDER OR SUPPLIER STREET A 200 NOF ONAMIA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency. An Incident Report submitted to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late afternoon 1/27/15" and further that R47 had a conflict "this past weekend" with a nursing assistant. Following a review of the related progress notes by the "Stand Up Team" and "Behavior Management Team", it was originally determined incident was due to [R47's] "dementia symptoms" The report referred to a nursing progress note which indicated that [R47] "claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified. A review of the SSIRF, the internal email, and the initial report submitted to the state agency indicated an incident occurred sometime during the night shift/early morning hours of 1/25/14. The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CA A. BUILDING: D0374 B. WING D0074 STREET ADDRESS, CITY, STATE SOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 49 22000 because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late afternoon 1/27/15" and further that R47 had a conflict "this past weekend" with a nursing assistant. Following a review of the related progress notes by the "Stand Up Team" and "Behavior Management Team", it was originally determined incident was due to [R47's] "dementia symptoms" The report referred to a nursing progress note which indicated that [R47] "claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified. A review of the SSIRF, the internal email, and the initial report submitted to the state agency on 1/28/2015 (three days after the incident was reported to the state agency on 1/28/2015 (three days after the incident indicated the incident tallegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: OUTOER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SMMDARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDENCIES (EACH DEFICIENCY MUST BE PRECIDENCY (ALL AND TEAM" and "Behavior Management Team", it was originally determined incident was due to [R47'S] "dementia symptoms" The report referred to a nursing progress note which indicated that [R47] "Claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified. Internal must first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident and reported to the state agency on 1/28/2015 (three days after the incident tallegedly occurred). There was no indicatin this incident was reported immediately to the admin	OP DEFICIENCIES F CORRECTION (N1) PROVIDERSUPPLIENCIAN IDENTIFICATION NUMBER: QC2 MULTIPLE CONSTRUCTION A BUILDING (X2) OUT A BUILDING DOUBLE OR SUPPLIEN STREET ADDRESS, CITY, STATE, ZP CODE SUMMARY STREEM TO PERFOLICIENCIES SUMMARY STREEM TO PERFOLICIENCIES REGULATORY OR LSC IDENTIFIYING INFORMATION) D REGULATORY OR LSC IDENTIFIYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION DE CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY MUST END PRECEDED BY FULL REGULATORY OR LSC IDENTIFIYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION DE CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY MUST END PRECEDED BY FULL REGULATORY OR LSC IDENTIFIYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION DE CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY MUST ENT TAG Continued From page 49 22000 22000 Declause the notes indicated "the resident allegedly struck a NAR [nursing assistant] allegedly struck a NAR [nursing assistant]. DEFICIENCY An Incident Report submitted to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late affermoon 1/27/115" and further that R47 had a conflict "this past weekend" with a nursing assistant. FREENCE TO FREENCE TO THE REGULATION APPROVEMENT IN THE REGULATION IN THE SAM ADDRESS PREFERENCE TO TO the state agency indicated the IRAPA for the NAR struck her," thus requiring a report to the state agency, and "an internal investigation of an eaccordingly as per policy." The alleged perpetrator (AP) was unidentified. Areview of the SSIRF, the internal email, and the incident was repor

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00074	B. WING			
	ROVIDER OR SUPPLIER	00374	DDRESS, CITY, STATE		07	//23/2015
			TH ELM STREET	, 0002		
MILLE LA	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 50	22000			
	during the investigation	on.				
	state agency on 2/2/1 SW met with R47 "on 1/30/15," and "Reside incidents of concern w weekend." The SW w NA-C, (identified as the involved) until 2/2/15 learned of the incident schedule not coincidit with NA-C by phone of NA-C "acknowledged described" by LPN-D saying she had not st had merely tried to lift back down" The re apparent evidence of investigative report in perpetrator was NA-C	(7 days after the SW it) "in part due to her work ing with the SW." SW spoke on 2/2/15, at 10:45 p.m. The incident happened as 's note, and further, "[NA-C] ruck resident in any way, but t [R47's] legs to help her lay port indicated "There is no NAR striking resident." The				
	stated in the investiga recall if the incident h had dementia. The S suspended during he could not be proven t NA-C continued to be SW said NA-C was co	/23/15, at 5:10 p.m., the SW ation, R47 was unable to ad happened, and that R47 W said NA-C was not r investigation because it hat NA-C abused R47, and on the work schedule. The punseled on how to provide as asked for ideas from a R47 safe.				
	2015, indicated NA-C	s MLHS-LTC NA/R ry 26, 2014 to February 8, worked on the night shift on while the investigation of				

STATEMENT	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/20	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
22000	Continued From pag	e 51	22000			
	this incident was in p	rogress.				
	a.m., of possible abu The SSIRF indicated (electronic progress in verbal statements an resident [R47]; possi maltreatment but jus resident's dementia." indicated the incider Investigative Team of reported submitted to 3/3/2015 at 12:30 p.r NA-C was a person of the situation.	ble indication of st a likely symptoms of				
	state agency on 3/3/ maltreatment of R47 referenced "two prog shift early that a.m. o some behavioral con by resident [R47] at v maltreatment of resid indicated uncertainty	15 regarding possible on 3/2/15. The report press notes from NOC (night) of 3/2 that suggests either acerns/dementia symptoms work or possible dent by staff." The report by staff on whether this was SW decided to go ahead and				
	a.m., written by LPN- "kicking at staff" and going to report 'her' to indicated R47 told st everyone I heard" (second progress note	ote, dated 3/2/215 at 4:03 -B, indicated [R47] was [R47] told staff "she was o the nurse" The note also aff "you go around hitting On 3/2/15 at 6:03 a.m., a ed indicated staff went to 47's] lip, and [R47] hit staff.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY PLETED
					-	
		00374	B. WING		07	/23/2015
iame of Pi	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
AILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
22000	Continued From pag	e 52	22000			
		that after R47 hit staff, R47 report you for hitting me."				
	was taken to protect during this investigat Documentation of the did not include deten bloody lip, and there with the nursing assi R47. The SSRIF als	on did not indicate any action R47 and other residents ion of potential abuse. e investigation of this incident mination the cause of R47's was no evidence of interview stant who provided cares for o indicated there was no of this incident to the state ator.				
	state agency on 3/0 The report indicated interviewed by RN C this SW. Resident d happening this past or the nighttime that	Report was submitted to the 6/15 regarding the incident. on 3/2/15 the "resident was are Coordinator (RN- A) and enied remembering anything weekend during the daytime upset her in any wayShe nits her or has been mean to				
	also indicated "SW of about progress notes shift, "indicating the I the EZ lift (mechanic bathroom per residen noticed resident's lip	it anyone else." The report communicated with [LPN-B] s from 3/2/15 during night NAR was situating resident in al lift) to help her to the nt's request and the NAR had been bleeding rom being chapped with dry,				
	the dried blood off, h causing NA's glasses The report indicated and assisted [R47] w same night, the NA w	Id [R47] she was going wipe but R47 struck out at NA, s to dismount from her face." NA-C re-approached later vithout incident. Later the vas doing rounds and s feet back in bed, and				
nooota Dar		A-C. The report then ations made by R47, that she eport did not confirm a				

STATE FORM

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STATEMENT	Department of Healt OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/20	
NAME OF PR	OVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	, ZIP CODE		
MILLE LAC	S HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
22000	R47's care plan was were made on how to cares. The report als coached by the SW a progress note chartir have been reminded reports. The report in not resting well with t maltreatment of resic particular incident, S' and ears open for pa conduct, etc." Review of the facility Schedule from Febru 2015, indicated NA-0 3/2/15 (the night of th worked on 3/3/15. During interview 7/23 stated, in review of th "concerns with NA-C she had really done a felt they could not su against NA-C, and th "suspension or discip investigation. There we thorough investigation R12's quarterly MDS was moderately, cog extensive assist with grooming. R12's car indicated she had po	Additional states of the second states of the secon				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/20	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	123/2013
			RTH ELM STREET			
	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
22000	Continued From page	e 54	22000			
	(SSIRF), signed by the indicated there was a early A.M.", which all was described as: "[I Res re some issues. want to go home, the lady with the ponytail up yesterday', and 'T when she tried to ma 4p.m. resident [R12] concerns." The SSIR following: an internal on 2/18/15; that the re received by the SW in listed; the incident was "Investigative Team"	l email report was completed eport of alleged abuse was n person, no date or time as discussed with on 2/18/15 at 0833; and that al report was submitted on				
	agency on 2/18/15, ir was "slapped on her this morning while sta her to take some med R12 had no apparent consistent with this cl The report also indica investigation is warra					
	State Agency indicate occurred in the early possibly earlier, no ac or staff until it was dis on 2/18/15. There was	F, and the initial report to the ed, that although this incident morning of 2/18/15, and ction was taken by the facility scussed later that morning as no indication the incident orted to state agency and er, the investigation				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00374	B. WING		07	/23/2015
AME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
22000	Continued From pag	e 55	22000			
	R12 was slapped; ar have R12 positively i (possibly NA-C) who Although NA-C was room without a collea documentation offere were put in place for	ed no indication protections other residents who were ring the investigation of this				
	state agency on 2/23 indicated the "Initial I agency]at 4 p.m., was made to local la indicated R12 had m but the only allegatio the one about some administration of Mill morning (the white s SW and DON procee information about wh the MOM that mornin according to the sche the persons on duty. indicated, "DON and freely admitted havin direction of [LPN-B]." "[NA-C] said residen resident took the cup over." and "[NA-C] tr bedding, resident's of wet wipes." The rep slapping resident in a wiping R12's face of report indicated "It is	Reports submitted to [state " on 2/18/15, and also a call w enforcement. The report ade numerous allegations, in that could be "tracked, was one slapping her during the k of Magnesia (MOM) that tuff)." The report indicated				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. DOILDING.			
		00374	B. WING		07	//23/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 56	22000			
	lady who slapped her "[R12] was sleeping s decided not awaken l "NA-C's willingness to believe she [NA-C] is slapping resident." T spoke to LPN-B by pl LPN-C admitted askin R12 due to LPN-C be LPN-C also acknowle (R12's) claim of being The report then indica to having "two persor this resident and NA- room without a collear During interview on 7 stated she did not su could not prove [NA-C acknowledged NA-C multiple incidents, an [NA-C], but did not fe suspend" or provide of during this investigati Review of the facility'	her." The report indicated o go, however, leads SW to being truthful about not the report indicated the DON hone on 2/23/15 at 3:20 p.m. ng NA-C to give MOM to eing occupied elsewhere edged that NA-C did report g slapped by a "blonde lady." ated staff have been alerted ns present" during cares with C was instructed not to enter egue present. 7/23/15, at 5:20 p.m. the SW spend NA-C since "they C] slapped [R12.]" The SW had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on.				
	2015, indicated NA-C 2/22/2015, that is on incident, and during t	worked on 2/17/15 through the date of the alleged he subsequent investigation. ion a thorough investigation				
	she had depression a accident (CVA), and	S dated 4/24/15, indicated and a cerebral vascular was moderately cognitively I limited assist with transfers				

	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
			A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
22000	Continued From page	e 57	22000			
	plan dated 5/3/15, ind with toileting and tran depression and sadn care plan further india abuse from others re weakness, aches and indicated "resident w needs met in a safe of During observation o lifted her pant leg and right shin measuring (centimeters) x 2 cm. be black, fading to da apparent swelling. In p.m. R22 stated that "roughly by the staff" who works the night a R22 went on to state "grabbed her arm wh caused a large bruise	ess/isolating self. R22's cated she had potential for lated to her general d pains. The care plan goal ill remain safe and have environment." n 7/20/15 at 5:54 p.m., R22 d displayed a bruise on her				
	state agency on 6/27 alleged mistreatment The report also ident right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm report was submitted the initial reporter, N/ perpetrator in this inc nursing assistant (N/ she had toileted R22 told [NA-C] she was	an Incident Report to the /15 regarding an incident of and physical abuse of R22. ified a bruise on R22 top g 5.5 cm x 5 cm, circular in bruise on R22's lower right , circular in shape. The by RN-D, and indicated that A-C, was also the alleged cident. The report indicated, A)-C reported at 5:15 a.m., , after being toileted, R22 not coming back tonight,and er." NA-C asked who, and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING.			
		00374	B. WING		07	//23/2015
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET , MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
22000	Continued From pag	e 58	22000			
	report then indicated (RN)-A, followed up a asked her to tell her reported she is not si is not going to be tre- explained that staff w night for getting up to times, and that a "gir into bed." R22 points said "this is where sh bruise on top of right (centimeters) x 5 cm reported when she th leg on something me outer lower shin mea circular in shape. R2 girl was, nor her nam around 0400. The r was the nursing assis during the night, and charge. No other inj reassured she will re removed from workin An additional Incident the state agency on injury of unknown so "8 x 5 cm, reddish pu shape." The date of i unknown. The report happened a few days	that registered nurse with R22 in the morning and what happened: "Resident taying her again tonight and ated like this anymore." R22 vas mad at her during the o use the bathroom so many I grabbed me and threw me ed out her hand hurt, and he grabbed me," noted a hand measures 5.5 cm circular is shape. R22 also hrew me into bed, "I hit my otal" a bruise noted on right usures 2.5 cm x 2.5 cm 22 could not recall who the he. R22 thought it was eport further indicated NA-C stant working on that wing LPN-A was the nurse in juries noted, resident was main safe here, NA-C will be ng with resident at this time. At Report was submitted to 7/1/15, which identified an urce on R22's right forearm urple in color and oval in ncident occurrence was t indicated R22 said "It s ago."				
	nursing (DON) and s tried to investigate th been unable to subst	ocial worker (SW) "have is issue thoroughly and have tantiate who the alleged r certain, but have reached a				

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 22000 Continued From page 59 22000 22001 conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Eder Justice Act." Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 71/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'tS because I report things and others don't, so I end up getting in trouble." The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 78966 but was not specifically named as AP."		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
Aute of PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE MULE LACS HEALTH SYSTEM 200 NORTH ELM STREET ONAMIA, MN 56359 O(4) D PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC DENTIFYING INFORMATION) ID PRETIX TAG PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC DENTIFYING INFORMATION) ID PRETIX TAG PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC DENTIFYING INFORMATION) ID PRETIX TAG 22000 Continued From page 59 conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report laid cated, "The details of our internal investigation to be limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 77/171, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the tolet 6-8 times than night (G27/15). The report then indicated (SW and DON) "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face redoking and voice tightening, saying 'Its because I report things and others dont, so I end up getting in trouble." The report further listed, that during an intruview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having hear from reside (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very rice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C fad been "implicated in report 7866 but was not specifically named as AP."				A. BUILDING.			
ADVICE IN STREET DNAMA, MN 65339 CMUD REXX TAG SUMMARY STATUMENT OF DEFICIENCIES (EACH OPRICETY PLAN OF CORRECTION (EACH OPRICETY) (EACH OPRICETY) (EA			00374	B. WING		07	/23/2015
Display Summary stratement of DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Display PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) OPENDIFYING INFORMATION) 22000 Continued From page 59 22000 conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act.* Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency.* The Investigative Report further indicated on 7/11/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and vice tightening, saying "its because I report things and others don", so I end up getting in trouble.'* The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-O, who stated she "reported having the state is not very nice, etc. The blond hair with the boargs fits description of NA-C. The report further induced that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she thes to perform cares; received coaching in these incidents. NA-C was also involved in report 73966 but was not specifically named as AP." Display the described NA-C as the staff	IAME OF PI	ROVIDER OR SUPPLIER			, ZIP CODE		
IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG CACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY) Continued From sage 59 22000 22000 Conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further the report indicated. "The details of our internal investigative Report further indicated on 7/1/15, the DON and SW met with the AP. (NA-C) who stated R22 had requested to use the toilet 6-8 limes than tight (627/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face redening and voice tightening, saying 'It's because I report things and others dont, so I end up getting in trouble." The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having hear form resident (R22) on 6/30, that [R22] is arriad of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she ties to perform cares; received coaching in these incidents. NA-C was also involved in report 7986 but was not specifically named as AP."	AILLE LA	CS HEALTH SYSTEM					
conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and voice tightening, saying it's because I report things and others don't, so I end up getting in trouble.'" The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 7866 but was not specifically named as AP." Although R22 had described NA-C as the staff	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others dont, so I end up getting in trouble." The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75314, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP." Although R22 had described NA-C as the staff	22000	Continued From page	e 59	22000			
member who had hurt her and NA-C was caring for her and received multiple large bruises, the incident documentation indicated no action taken to protect residents during investigation of these incidents. Also, there was no indication that a		may have occurred in hence submitting a re enforcement, in acco Act." Further the rep our internal investigat are being submitted to agency." The Investi- indicated on 7/1/15, to the AP, (NA-C) who so use the toilet 6-8 time report then indicated with the AP the numb- involving this NAR, wher credibility, and sh defensive, face redde saying 'it's because I don't, so I end up get further listed, that dur DON and SW meet w "reported having hea 6/30, that [R22] is afr hair and bangs, that so The blond hair with th NA-C. The report fur been "implicated in p 78740, and 79433 wi with residents, as she received coaching in also involved in repor specifically named as Although R22 had de member who had hur for her and received to incident documentation to protect residents d	a the form of assault, and are eport also to law rdance with Elder Justice ort indicated, "The details of tion to the limits of our ability to OHFC and the state gative Report further he DON and SW met with stated R22 had requested to as that night (6/27/15). The [SW and DON] "discussed ber of previous incidences which can raise red flags re- te became somewhat ening and voice tightening, report things and others ting in trouble.' " The report ring an interview 7/2/15 the with NA-D, who stated she rd from resident (R22) on aid of the girl with the blonde she is not very nice, etc. he bangs fits description of ther included that NA-C had revious reports 75814, th possible "power struggles" e tries to perform cares; these incidents. NA-C was to 79866 but was not as AP."				

Minnesota Department STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/201	
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
22000	Continued From page	e 60	22000			
	DON stated she "has be doing the accusat not certain." The DO during the night shift, on that do that." The were to report to her have concerns. In an interview on 7/2 stated she "did not ta staff regarding abuse DON stated, "I don't witch hunt." The DON name keeps coming guilty." The DON als around "data privacy further stated, when a allegations come up on duty initiates the O said the nurse would address any immedia NA-C, the SW stated several residents she but that does change the allegation is not s further stated, in rega allegation of abuse, " The SW also said the "not intensive, and th plan initiated and no or mentoring done."	7/23/15, at 4:50 p.m. the concerns that NA-C might ions," but stated she "was N said, "staff monitor [NA-C] " and also "we have nurses DON stated the nurses if they notice anything and 23/15, at 5:03 p.m., the SW lk with other residents or e allegations by [R22]." The generally do that, it's not a N said, "Just because their up does not make them to said there were issues and confidentiality." SW something regarding abuse over the weekend, the nurse DHFC reporting. The SW talk to the resident, and ate concerns. Regarding d, "At times there have been e is not allowed to care for, e if, during the investigation substantiated." The SW and to NA-C, after the first a lot of coaching was done." e coaching for NA-C was here was no improvement documentation of education				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		00374	B. WING		07	7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		TH ELM STREET MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 61	22000			
	 2000 Continued From page 61 During an interview on 07/23/15, at 5:14 p.m., the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?" During an interview on 07/24/15 5:14 a.m., NA-E stated, "I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated, one of the resident mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights. 					
	stated she works par LPN-H stated she ha NA-C is rough with th witnessed it directly. aware that she is to r night shift when she she had heard R12 h slapped her and also on the North wing an because of the cat no care of any certain re aides on the night sh prefer to work on eac					
		OWN ORIGIN e Adult Policy, revised 7/15, nown Origin as "source of				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
00374		B. WING				
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		07	/23/2015
			RTH ELM STREET	, 211 000E		
	CS HEALTH SYSTEM	ONAMIA	A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 62	22000			
	the injury was not ob- suspicious." The pol definition to include c interpretive guidance	icy did not expound on this riteria from the CMS				
v c a a	was moderately, cog dated 3/30/15, indica assist with all activitie a mechanical stand for	dated 3/9/15, indicated she nitively impaired. The CP, ted R39 required extensive es of daily living (ADLs), used or transfers, and was buse, because of dementia.				
	had a large, dark pur portion of her buttock injury, and R39 was ' bruising occurred. Th "a few days ago had not standing when tra Hoyer (a mechanical SSRIF further indicat	he SSIRF also indicated R39 been lowered to floor due to ansferring & then lifted with lift) Possible cause." The red R39 used a medication				
	chart contained "falls that could likely have SSIRF indicated R39 reported to the state investigation was con though there was no	uising, and also that R39's or other recent incidents produced the injury." The 's injury was "minor" and not agency. No further mpleted for this incident even indication R39 had struck or as she was lowered to the				
	DON stated, when R floor "it would be hard during that event." T	on 7/24/15, at 12:54 p.m., the 39 had been lowered to the d to know if injury occurred the DON said R39 bruised anticoagulant medication, so vas "not considered				
	reportable."	oderately impaired and				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
00374		B. WING			//23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	07	123/2015
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
22000	was no evidence that investigation was cor	the bruise occurred, there t a more in-depth npleted to determine the s R39's injury of unknown	22000			
	she was moderately, CP, dated 6/3/15, inc	ist for all ADLs, and was at				
	had a bruise to the to purple in color, and n SSIRF indicated R11 injury occurred, but F medication, and R11	ated 10/21/15, indicated R39 op of her right hand, dark neasured 8 cm x 8 cm. The was unable to state how the R11 used anticoagulant 's bruise was described as idministrator was notified but to the state agency.				
	had bruising noted to her left eyebrow. The unable to state the ca	ed 11/4/14, indicated R11 her left temple and above e SSIRF indicated R11 was ause of the injury. The was notified, but the injury he state agency.				
	a bruise of unknown dark purple in color, a inches. The SSIRF ir "unknown", that R11 cause of the injury, u indicated the injury w	12/18/14, indicated R11 had origin to her left inner knee, and measuring 1 x 1 3/4 ndicated the injury was was unable to report the sed anticoagulants; and also vas considered to be "minor." ator was notified, but the ed to the state agency.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00374		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		B. WING				
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		07	//23/2015
			RTH ELM STREET	, 0002		
MILLE LA	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 64	22000			
	unknown origin on 7/ stated, R11 "had mor have ever known." TH R11's hand "may hav trimming of [R11's] na the bruise herself. Re R11's temple and for nursing felt the bruisi [R11's] nebulizer mas stated, she interviewe she slipped and fell of SW further stated R1 Hoyer lift [a mechanic there were no record bruising was "likely d nebulizer mask." No completed for this inji During an interview of DON stated R11 "cou reporting nurse asked	bout the three injuries of 24/15, at 12:54 p.m., the SW re bruising than anyone I he SW said the bruise on re been caused by recent ails," indicating R11 caused egarding the bruise noted to ehead, the SW stated that ng "was due to placement of sk," however, the SW ed R11 who reported that in her way back from supper. 1 did not ambulate, used a cal lift] for transferring, and s of any falls. SW added the ue to placement of [R11's] further investigation was ury. on 7/24/15, at 12:54 p.m., the uld reliably answer" when the d if bruising was related to DON felt the injury was not				
	Although R11 was ide cognitively impaired, different locations, th investigation complet causes of R11's bruis was notified of the inj incidents were submi R66's quarterly MDS was moderately, cog dated 2/9/15, indicate	entified to be moderately and had multiple bruises at ere was no indepth red to determine the actual ses. The facility administrator uries but none of these tted to the state agency.				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	07	123/2015
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page risk for delirium and p depression. A review of SSIRF da a review of R66's nur 1/26/2015, there was bruises" on [R66] bot identified as bruising The SSIRF also indic sleeve/arm protectors was an "unknown inju- state the cause, and to be "minor." The in- facility administrator, the state agency. During an interview of SW stated, the bruise was reviewing R66's said she "spoke with bruising was assessed therefore not reportal During an interview of DON said R66 used and R66 did not alwa occasionally "flailing stated R66 was confu "hard to say if R66 w talk about how the br time had passed."	e 65 botential abuse, related to ated 2/3/15, indicated during rsing progress note dated s "presence of unknown th arms, the size was "from hands to shoulder." cated R66 now wore s. The SSIRF indicated this ury", that R66 was unable to that the injury was assessed jury was reported to the but was not not reported to on 7/24/15, at 12:54 p.m., the es were noted while the DON progress notes. The SW nursing" and determined the ed "to be a minor injury, and ble to the state agency." on 7/24/15, at 12:54 p.m., the a Hoyer lift (mechanical lift), ays cooperate in lift, her arms." The DON further used, and that it would be ould have been able to to ruising occurred after any	22000			
	unwitnessed and the identify what happen immediately reported agency nor was a the	resident was unable to ed. The facility had not I the incident to the state prough investigation ine if R66 was "flailing her				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00374			(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	, ZIP CODE	1	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 66	22000			
	was severely cognitiv 7/10/15, indicated R4 with ADLs, and was a short term memory lo decision-making skill A review of SSIRF da had a purple bruise of forearm, measuring 6 found during her bath was an "unknown" in the cause of injury. The geminor". The facili	•				
	SW stated, "The injur nursing staff to be 'm suspicious criteria. T a need to report" to th					
	DON stated, "[R44] v	24/15, at 12:54 p.m., the vould have been able to tell pened, she could make her				
	cognitively impaired, origin, on the posterio indication the facility investigation to deter	s assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her ent was not reported to the				

	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
20074						
		00374	B. WING		07	//23/2015
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 67	22000			
	her to be severely co requiring assist of two living. CP dated 5/15 extensive assist for a	um data set (MDS) identified gnitively impaired and o staff for activities of daily /15 indicated R8 required ictivities of daily living and related to diagnosis of				
	had a bruise measuri her thumb and forefir thumb to her wrist. Th initial evaluation and resulted from R8 wrir	ated 8/18/14, indicated R8 ing 8.5cm in length between nger from the base of her he reporting nurse did the determined the bruising nging her hands, and the s was witnessed by staff.				
	SW stated, the injury staff witness of the po- investigation of the in facility administrator a report was not mad Social Services Incide	on 7/24/15, at 12:54 p.m., was not reportable due to otential cause. No further njury was completed. The was notified of the injury but le to the state agency. A ent Referral form was ury but was not received.				
	and had a bruise 8.5c forefinger from the ba There was no indicat thorough investigation	ere cognitive impairment, cm between her thumb and ase of her thumb to her wrist. ion the facility completed an n to determine the source of cident was not reported to				
	SW stated, when ma	on 7/24/15, at 12:54 p.m., king a determination of ort an injury to the state o statutes, and uses a				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	//23/2015
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 68	22000			
	looks at whether a re- injury, or if someone a history of other reco SW further stated, "If- injury or injury not su location, it does not r During an interview of DON said, minor inju state agency. She fur criteria or policy" the determine whether an "major." The DON all the nurses judgemen injury was minor or r charge "followed up of she stated there was	n 7/24/15, at 12:54 p.m., the ries are not reportable to the rther stated, there was "no facility has to identify and n injury was "minor" versus so stated she "would use t" when determining if an hajor, and that the RN in on the injuries." However, no charting on the clinical ow evidence that follow-up				
	7/15, indicated as its who are vulnerable to policy included: "To everything within its of occurrence of abuse attempt to obtain info employers and or/cur NA-A's personnel re hired on 7/13/15. The	Prevention Policy, revised purpose "to protect adults o abuse" Further, the assure the facility was doing control to prevent the or neglectthe facility would irmation from previous				
	hired on 6/30/15. The	cord identified they were e personnel record lacked hecks were completed prior				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	00374		B. WING		07/23/2015	
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 0/	123/2013
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 69	22000			
	they were hired on 6/ lacked evidence refe completed prior to en Registered nurse (RM identified they were h personnel record lack checks were complet the facility. On 7/23/15, at 8:45 a staff stated four of the did not have docume HR stated there was that reference checks facility used the appli about the position he rehire and any feedb SUGGESTED METH The Administrator an and inservice facility to abuse and neglect	N)-B's personnel record nired on 5/11/15. The ked evidence reference ted prior to employment at n.m. human resources (HR) e five newly hired employees ntation of reference checks. "not a process" to document s had been completed. They cation references "to inquire Id, date of hire, eligibility for ack."				



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Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/y From F1: 07/20/15 To F2: 07/23/15	Extended Survey Da From F3: 07/24/15 T	te Format: mm/dd/yy o F4: 07/27/15					
Name of Facility: MILLE LACS HEALTH SYSTEM	Provider Number: 245127	Fiscal Year ending:					
Address: 200 NORTH ELM STREET, ONAM	A, MILLE LACS, MN 56359						
Telephone Number: F6 320-532-2585	State/County Code: MN / MILLE LACS	State/Region Code: MN / 05					
 A. F9 03 - SNF/NF - Medicare/Medica B. Is this facility hospital based? F10 Y If yes, indicate Hopsital Provider Nu 	S						
Ownership: F12 05 - Non Profit - Non	rofit Corporation						
Owned or leased by Multi-Facility Organization: F13 No Name of Multi-Facility Organization: F14							
Dedicated Special Care Units (show nu	ber of beds for all that apply)						
AIDS F15 0 Dialysis F17 0 Head Trama F19 0 Huntington's Disease F21 0 Other Spec Rehab. F23 0	Alzheimer's Disease F16 0 Disabled Child Young Adult F18 0 Hospice F20 0 Ventilator/Respiratory Care F22 0						
Does the facility currently have an orga	ized resident group? F24	Yes					
Does the facility currently have an orga residents? F25	Yes						
Does the facility conduct experimental	No						

Is the facility part of a continuing care retirement community (CCRC)? F27 **No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

The following three questions are to be completed by the survey team							
Does the facility currently have an approved nurse competency program? F32	Yes						
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30 NA	Hours waived per week: F31 NA					
Waiver of seven day RN requirement.	Date: mm/dd/yy F28 NA	Hours waived per week: F29 NA					

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?

No - Not Staggered Surveyor to Complete Surveyor to complete AM

2) If staggered, day of the week starting?

3) If staggered, starting time?

FACILITY STAFFING					
		A B		С	D
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		160	20	0
Physician Services	F34	Yes No Yes			
Medical Director	F35		0	8	0
Other Physician	F36		80	0	0
Physician Extender	F37	No No Yes	0	0	0
Nursing Services	F38	Yes No No			
RN Director of Nursing	F39		80	0	0
Nurses with Admin Duties	F40		160	40	0
Registered Nurses	F41		0	144	0
Licensed Practical/ Vocational Nurses	F42		80	480	8
Certified Nurse Aides	F43		480	1,168	0
Nurse Aides in Training	F44		0	0	0

Medication	F45		0	96	0
Pharmacists	F46	Yes No No	0	0	8
Dietary Services	F47	Yes No No			
Dietitian	F48		0	40	0
Food Service Workers	F49		320	120	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes No Yes	0	24	0
Occupational Therapy Assistant	F52		0	16	0
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes No Yes	0	40	0
Physical Therapy Assist	F55		0	0	0
Physical Therapy Aides	F56		0	20	0
Speech/Language	F57	Yes No Yes	0	8	0
Therapeutic Recreation Spec.	F58	No No No	0	0	0
Qualified Activities Prof.	F59	Yes No No	80	0	0
Other Activities Staff	F60	Yes No No	80	182	0
Qualified Social Workers	F61	Yes No No	80	0	0
Other Social Services Staff	F62	No No No	0	0	0
Dentists	F63	Yes No No	0	0	0
Podiatrists	F64	Yes No No	0	0	0
Mental Health Services	F65	Yes No Yes	0	0	0
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	Yes No Yes			
Diagnostic X-ray Services	F68	No No Yes			
Administration Storage of Blood	F69	No No Yes			

Housekeeping Services	F70 Yes No No	204	360	0
Other	F71	160	64	0
Name of Person Completing Form: Kathleen Smude, RN DON			Date: 07/28/15	

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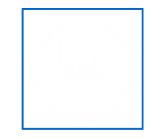
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Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-671 form for data entry?	<u>Go to CMS-671</u>
I'm finished and would like to exit the application.	Exit

MILLE LACS HEA	LTH SYSTEM			
Provider No. 245127	Medicare F75 2	27	Other F77 21	Total Residents F78 50

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 0	F80 43	F81 7
Dressing	F82 1	F83 40	F84 9
Transferring	F85 7	F86 37	F87 6
Toilet Use	F88 3	F89 41	F90 6
Eating	F91 26	F92 21	F93 3

A. Bowel/Bladder Status	B. Mobility
F94 2 With indwelling or external catheter.	F100 1 Bedfast all or most of time
F95 Of total number of residents with catheters, 2 were present on admission.	F101 37 In chair all or most of time.
F96 28 Occasionally or frequently incontinent of bladder.	F102 1 Independently ambulatory.
F97 23 Occasionally or frequently incontinent of bowel.	F103 26 Ambulation with assistance or assistive device.
F98 0 On individually written bladder training program.	F104 0 Physically restrained.

F99 0 On individually written bowel training program.	F105 Of total number of residents with restrained, 0 were admitted with orders for restraints.
	F106 1 With contractures.
	F107 Of total number of residents with contractures, 0 had contractures on admission.
C. Mental Status	D. Skin Integrity
F108 0 With mental retardation.	F115 2 With pressure sores (exclude stage I).
F109 0 With documentation signs and symptoms of depression.	F116 1 Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?
F110 0 With documentation psychiatric diagnosis (excluding dementias and depression).	F117 35 Receiving preventive skin care.
F111 0 Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.	F118 0 With rashes.
F112 0 With behavioral symptoms.	
F113 0 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.	
F114 0 Receiving health rehabilitative services for MI/MR.	
E. Special Care	
F119 0 Receiving hospice care benefit.	F127 0 Receiving suction.
F120 0 Receiving radiation therapy.	F128 5 Receiving injections (exclude vitamin B12 injections)
F121 0 Receiving chemotherapy.	F129 0 Receiving tube feedings.
F122 0 Receiving dialysis.	F130 9 Receiving mechanically altered diets including pureed and all chopped food (not only meat).
F123 0 Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.	F131 5 Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).
F124 7 Receiving respiratory treatment.	F132 4 Assistive devices while eating.

F. Medication	G. Other
F133 21 Receiving any psychoactive medication.	F140 2 With unplanned significant weight loss/gain.
F134 3 Receiving antipsychotic medications.	F141 0 Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 2 Receiving antianxiety medications.	F142 0 Who use non-oral communication devices.
F136 16 Receiving antidepressant medications.	F143 29 With advance directives.
F137 1 Receiving hypnotic medication.	F144 46 Received influenza immunization.
F138 1 Receiving antibiotics.	F145 45 Received pneumococcal vaccine.
F139 33 On pain management program.	

I certify that this Information is accurate to the best of my knowledge.			
Name of Person Completing Title Date			
Kathleen Smude	RN., DON 07/28/2015		

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? Yes
F147 Was ombudsman present during any portion of the survey? Yes
F148 Medication error rate 0%

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SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245127	MILLE LACS HEALTH SYSTEM
Type of Survey (select all that ap	pply): A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanction/Hearing C Federal Monitoring G Validation K State License
	D Follow-up Visit H Life safety Code L Chow
Extent of Survey (Select all that	apply):
	A Routine/Standard (all providers/suppliers)
В	B Extended Survey (HHA or long term care facility)
	C Partial Extended Survey (HHA)

D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

			_		-				
Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (Hours (H)	off-Site Report Preparation Hours (I)	
1. 20794	07-27-2015	07-27-2015	0.00	0.00	7.00	0.00	2.00	2.00	
2. 28598	07-27-2015	07-27-2015	0.25	0.00	6.00	0.00	2.00	24.00	
³ . 29625	07-20-2015	07-23-2015	0.50	1.25	24.75	2.25	5.00	2.50	
4. Team Leader 32613	07-20-2015	07-27-2015	1.00	4.25	42.50	2.50	4.00	37.25	-
5. 34987	07-20-2015	07-21-2015	0.25	0.00	11.75	2.25	2.00	0.00	
6. 35569	07-20-2015	07-27-2015	0.00	4.25	36.00	9.00	4.00	29.25	_
7. 35992	07-20-2015	07-24-2015	0.00	4.25	36.50	2.50	2.00	0.00	-
8.									
9.									
10.									-

Total Supervisory Review Hours	12.50
Total Clerical/Data Entry Hours	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey? \ldots	Y

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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P	rović	ler/Su	pplie	er Numl	ber		-	Provider/Supplier Name		
		245	127					MILLE LACS HEALTH SYSTEM		
Тур	e of	Surve	y (se	lect a	all th	at ap	ply):	A Complaint Investigation	E Initial Certification	I Recertification
	н	ĸ	I					B Dumping Investigation	F Inspection of Care	J Sanction/Hearing
			-					C Federal Monitoring	G Validation	K State License
								D Follow-up Visit	H Life safety Code	L Chow
Ext	ent o	f Sur	vey (Select	all	that	apply):			
								A Routine/Standard (all pr	oviders/suppliers)	
	A							B Extended Survey (HHA or	long term care facility)	
ı	I	1	1	1	1			C Partial Extended Survey	(HHA)	

D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

1.									
Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (Hours (H)	off-Site Report Preparation Hours (I)	
Team Leader 1. 03005	07-22-2015	07-22-2015	1.00	0.00	3.00	0.00	4.00	1.00	
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									-

Total Supervisory Review Hours	0.50
Total Clerical/Data Entry Hours	0.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	

FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUM	BER	FACILITY	NAME					SURVEY DATE
K1 245127	,	MILLE	LACS HEALTH SYST	TEM				*K4 07/22/2015
K6 DATE O APPROV		1	X3 : MULTIPLE CONSTRU ΓΟΤΑL NUMBER OF BUILD NUMBER OF THIS BUILDIN	INGS	101		А	A BUILDING B WING C FLOOR D APARTMENT UNIT
LSC FORM IND	ICATOR				COMPLETE	IF ICF/MR IS SU	RVEYED UNDER (CHAPTER 21
	Н	ealth Care	Form	ן ר	SMALL		(16 BEDS OR	LESS)
12	2786 R		2000 EXISTING				1 PROMPT	
12	2786 R		2000 EHISTING		K8:		2 SLOW	
15	2780 K		2000 IVE W				3 IMPRACTI	CAL
	-	ASC For	m	4				
14	2786 U		2000 EXISTING		LARGE		4 PROMPT	
15	2786 U		2000 NEW				5 SLOW	
		CF/MR Fo		ר I	K8:		6 IMPRACTI	CAL
16	2786 V, W, X		2000 EXISTING					
17	2786 V, W, X		2000 EABTING	-	APARTME	NT HOUSE		
	229 or K56 are m		D FROM ABOVE		K8:		7 PROMPT 8 SLOW 9 IMPRACT	ICAL
	T, U, V, W, X, Y				ENTER E-S	SCORE HERE		
K29:		K56:			K5:		e.g 2.5	
*K9 : FACILIT	Y MEETS LSC BA	ASED ON: (Check all that apply)					
A1 (COMP. ALL PROV			A2	A3 (WAI	VERS)	A4 (F:	SES)	A5 (PERFORMANCE BASED DESIGN)
FACILITY DO	ES NOT MEET LS	C:		X SPRINKLERI I areas are sprir			SPRINKLERED reas are sprinklered)	C. NONE (No sprinkler system)

*MANDATORY

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

Project No: F5127023

2000 CODE Form Approved OMB No 0938-0242

	PORT 2000 CODE - HEALTH CA are – Medicaid	ARE 1. (A) PROVIDER NUMBER 1. (B) ME 245127	EDICAID I.D. NO.
*		y Code, New and Existing Recommendation Form	
Identifying information as shown in applic	cable records. Enter changes, if any, al	ongside each item, giving date of change.	
2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, 2	ZIP CODE) A Fully Sprinklered
Mille Lacs Hospital and Home C & NC	A. BUILDING <u>X</u> B. WING C. FLOOR	200 Elm St. Onamia, MN 56359	(All required areas are sprinklered) BOPartially Sprinklered (Not all required areas are sprinklered) CONONE (No sprinkler system)
3. SURVEY FOR	4. DATE OF SURVEY 7-22-2015	DATE OF PLAN APPROVAL SURVEY UNDER 5. 2000 EXISTING K6	G 6. 2000 NEW
5. SURVEY FOR CERTIFICATION OF 10HOSPITAL 2. 3KILLED/NU	RSING FACILITY 4.OICF/MR UN	NDER HEALTH CARE 5. OIOSPICE	
IF "2" OR "5" ABOVE IS MARKED, CHECK APPR 1 ENTIRE FACILITY 2 DISTINCT P/	OPRIATE ITEM(S) BELOW ART OF (SPECIFY)	3. JIF DISTINCT PART OF HOSPITA JCAHO/AOA? a. O'ES	IL, IS HOSPITAL ACCREDITED BY
	C. NUMBER OF SKILLED	D BEDS 57 d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 57	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID 0
7. A THE FACILITY MEETS, BASED UPON (1 COMPLIANCE WITH ALL PROVISI B THE FACILITY DOES NOT MEET THE S	ONS 2. OCCEPTANCE OF A PLAN OF COP		S 5 SPERFORMANCE BASED DESIGN
SURVEYOR (Signature)	TITLE	OFFICE	DATE
SURVEYOR ID Jeff Juntunen C 65	Deputy State Fire Marshal	State Fire Marshal	07/22/2015
FIRE AUTHORITY OFFICIAL (Signature)	TITLE	OFFICE	DATE
TS	Fire Safety Superviso	or State Fire Marshal	7-24-15

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

ID PREFIX	<			MET	NOT MET	N/A	REMARKS
		PART I - LSC REQUIREMENTS - Ite	ems in italics relate to the FSES				
		BUILDING CON	STRUCTION				
(11	the or resist addi shall	e building has a common wall w common wall is a fire barrier ha stance rating constructed of ma ition. Communicating openings I be protected by approved self 1.1.4.1, 18.1.1.4.2, 19.1.1.4.1, 1	aving at least a two hour fire aterials as required for the occur only in corridors and f-closing fire doors.				
2	2000	0 EXISTING					
		ding construction type and heig .6.2, 19.1.6.3, 19.1.6.4, 19.3.5					
	1	I (443), I (332), II (222)	Any Height				
	2	II (111)	One story only (non-sprinklered).				
	3	II (111)	Not over three stories with complete automatic sprinkler system.				
	4	III (211)					
	5	V (111)	Not over two stories with				
	6	IV (2HH)	complete automatic sprinkler system.				
	7	II (000)					
	8	III (200)	Not over one story with				
	9	V (000)	complete automatic sprinkler system.				
	Give of st loca	Building contains fire treated wo a brief description, in REMARKS tories, including basements, floor ttion of smoke or fire barriers ar tch or attach small floor plan of	<i>S,</i> of the construction, the number rs on which patients are located, nd dates of approval. Complete				

ID				МЕТ	NOT	N/A	REMARKS
PREFIX K12	200	00 NEW			MET		
	Bui	ilding construction type and height .1.6.2, 18.1.6.3, 18.2.5.1	meets one of the following:				
	1	I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2	II (111)	Not over three stories with complete automatic sprinkler system				
	3	III (211)					
	4	V (111)	Not over one story with complete automatic sprinkler system.				
	5	IV (2HH)					
	6	II (000)					
	7	III (200)	Net Deveritted				
	8	V (000)	- Not Permitted				
	Giv nui are api	Building contains fire treated wood we a brief description, in REMARKS mber of stories, including basemer be located, location of smoke or fire proval. Complete sketch or attach s ilding as appropriate.	S, of the construction, the nts, floors on which patients barriers and dates of				
K103	cor	erior walls and partitions in building nstruction shall be noncombustible aterials. 18.1.6.3, 19.1.6.3	gs of Type I or Type II or limited-combustible				
	trea	dicate N/A for existing buildings us ated wood studs within non-load bo rtitions.)	ing listed fire retardant earing one-hour rated				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	INTERIOR FINISH				
K14	2000 EXISTING				
	Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2				
	Indicate flame spread rating/s				
	2000 NEW				
	Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower portion of corridor walls can be Class C. 18.3.3.1, 18.3.3.2				
	Indicate flame spread rating/s				
(15	2000 EXISTING				
	Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2				
	Indicate flame spread rating/s				
	2000 NEW				
	Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2.				
	Indicate flame spread rating/s				

		1	1	,	
ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 18.3.3.3, 19.3.3.3 (Indicate N/A for existing interior floor finish.)				
	In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.				
	CORRIDOR WALLS AND DOORS				
K17	2000 EXISTING				
	Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5				
	If the walls have a fire resistance rating, give rating if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.				
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5				

ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 ³ / ₄ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 New				
	Doors protecting corridor openings shall be constructed to resist the passage of smoke. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5, 18.3.6.3.1, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4				
	VERTICAL OPENINGS				
K20	2000 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6, 19.3.1.1				

ID PREFI)	<	MET	NOT MET	N/A	REMARKS
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. \Box				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and sprinklered buildings up to three stories in height.) 18.3.1.1. An atrium may be used in accordance with 8.2.2.3.5.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure shall be permitted to be held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:				
	\Box (a) The required manual fire alarm system and				
	(b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and				
	\Box (c) The automatic sprinkler system, if installed				
	18.2.2.2.6, 19.2.2.2.6, 7.2.1.8.2				
	Describe method used in REMARKS				
<33	2000 EXISTING				
	Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1				

			NOT	
ID PREFIX		MET	NOT MET	N/A
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.			
	If enclosures are less than required, give a brief description and specific location in REMARKS.			
	2000 NEW			
	Exit components (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 8.2.5.4, 18.3.1.1			
	If enclosures are less than required, give a brief description and specific location in REMARKS.			
	SMOKE COMPARTMENTATION AND CONTROL			
K23	2000 EXISTING			
	Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2			
	2000 NEW			
	Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2			
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1			
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.			

ID		MET	NOT MET	N/A	REMARKS
REFIX K25	2000 EXISTING Smoke barriers shall be constructed to provide at least a one- half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments shall be provided on each floor. Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4		MEI		
	2000 NEW Smoke barriers shall be constructed to provide at least a one- hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments shall be provided on each floor. Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3				
K26	Space shall be provided on each side of smoke barriers to adequately accommodate those occupants served. 18.3.7.4, 19.3.7.4				
K27	2000 EXISTING Door openings in smoke barriers have at least a 20 minute fire protection rating or are at least 1 ³ / ₄ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7				
	2000 NEW Door openings in smoke barriers have at least a 20 minute fire protection rating or are at least 1 ³ / ₄ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				

ID PREFI>	< li>			MET	NOT MFT	N/A	REM
K28	2000 EXISTING						
	Door openings in smoke width of 32 inches (81 cr Vision panels are of fire- steel frames. 19.3.7.5, 1	m) for swinging or rated glazing or	or horizontal doors.				
	2000 NEW						
	Door openings in smoke horizontal doors shall pre						
	Provider Type	Swinging Doors	Horizontal Sliding Doors				
	Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)				
	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
	Vision panels of fire-rate frames are provided for						
K104	Penetrations of smoke b accordance with 8.3.6.	parriers by ducts	are protected in				
	Describe any mechanica	al smoke control	system in REMARKS.				
		HAZARDOUS	AREA			•	
K29	2000 EXISTING						
	One hour fire rated cons an approved automatic f with 8.4.1 and/or 19.3.5. approved automatic fire areas shall be separated partitions and doors. Doo field-applied protective p the bottom of the door a	ire extinguishing 4 protects hazar extinguishing sy d from other spa- ors shall be self- plates that do not	system in accordance dous areas. When the stem option is used, the ces by smoke resisting closing and non-rated o exceed 48 inches from				
	Area a. Boiler and Fuel-Fired Heater Roor c. Laundries (greater than 100 sq feet d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe I f. Combustible Storage Rooms/Space	ns t) Hazard - see K31)	atic Sprinkler Separation N/A				

					NGT		
ID PREFIX				MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in a areas shall be enclosed with a one ³ / ₄ hour fire-rated door, without wind Doors shall be self-closing or autom with 7.2.1.8. 18.3.2.1	hour fire-rated ows (in accord	barrier, with a lance with 8.4).				
	Area a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair, Maintenance and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms m.Combustible Storage Rooms/Spaces (over 100 sq feet) Describe the floor and zone location						
K30	are deficient in REMARKS. Gift shops shall be protected as has storage or display of combustibles i hazardous. Non-rated walls may se	zardous areas n quantities co	when used for insidered				-
	considered hazardous, have separa are completely sprinkled. Gift shops if they are not considered hazardou storage, are completely sprinklered square ^o feet. 18.3.2.5, 19.3.2.5	ate protected s s may be open s, have separa	torage and that to the corridor ate protected				
	Area L. Gift Shop storing hazardous quantities of combustibles	Automatic Sprinkler	Separation N/A				
K211	 2000 EXISTING Where Alcohol Based Hand Rub (A installed: The corridor is at least 6 feet wide The maximum individual fluid disponent in the dispensers shall have a minine each other Not more than 10 gallons are used compartment outside a storage carbon compartment outside a storage carbon compartment is carpeted, the building CFR 403.744, 418.100, 460.72, 48 	e benser capacity mum spacing o ed in a single s abinet. or adjacent to g is fully sprinl	y shall be of 4 ft from moke an ignition klered. 19.3.2.7,				

			1		I
ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	 2000 NEW Where Alcohol Based Hand Rub (ABHR) dispensers are installed: The corridor is at least 6 feet wide The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) The dispensers shall have a minimum spacing of 4 ft from each other Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. Dispensers are not installed over or adjacent to an ignition source. If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 				
	EXIT AND EXIT ACCESS				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2				
	EXITS AND EGRESS				
K34	Stairways and smokeproof towers used as exits are in accordance with 7.2. 18.2.2.4, 19.2.2.3, 19.2.2.4				
K35	Capacity of exits in number of persons per unit of exit width is in accordance with 7.3. 18.2.3.1, 19.2.3.1				
K36	Travel distance (exit access) to exits are in accordance with 7.6. 18.2.6, 19.2.6				
K37	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10				

ID		мет	NOT	N/A
PREFIX	2000 NEW		MET	
	Every exit and exit access shall be arranged so that no			
	corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10			
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1			
K39	2000 EXISTING			
	Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3			
	2000 NEW			
	Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4			
K40	2000 EXISTING			
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5			
	2000 NEW			
	Exit access doors and exit doors used by health care occupants are of the swinging type, with openings of at least 41.5 inches wide. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In ICFs/MR, doors are at least 32 inches wide. 18.2.3.5			
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1, 18.2.5.9, 19.2.5.9			
	If doors lead directly to grade from each room, check this box. \Box			
K42	Any room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2			

ID PREFIX		MET	NOT MET	N/A
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key.			
	Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5			
	If door locking arrangement without delay egress is used indicate in REMARKS			
	18.2.2.2.2, 19.2.2.2.2			
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5			
	ILLUMINATION AND EMERGENCY POWER		1	
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. 18.2.8, 19.2.8, 7.8			
K46	Emergency lighting of at least 1 ¹ / ₂ hour duration is provided in accordance with 7.9. 18.2.9.1, 19.2.9.1.			
K47	2000 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 buildings with less than 30 occupants where the line of exit travel is obvious.)			
	2000 NEW			
	Exit and directional signs are displayed with continuous illumination also served by the emergency lighting, system in accordance with 7.10. 18.2.10.1			

ID			NOT		
PREFIX		MET	MET	N/A	REMARKS
(105	2000 NEW (INDICATE N/A FOR EXISTING)				
	Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2, 18.5.1.1, 18.5.1.2				
	(Indicate N/A if life support equipment is for emergency purposes only).				
(107	2000 NEW (INDICATE N/A FOR EXISTING)				
	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1, 18.3.4.1.3				
(108	2000 NEW (INDICATE N/A FOR EXISTING)				
	Alarms, emergency communication systems, and illumination of generator set locations are in accordance with NFPA 70. 9.1.2				
	EMERGENCY PLAN AND FIRE DRILLS				
(48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1				
(50	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2				

			NOT		
ID PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	2000 EXISTING				
	A fire alarm system with approved component, devices or equipment installed according to NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system shall be by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas, may be omitted provided that manual pull stations are within 200 ft of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests shall be available. A reliable second source of power must be provided. Fire alarm systems shall be in accordance with NFPA72, and records of maintenance kept readily available. There shall be annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6				
	2000 NEW				
	A fire alarm system with approved component, devices or equipment installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system shall be by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests shall be available. A reliable second source of power must be provided. Fire alarm systems shall be maintained in accordance with NFPA72, and records of maintenance kept readily available. There shall be remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6				
K52	A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4				
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8				

2000 CODE

ID PREFIX		MET	NOT MET	N/A	REMARKS
53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES)				
	In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70				
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES)				
	An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
(109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES)				
	An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1				
	Smoke Detection System Corridors Rooms Bath				
(54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3				
	Give a brief description, in REMARKS of any smoke detection system which may be installed.				

	MET	NOT MET	N/A	REMARKS
2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8				
2000 NEW				
Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
AUTOMATIC SPRINKLER SYSTEMS				
2000 EXISTING				
Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. 19.3.5, NPFA 13				
2000 NEW				
There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. 18.3.5.				
	Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8 AUTOMATIC SPRINKLER SYSTEMS 2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. 19.3.5, NPFA 13 2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8 2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. 19.3.5, NPFA 13 2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are	METMET2000 EXISTINGEvery patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8Image: Comparison of the state of the	METMETMETMET2000 EXISTINGEvery patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.82000 NEWEvery patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8Image: Comparison of the floor state of the state of

		1	1	1	
ID PREFIX		MET	NOT MET	N/A	REMARKS
K154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.				
	A. Date sprinkler system last checked and necessary maintenance provided.				
	B. Show who provided the service				
	C. Note the source of water supply for the automatic sprinkler system.				
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)				
K60	Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems. 18.3.4.2, 19.3.4.2, 9.6.2.1				
K61	Required automatic sprinkler systems shall have valves supervised so that at least a local alarm will sound when the valves are closed. 9.7.2.1, NFPA 72				
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5				
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13				
K64	Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6				

ID			NOT		
PREFIX		MET	MET	N/A	REMARKS
	SMOKING REGULATIONS	1	1		
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4				
	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.				
	 (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. 				
	□ (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.				
	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2				
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.				
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96				
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).				
	18.7.8, 19.7.8				
		1		1	

			NG-	
ID PREFIX		MET	NOT MET	N/A
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82			
	 (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5. 			
	 (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. 			
	 (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. 			
	 (4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use. 			
K160	2000 EXISTING			
	All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators.</i> 19.5.3, 9.4.3.2			
	ANSI A17.1 states 25 ft or more above or below the designated level and defines "designated level" as the main floor or other floor level that best serves the needs of emergency personnel for fire fighting purposes or rescue purposes identified by the building code or fire authority. Depending on floor slab thickness and heights this would generally apply to a three-story building, and almost certainly to a four-story building.			
	Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors. 19.5.3, 9.4.3.2			

ID		MET	NOT	N/A
PREFIX	2000 EXISTING		MET	
K161	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ ANSI A17.3, <i>Safety Code for</i> <i>Existing Elevators and Escalators.</i> 19.5.3, 9.4.2.2			
	Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.			
	2000 NEW			
	All elevators, escalators, and conveyors comply with ASME/ ANSI A17.1, <i>Safety Code for Elevators and Escalators</i> (Includes car emergency signaling, firefighters service phase I key and smoke detector automatic recall, firefighters service phase II emergency in-car operation, machine room smoke detectors, elevator lobby smoke detectors). 18.5.3, 9.4			
	FURNISHINGS AND DECORATIONS			
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10			
K73	No furnishings or decorations of highly flammable character shall be used. 18.7.5.2, 18.7.5.3, 18.7.5.4, 19.7.5.2, 19.7.5.3, 19.7.5.4			
K74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with provisions of 10.3.1 and NFPA 13 Standard for the Installation of Sprinkler Systems. Except shower curtains shall be in accordance with NFPA 701.			
	 Newly introduced upholstered furniture shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.1. 18.3.5.3 and NFPA 13 Newly introduced mattresses shall meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 			
	Newly introduced upholstered furniture and mattresses means purchased since March, 2003.			

ID PREFIX		MET	NOT MET	N/A
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft ² (20.4 L/m ²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft ² (5.9-m ²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5			
	LABORATORIES			
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) Laboratories in Health Care occupancies and medical and dental offices shall be in accordance with NFPA 99, Standard for Health Care Facilities 10.5.1.			
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with NFPA 99, 10.2.1.3.1, 18.3.2.2., 19.3.2.1			
K131	Emergency procedures shall be established for controlling chemical spills in accordance with NFPA 99. 10.2.1.3.2			
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with NFPA 99. 10.2.1.4.2			
K133	Fume hoods shall be in accordance with NFPA 99. 5.4.3, 5.6.2			
K134	Emergency Shower: Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with NFPA 99, 10.6.			

			NOT		
ID PREFIX		MET	NOT MET	N/A	REMARKS
(135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code NFPA 99, 4.3, 10.7.2.1.				
	MEDICAL GASES AND ANESTHETIZING AREAS				
< 76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.				
	 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99, 4.3.1.1.2, 18.3.2.4, 19.3.2.4 				
<77	Piped in medical gas systems comply with NFPA 99, Chapter 4.				
K78	 Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% NFPA 99 4.3.1.2.3(n) and 5.4.1.1, 18.3.2.3, 19.3.2.3 				
<140	 (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4.3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4.3.1.2.2(b) 3 a, b, c and d and with 4.3.1.2.2(c) 2 and 5 shall be permitted. (4.4.1 exception No. 4). 				
K141	Non-smoking and no smoking signs in areas where oxygen is used or stored shall be in accordance with 18.3.2.4, 19.3.2.4, NFPA 99, 8.6.4.2				
<142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.				

ID		1	NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
K143	Transferring of oxygen shall be: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and				
	(b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and				
	(c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8.6.2.5.2				
	ELECTRICAL				
K106	The hospital and all nursing homes and hospices with life support equipment has a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99, 3.4.2.2, 3.4.2.1.4				
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99, 3.4.4.1, NFPA 110, 8.4.2				
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and shall be in accordance with NFPA 99, 3.4.2.2.2				
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of $1^{1/2}$ hour after loss of the normal source NFPA 99, 3.6.				
K147	Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. 9.1.2				
K130	Miscellaneous				
	List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)		JUSTIFICATION	
84			
rvevor (Signature)	Title	Office	Date
rveyor (Signature)	Title	Office	Date
rveyor (Signature) e Authority Official (Signature)	Title	Office	Date

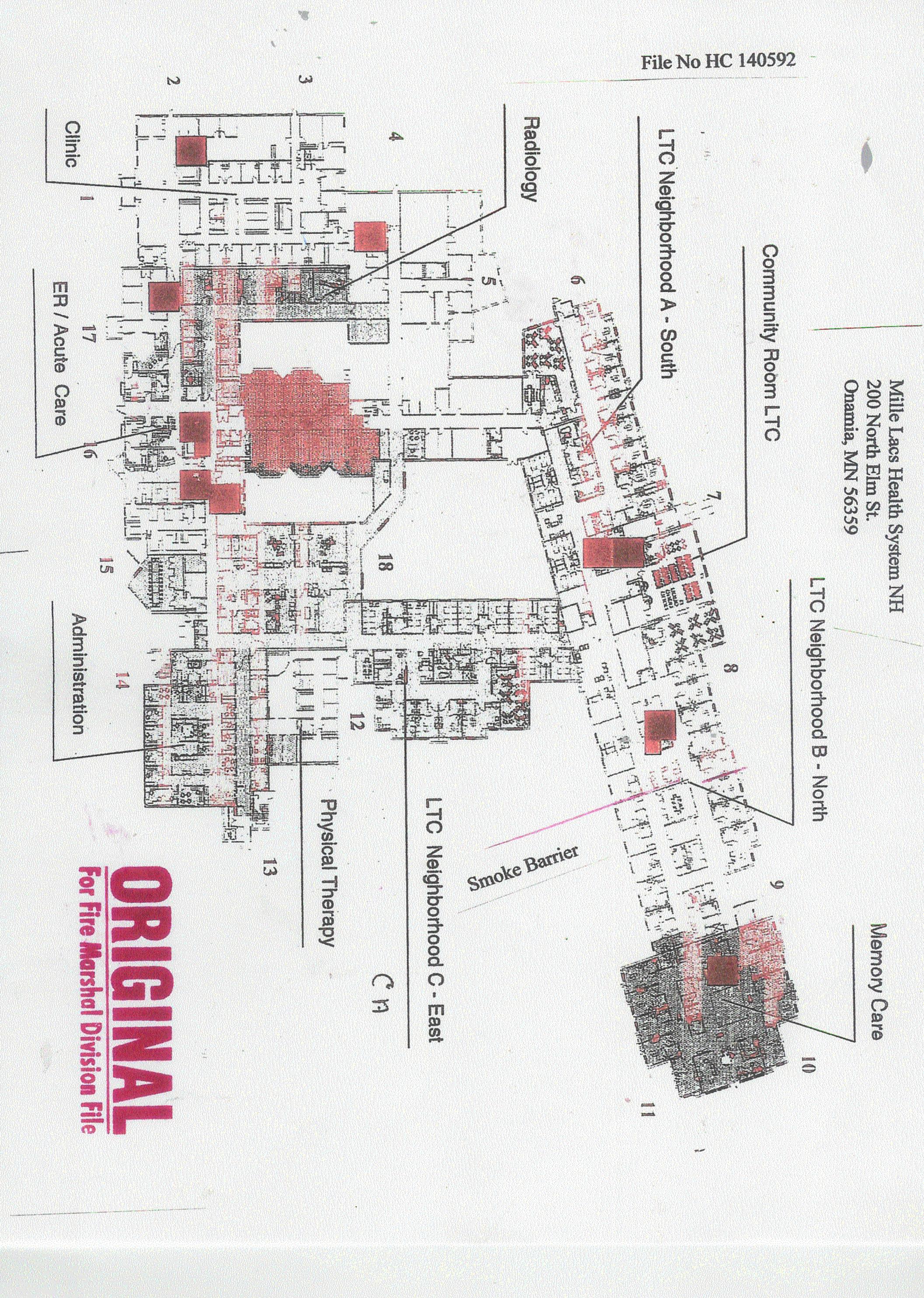
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PROVIDER NUMBER	FACILITY NAME		SURVEY DATE
K1			* K4
	K3 MULTIPLE CONSTRUCTION	NO	A BUILDING
K6 UAIE OF PLAN APPROVAL	TOTAL NUMBER OF BUILDINGS	GS	
	NUMBER OF THIS BUILDING		D APARTMENT UNIT
LSC FORM INDICATOR		ETE IF IO	ED UNDER CHAPTER 21
Health Care Form	are Form	SMALL (16 BEDS OR LESS)	3)
12 2786R 20	2000 EXISTING		
13 2786R 20	2000 NEW		
		LAHGE	
2786U	2000 EXISTING	4 PROMPT	
		K8: 5 SLOW	
ICF/MR Form	3 Form	6 IMPRACTICAL	
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	SELECT NI IMBER OF FORM LISED FROM ABOVE	K8: 8 SLOW	
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(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)	are marked as not applicable U, V, W, X and Y.)	ENTER E – SCORE HERE	
K29:	K56:	K5: e.g. 2.5	
*K9: FACILITY MEETS LSC B	S LSC BASED ON <i>(Check all that apply)</i>		
A1.	A2. A3.	A4.	A5.
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC) ((WAIVERS) (FSES)	(PERFORMANCE BASED DESIGN)
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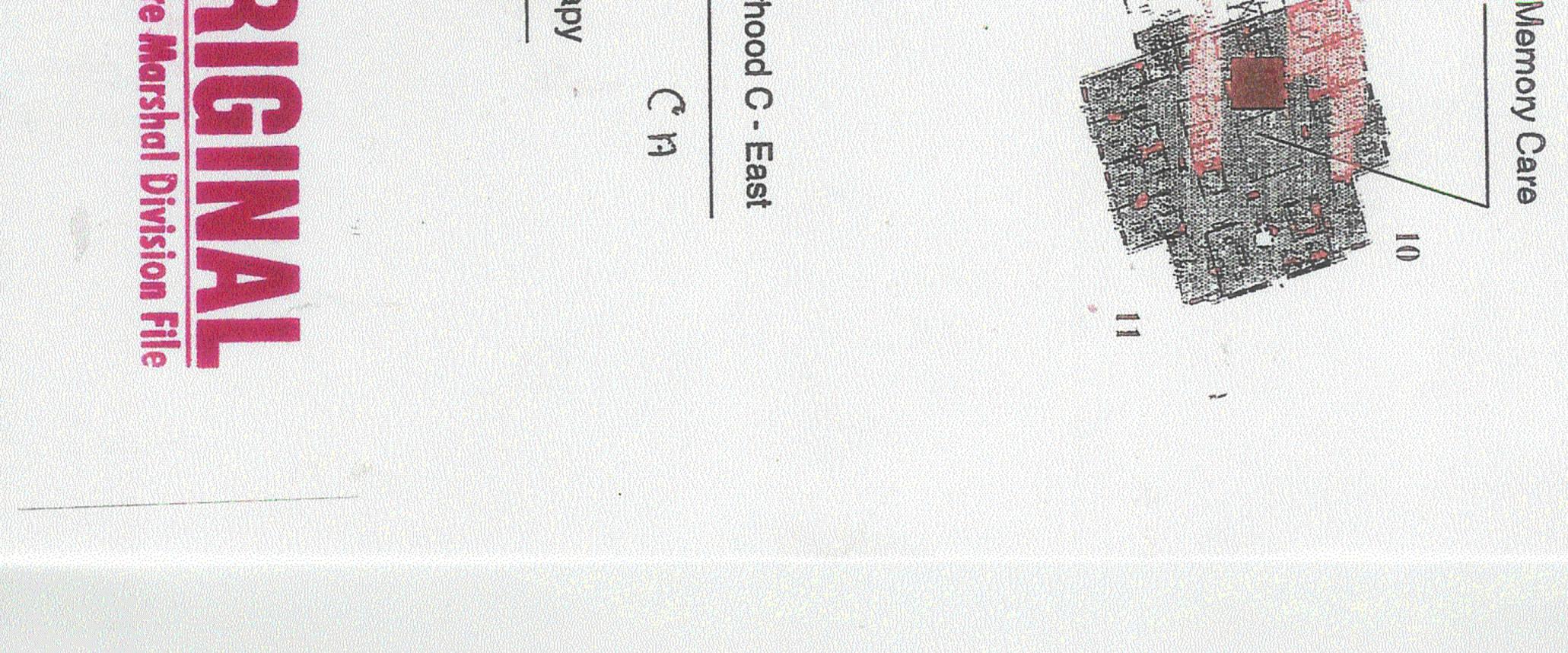
Page 27

PROJEC	T NUMBER:	PROVIDER NAME			SURVEY DATE
Adminis	trator:		Phone Nun	iber:	
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State Fire	e Inspector:		-		
These are by US Ma		findings only. A complete and final S	tatement of Deficiencie	es 2567 report	will be provided
Safe	ety Code app he Medicare/I	s inspection. this facility was found t licable to: SNF/NF Hospital Medicaid programs. re/life safety deficiencies were fou		Facilities parti	
K TAG S& S		Summary of Deficiency(ies)	Revisit		arance
				*** ** *	

Minnesota State Fire Marshal Division-CMS Survey Draft Statement of Deficiencies

Page ____ of ____







September 4, 2015

Ranjita Adhikari, M.D. Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Dr. Ranjita Adhikari,

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of:

Mille Lacs Health System 200 North Elm Street Onamia, MN 56359,

which was completed on July 27, 2015, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

F0226 -- S/S: F -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

Resident Behavior and Facility Practices (§483.13). Regulations in this area grant residents the right to be free from abuse, mistreatment, and unnecessary physical and chemical restraints.

The above facility has prepared a plan to correct the deficiencies which we found during the survey. You can assist by discussing the survey findings with the facility's medical director. Copies of the survey findings which provide detailed information on the violations can be reviewed at the facility or at the address below.

ate Comston ¥

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



September 4, 2015

Roger Boettcher, M.D. Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Dr. Roger Boettcher:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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September 4, 2015

Thomas Bracken, M.D. Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Dr. Thomas Bracken:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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September 4, 2015

Cathy Donovan, M.D. Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Dr. Cathy Donovan:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of:

Mille Lacs Health System 200 North Elm Street Onamia, MN 56359,

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Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



September 4, 2015

Mohan Karki, M.D. Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Dr. Mohan Karki:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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Resident Behavior and Facility Practices (§483.13). Regulations in this area grant residents the right to be free from abuse, mistreatment, and unnecessary physical and chemical restraints.

The above facility has prepared a plan to correct the deficiencies which we found during the survey. You can assist by discussing the survey findings with the facility's medical director. Copies of the survey findings which provide detailed information on the violations can be reviewed at the facility or at the address below.

ate Comston ¥

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



September 4, 2015

Lynne Steiner, M.D. Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Dr. Lynne Steiner:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of:

Mille Lacs Health System 200 North Elm Street Onamia, MN 56359,

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September 4, 2015

David Strobel, M.D. Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Dr. David Strobel:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



September 4, 2015

Arden Virnig, M.D. Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Dr. Arden Virnig:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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If you have any questions, please feel free to contact me.

Vale Compton >

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



September 4, 2015

Patty Hook-Virnig, M.D. Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Dear Dr. Patty Hook-Virnig:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

S5127025

MINNESOTA DEPARTMENT OF HEALTH Division of Health Policy, Information and Compliance Monitoring 85 East Seventh Place, Suite 300, P.O. Box 64900 St. Paul, Minnesota 55164-0900

National Provid One facility m provider type the Nursing H	INISTRATOR: <u>k Kucera@m/he</u> ler Identifier (NPI) Number: <u>1356504</u> hay have multiple NPI Numbers. Please verify the for this survey, i.e. for a nursing home survey, the lome.	864 ne NPI number associated with the he NPI Number will be associated with
OWNERSHIP I	NFORMATION AT THE TIME OF SUF	<u>RVEY</u>
Name of Facility:	MILLE LACS HEALTH SYSTEM	City: <u>ONAMIA</u>
Name of Legal Er	ntity Operating Provider: <u>MILLE LACS HI</u>	EALTH SYSTEM
Name and Addres	ss of Governing Board President:	
Name:	MARK TADYCH	
Address:	PO BOX 81	
City/State/Zip:	GARRISON, MN 56450	
	president of the governing board is different	than what is noted above, please
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Electronically delivered August 10, 2015

Ms. Kim Kucera, Administrator Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

RE: Project Number S5127025

Dear Ms. Kucera:

On July 23, 2015, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate

Mille Lacs Health System August 10, 2015 Page 2

> jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor Minnesota Department of Health Health Regulation Division 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7338 Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 5, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 5, 2015 the following remedy will be imposed:

Mille Lacs Health System August 10, 2015 Page 3

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mille Lacs Health System is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective July 27, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 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 <u>https://dab.efile.hhs.gov</u> 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:

Mille Lacs Health System August 10, 2015 Page 4

Jan.Suzuki@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) 565-9462

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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action

Mille Lacs Health System August 10, 2015 Page 5

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed. Mille Lacs Health System August 10, 2015 Page 6

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division Mille Lacs Health System August 10, 2015 Page 7

> P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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,

Vale Compton

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		CONSTRUCTION		SURVEY PLETED
		245127	B. WING _			07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLEIA	CS HEALTH SYSTEM			20	00 NORTH ELM STREET		
	OUTERENT OTOTEM			0	ONAMIA, MN 56359		
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F 000	INITIAL COMMENTS		FC	000			
F 176 SS=D	as your allegation of of Department's accepta bottom of the first pag be used as verificatio Upon receipt of an acc revisit of your facility of validate that substant regulations has been your verification. An extended survey of Minnesota Departmen 483.10(n) RESIDENT DRUGS IF DEEMED	ance. Your signature at the ge of the CMS-2567 form will n of compliance. Exceptable POC an on-site may be conducted to ial compliance with the attained in accordance with was conducted by the nt of Health on 7/27/2015 SELF-ADMINISTER SAFE a may self-administer drugs if eam, as defined by	F 1	176			
	by: Based on observatio review, the facility fail self-administration of 1 residents (R63) obs of a nebulizer treatme Findings include:	medications (SAM) for 1 of served for self-administration ent.					
	was observed alone i (a drug delivery devic medications in the for	n 7/20/15, at 7:28 p.m. R63 n her room with a nebulizer e used to administer m of a mist inhaled into the SUPPLIER REPRESENTATIVE'S SIGNATURE	_		TITLE		(X6) DATE

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

PRINTED: 08/10/2015

						IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
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MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
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F 176	lungs) running, with a medication aide (TMA the medication was o dining room passing r other residents in their mask off her nose and mask on her chest wi around the back of her R63's room while R63 and into the room new made no attempted to to R63's nose and mo medication. At 7:44 p room, turned off the n mask from R63's chear R63's diagnoses inclu behavioral disturbance chronic obstructive pu and congestive heart plan dated 6/2/15, inclu- disorientated to time a moderately impaired of The Physician's Order	A)-A who had administered A)-A who had administered in the opposite side of the medications and assisting ir rooms. R63 removed the d mouth and placed the th the elastic strap still er neck. TMA-A walked past 3 had the mask on her chest 4 to R63 twice. TMA-A to check, or reapply the mask buth for installation of the .m. TMA-A entered R63's nebulizer and removed the st. uded dementia with tes, depression, anxiety, ulmonary disease (COPD) failure. A cognition care dicated R63 was and place and had cognition. ers and the Medication d (MAR) for 7/15, directed	F 17	6		
	hand written note on not like the nebulizer in front of her face an					
	During interview on 7 stated she did not kno	/20/15, at 7:50 p.m. TMA-A ow if R63 could be left alone /A-A added she usually				

If continuation sheet Page 2 of 65

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA				10. 0938-039 TE SURVEY
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		245127	B. WING		0	7/23/2015
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MILLE LA	CS HEALTH SYSTEM			NORTH ELM STREET MIA, MN 56359		
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	busy she left R63 alo					
	(RN)-A stated R63 wa alone to SAM the net	a.m. registered nurse as assessed to not to be left pulizer. In the past she would ask but now will allow staff to t of her.				
F 225 SS=E	483.13(c)(1)(ii)-(iii), (INVESTIGATE/REPC ALLEGATIONS/INDI	DRT	F 225			
	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowl court of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a in employee, which would service as a nurse aide or ne State nurse aide registry es.				
	involving mistreatment including injuries of understanding misappropriation of re- immediately to the act to other officials in act	nknown source and esident property are reported Iministrator of the facility and cordance with State law procedures (including to the				

Facility ID: 00374

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						FORM	D: 08/10/2015
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		245127	B. WING			07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	to the administrator of representative and to with State law (includi certification agency) v incident, and if the all	stigations must be reported	F	225	5		
	by: Based on observation review, the facility fail of abuse, neglect, mis unknown were immed adminstrator and state investigated, and resi- their investigations for R12, R22, R39, R11, allegations reviewed. reference checks for 4 employees (NA-A, NA Findings include: Investigation and Prof During interview 7/23/ worker (SW) stated th has been implicated in January 2015 to July alleged perpetrator (A Review of facility Incid reports indicated the f	e agency, were thoroughly dents were protected during r 8 of 15 residents' (R47, R66, R44 and R8) The facility failed to conduct 4 of 5 newly hired A-B, DA-A and RN-B). tection (15, at 5:09 p.m. with social hat nursing assistant (NA)-C n four incident reports from 2015 as the potential AP).					

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	S FOR MEDICARE &					NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	θE	
	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 225	Continued From page	e 4	F 2	25		
		tensive assistance in ADLs.				
	-	d 2/26/15, indicated she had				
	dementia and needs					
		g. The care plan further ght alteration in cognition				
		nd that resident will continue				
	to be oriented to pers	on, place and time.				
	Mille Lacs Nursing Ho	ome Progress Notes dated				
	1/24/15, at 3:49 a.m. indicated: "This nurse [LPN-D] was in a res. room, 5 rooms away from					
		appened, but heard a distinct a woman's out cry. This				
		on the walkie [walkie-talkie]				
		ide stated (in her words) On				
		to check resident in room				
		sident in 45 -2 [R47] in the time and said she				
		and try and get some sleep				
	-	7] said "No, I want to sit up				
	-	aid "No lets lay down" and				
		[R47's] feet to bring them in and hit me in the head,				
		velled out "ow" and NA-C				
		me, R47 said "I didn't, you				
		NA-C] walked out and [his nurse [LPN-D] asked				
		he aide. Res. [R47] stated				
	that the aide hit her."					
		ubmitted to the state agency				
		that R47 had a conflict with n 1/24/15. Following a				
	review of the related					
		as originally determined				
		ue to her dementia. Further				
	-	47 allegedly struck a nursing				
	nursing assistant stru	t [R47] also alleged the				

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		D HUMAN SERVICES				FORM): 08/10/2015 APPROVED
STATEMENT (S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245127	B. WING		_	07/:	23/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	a further investigation A follow-up Investigat the state agency on 2 the SW met with the r 1/28/15 and 1/30/15 a recall any incidents of unable to speak with after the SW learned to her work schedule SW spoke with NA-C 10:45 p.m. NA-C ack happened as describe stated she had not str had tried to lift R47's I The investigative repor NA-C. This report als been implicated in a p During interview 7/23 stated the resident was incident had happene dementia. The SW suspended during hel could "not be proved" R47 continued to be of SW said NA-C was co cares for R47, and was NA-C on how to keep Review of the facility's Schedule indicated N pending the investiga 1/28/15 and NA-C was and 1/29/15, while the progress.	ive Report was submitted to //2/15. The report indicated resident R47 on the a.m. of and resident was unable to f concerns. The SW was NA-C until 2/2/15 (7 days of the situation) in part due not coinciding with the SW. by phone on 2/2/15, at nowledged the incident ed by LPN-D's note. NA-C ruck R47 in any way, but legs to help her lay down. ort indicated the AP was to included that NA-C had previous submitted report. /15, at 5:10 p.m., the SW as unable to recall if the d, and said R47 had said NA-C was not r investigation because it that NA-C abused R47, and on the work schedule. The punseled on how to provide as asked for ideas from R47 safe. s MLHS-LTC NA/R A-C was not suspended tion of the incident dated s scheduled to work 1/28/15	F 225				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/10/2015 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	1/27/15. The investig the R47 was actually suspend NA-C or take during the investigation that a thorough invest R47. R47 had another facil Referral Form (SSIRF R47 was involved in a a.m., of possible abus The SSIRF indicated: (electronic progress in verbal statements and resident [R47]; possib maltreatment but just resident's dementia." indicated the incident Investigative Team on reported submitted to 3/3/2015 at 12:30 p.m NA-C was a person w the situation. An initial Incident Rep state agency on 3/3/1 of R47 on 3/2/15. The progress notes from N a.m. of 3/2 that sugge concerns/dementia sy at work or possible m	the reported to the SA until ation did not determine if abused. The facility did not e action to protect residents, on. There was no indication tigation was completed for ity Social Service Incident f), signed by RN-C indicated an incident on "3/2/15 early se or resident aggression." RN-C noted PCC notes totes) by LPN-B questioning d other behaviors by ble indication of f a likely symptoms of The SSIRF further t was discussed with a 3/3/15 at 8:30 a.m., and		225		DEFICIENCY)		
	to go ahead and subn agency]"	reatment, and "SW decided nit the allegation to [state ote, dated 3/2/215 at 4:03						

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		D HUMAN SERVICES				FORM	0: 08/10/2015 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	
		245127	B. WING		_	07/2	23/2015
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET			
				ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page a.m., written by LPN-I "kicking at staff" and [going to report 'her' to indicated R47 told sta everyone I heard" C second progress note wipe dry blood off [R4 The note continued, th stated "I am going to I Facility documentation was taken to protect F during this investigation Documentation of the did not include determ bloody lip, and there w with the nursing assis R47. The SSRIF also immediate reporting c agency or administrat A final, Investigative F state agency on 3/06 The report indicated c interviewed by RN Ca this SW. Resident de happening this past w or the nighttime that u denied that anyone hi her or that she has hit also indicated "SW c about progress notes shift, "indicating the N the EZ lift (mechanica	 A 7 B, indicated [R47] was R47] told staff "she was the nurse" The note also ff "you go around hitting on 3/2/15 at 6:03 a.m., a d indicated staff went to 7's] lip, and [R47] hit staff. The at after R47 hit staff, R47 report you for hitting me." In did not indicate any action R47 and other residents on of potential abuse. Investigation of this incident the transmitter of the state or. Report was submitted to the f15 regarding the incident. In 3/2/15 the "resident was re Coordinator (RN- A) and nied remembering anything the daytime pset her in any wayShe ts her or has been mean to anyone else." The report of any municated with [LPN-B] from 3/2/15 during night AR was situating resident in I lift) to help her to the tis request and the NAR 	F 225				
	winter air. [NA-C] tolo	om being chapped with dry, I [R47] she was going wipe ut R47 struck out at NA,					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 08/10/2015 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245127	B. WING			_	07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	The report indicated and assisted [R47] wi same night, the NA wa attempted to lift R47's resident kicked at NA- referenced the allegat was slapped. The rep perpetrator in this inci R47's care plan was r were made on how to cares. The report also coached by the SW a progress note charting have been reminded t reports. The report in not resting well with th maltreatment of reside particular incident, SV and ears open for pat conduct, etc." Review of the facility' Schedule from Februa 2015, indicated NA-C 3/2/15 (the night of the worked on 3/3/15. During interview 7/23/ stated, in review of thi "concerns with NA-C" she had really done a felt they could not sub against NA-C, and the "suspension or discipli investigation. There we	to dismount from her face." NA-C re-approached later thout incident. Later the as doing rounds and a feet back in bed, and -C. The report then tions made by R47, that she port did not confirm a ident. The report indicated reviewed, and suggestions approach R47 during o indicated LPN-B was nd DON on more thorough g, and further, that staff to submit timely incident included: "Something is just his, and although there is no ents 'substantiated' in this V will continue to keep eyes terns and/or trends in 's MLHS-LTC NA/R ary 23, 2015 to March 8, C was assigned to work e alleged incident) and also (15, at 5:30 p.m. the SW is incident, she had 'but again could not prove inything wrong. The facility ostantiate the allegations erefore did not warrant a	F	225				

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						IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	E SURVEY IPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 225	R12's quarterly MDS was moderately cogn extensive assist with grooming. R12's care indicated she had pot related to cognitive in mobility. An initial Incident Reg agency on 2/18/15, in was allegedly slapped person who was atter medicine. The AP on listed as unknown. A final Investigative R state agency on 2/23, The report indicated R allegations, but the on "tracked," was the on [R12] during the adm Magnesia (MOM) tha indicated the SW and more information abo administered the MOI schedule, LPN-B and duty. At 10:45 p.m. o SW met with NA-C, M given MOM to R12 u NA-C said "[R12] didr took the cup and thre [NA-C] tried to clean i resident's clothing an The report indicated I any way, but acknowl with the wet ones. Th possible this was performed	dated 4/27/15 indicated she itively intact and needed dressing, bathing and e plan dated 1/31/15, tential for abuse from others inpairment and limited bort submitted to the state indicated that on 2/18/15, R12 d, on her cheek, by a staff mpting to administer in the Incident Report was Report was submitted to the /15, regarding the incident. R12 had made numerous inly allegation that could be e about someone slapping inistration of Milk of t morning. Firstly, the report I DON proceeded to seek but who would have M that morning. Per I NA-C were the persons on on 2/19/15, the DON and who freely admitted having inder direction of LPN-B. in't want the MOM, and [R12] w the MOM all over."	F 225			

Facility ID: 00374

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X) PROVEDBSUPPLIENCUA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245127 B. WING (X3) DATE SURVEY COMPLETED MILLE LACS HEALTH SYSTEM STREET ADDRESS, CITY, STATE, ZIP CODE 07/23/2015 MILLE LACS HEALTH SYSTEM STREET ADDRESS, CITY, STATE, ZIP CODE 000 NORTH ELM STREET ONAMIA, MN 56359 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) IP F 225 Continued From page 10 her as the lady who slapped her, and NA-C agreed to do so. [RT12] was sleeping soundly, however, so decided not awaken her. The report indicated TIAA-C'S] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident. The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 us to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not on enter room without a colleague present. F 225 During interview on 7/23/15, at 5:20 p.m. the SW stated she did not supped NA-C since they could not prove NA-C slapped R12. The SW Supped by a 'blonde lady." The report then indicated R1 have been alerted to have two persons present during cares with this resident and NA-C was instructed not			ND HUMAN SERVICES				FORM): 08/10/2015 1 APPROVED
NAME OF PROVIDER OR SUPPLIER International control of the second	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE	SURVEY
MILLE LACS HEALTH SYSTEM 200 NORTH ELM STREET ONAMIA, MN 56359 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X9) COMPLET DATE F 225 Continued From page 10 her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present. F 225 During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they During interview on 7/23/15, at 5:20 p.m. the SW			245127	B. WING		_	07/2	23/2015
MILLE LACS HEALTH SYSTEM ONAMIA, MN 56359 (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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 225 Continued From page 10 her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present. During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they	NAME OF P	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
Image: Construct of the second sec	MILLE LA	CS HEALTH SYSTEM		2	00 NORTH ELM STREET			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 225 Continued From page 10 her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated aff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present. The system of the SW stated she did not suspend NA-C since they				0	ONAMIA, MN 56359			
 her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present. During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		COMPLETION
acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation. The investigation of this incident by the facility did not determine if R12 was slapped, nor was there follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during this investigation of this incident, regardless of its outcome.	F 225	her as the lady who s agreed to do so. [R1, however, so decided indicated "[NA-C's] w leads SW to believe s about not slapping re- indicated the DON sp 2/23/15 at 3:20 p.m. NA-C to give MOM to occupied elsewhere that NA-C did report [slapped by a "blonde indicated staff have b persons present durin and NA-C was instruct without a colleague p During interview on 7 stated she did not sus could not prove NA-C acknowledged NA-C multiple incidents, an [NA-C], but did not fe suspend" or provide of during this investigation The investigation of th not determine if R12 of follow up to have R12 nursing assistant who NA-C was instructed without a colleague p offered no indication of for other residents who during this investigati regardless of its outcome	slapped her, and NA-C 2] was sleeping soundly, not awaken her. The report illingness to go, however, she [NA-C] is being truthful sident." The report then boke to LPN-B by phone on LPN-C admitted asking 0 R12 due to LPN being LPN-C also acknowledged [R12's] claim of being lady." The report then been alerted to have two ing cares with this resident cted not to enter room resent. 7/23/15, at 5:20 p.m. the SW spend NA-C since they c slapped R12. The SW had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on. his incident by the facility did was slapped, nor was there 2 positively identify the o provided cares. Although not to enter R12's room resent, the documentation protections were put in place no were assisted by NA-C on of this incident, ome.	F 225		DEFICIENCY)		

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CENTER STATEMENT (D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	FORM OMB NC (X3) DATE	D: 08/10/2015 // APPROVED 0. 0938-0391 SURVEY /LETED
		245127	B. WING			07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					200 NORTH ELM STREET		
MILLE LA	CS HEALTH SYSTEM				DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	accident (CVA), was r impaired and needed and extensive assist v plan dated 5/3/15, ind with toileting and tran- depression and sadne care plan further indic abuse from others rel- weakness, aches and indicated "resident will needs met in a safe e During observation or lifted her pant leg and right shin measuring a (centimeters) x 2 cm fading to dark purple swelling In an interview 7/20/1 that she had been tre- and there is a staff me shift that is rough with this staff member had transferring" which ca also stated she had a bar along the bottom The facility submitted state agency on 6/27/ alleged mistreatment The report also identifi right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm, report was submitted the initial reporter, NA	nd a cerebral vascular moderately cognitively limited assist with transfers with toileting. R22's care licated she needed assist sfers, had history of ess/isolating self. R22's tated she had potential for ated to her general pains. The care plan goal I remain safe and have nvironment." n 7/20/15, at 5:54 p.m. R22 I displayed a bruise on her approximately 8 cm R22's bruise was black, in color, with no apparent 5, at 5:54 p.m. R22 stated ated "roughly by the staff" ember who works the night on her. R22 went on to state "grabbed her arm when used a large bruise and lso hit her leg into the metal	F	225			

Facility ID: 00374

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
		245127	B. WING		0	7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER	•	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET NAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 225	Continued From page	e 12	F 225			
	she had toileted R22, told [NA-C] she was r that "some girl hurt he she [R22] stated she report then indicated (RN)-A, followed up v asked her to tell her v reported she is not st is not going to be treat explained that staff w night for getting up to times, and that a "girl into bed." R22 pointe said "this is where sh bruise on top of right (centimeters) x 5 cm reported when she th leg on something me outer lower shin meas circular in shape. R2 girl was, nor her nam around 0400. The re was the nursing assis during the night, and charge. No other inji reassured she will rer removed from workin.	with R22 in the morning and what happened: "Resident aying here again tonight and ated like this anymore." R22 as mad at her during the use the bathroom so many grabbed me and threw me ed out her hand hurt, and e grabbed me," noted a hand measures 5.5 cm circular is shape. R22 also rew me into bed, "I hit my tal;" a bruise noted on right sures 2.5 cm x 2.5 cm 2 could not recall who the e. R22 thought it was eport further indicated NA-C stant working on that wing LPN-A was the nurse in uries noted, resident was main safe here, NA-C will be g with resident at this time.				

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		10. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	6	CO	MPLETED
		245127	B. WING		0	7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		DE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	Continued From page	e 13	F 22	25		
	two submitted incider					
		nd social worker SW "have				
		s issue thoroughly and have				
		antiate who the alleged				
		certain, but have reached a asonable suspicion a crime				
		the form of assault, and are				
	hence submitting a re					
		rdance with Elder Justice				
	Act." Further, "The d					
		nits of our ability are being				
		Office of Health Facility agency." The Investigative				
		ed on 7/1/15, the DON and				
		(NA-C) who stated R22 had				
		toilet 6-8 times that night				
		then indicated [SW and				
		n the AP the number of nvolving this NAR, which				
		[regarding] her credibility,				
	÷	newhat defensive, face				
	reddening and voice					
	because I report thing	gs and others don't, so I end				
		" The report further listed,				
	-	ew 7/2/15 the DON and SW				
		stated she "reported having R22) on 6/30, that [R22] is				
	,	the blonde hair and bangs,				
	•	ice, etc. The blond hair with				
		tion of NA-C. The report				
		NA-C had been "implicated				
		5814, 78740, and 79433 with				
		gles" with residents, as she ; received coaching in these				
		also involved in report				
		pecifically named as AP."				
		scribed NA-C as the staff ther and NA-C was caring				
	member who had hur	t her and NA-C was caring				

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE							FORM): 08/10/2015 1 APPROVED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MILLE LACS HEALTH SYSTEM STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
MILLE LACS HEALTH SYSTEM 200 NORTH ELM STREET ONAMIA, MN 56359 (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 COM			245127	B. WING		_	07/2	23/2015
MILLE LACS HEALTH SYSTEM ONAMIA, MN 56359 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	NAME OF PF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE COM	MILLE LAG	ACS HEALTH SYSTEM						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM					ONAMIA, MN 56359			
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BI		(X5) COMPLETION DATE
F 225 Continued From page 14 for her and received multiple large bruises, no disciplinary action was taken. NA-C was not suspended pending the investigation. Also, there was no indication that a thorough investigation was completed by the facility to include other interviews with staff and residents. During interview on 7/23/15, at 4:50 p.m. the DON stated she has concerns that NA-C might be doing the accusations, but stated she was not certain. The DON sated the nurses on that do that." The DON stated the nurses on that do that. "The DON stated the nurses were to report if they notice anything and have concerns. In an interview on 7/23/15, at 5:03 p.m. the SW stated she did no talk with other residents or staff regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON asid at there were issues around "data privacy and confidentiality." SW further stated whe alon equilted the nurses on duty initiates the OHEC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residentale." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also all the cowering tor NA-C was "not intensive, and three was no improvement plan initiated and no documentation of education or mentoring done."	F 225	for her and received r disciplinary action was suspended pending th was no indication that was completed by the interviews with staff a During interview on 7. DON stated she has o be doing the accusati certain. The DON said during the night shift,' that do that." The DO report if they notice and In an interview on 7/2 stated she did not talk regarding abuse alleg stated, "I don't genera hunt." The DON said, keeps coming up doe The DON also said th "data privacy and com stated when somethin allegations come up o on duty initiates the C said the nurse would address any immedia NA-C, the SW stated several residents she but that does change the allegation is not si further stated, in rega allegation of abuse, "a The SW also said the "not intensive, and the plan initiated and not	nultiple large bruises, no s taken, NA-C was not he investigation. Also, there t a thorough investigation e facility to include other nd residents. //23/15, at 4:50 p.m. the concerns that NA-C might ons, but stated she was not id, "Staff monitor [NA-C] ' and "we have nurses on DN stated the nurses were to nything and have concerns. 3/15, at 5:03 p.m. the SW with other residents or staff gations by R22. The DON ally do that, it's not a witch "Just because their name s not make them guilty." here were issues around fidentiality." SW further ng regarding abuse over the weekend, the nurse DHFC reporting. The SW talk to the resident, and te concerns. Regarding I, "At times there have been is not allowed to care for, if, during the investigation ubstantiated." The SW rd to NA-C, after the first a lot of coaching was done." coaching for NA-C was ere was no improvement	F 22		DEFICIENCY)		

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		D HUMAN SERVICES				FORM	0: 08/10/2015 APPROVED
STATEMENT	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	
		245127	B. WING		_	07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	During an interview of administrator said, "W working on nights, we enough staff." The ad feel the DON and SW During an interview of the DON stated NA-C facility policy following R22 . She stated, "If I would have had to su who would take care of During an interview of stated, "I don't work a am mandated, but I d stated, "I have heard little rough, but I can't stated one of the resid being rough and leave the staff member as the resident and stated the threw me into the char bathroom again." NA the nurse a lot on night During interview on 77 stated she works part LPN-H stated she has NA-C is rough with the witnessed it directly. aware that she was to the night shift when si indicated she had hea NA-C had slapped he works on the North with was because of the care works on the North with	n 7/23/15 at 5:10 p.m., the //e have three young people e can't suspend; there is not ministrator further stated, " I / did the right thing." n 07/23/15, at 5:14 p.m. c was not suspended per the g the allegation made by had suspended one, I spend all three staff, then of the residents?" n 07/24/15, 5:14 a.m., NA-E a lot of overnights unless I o hear a few things." NA-E about people being super that some of the girls are a tell you who." She further dents mentioned about a girl ing bruises. NA-E described hey were described by the the resident said " the girl ir because I had to go to the -E stated she does not see	F 225				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 08/10/2015 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		CONSTRUCTION		(X3) DATE	
		245127	B. WING			-	07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET			
				0	NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	9 16	F 2	25				
		e night shift don't work o work on each unit alone.						
	INJURIES OF UNKNO	OWN ORIGIN						
	was moderately cogn plan, dated 3/30/15, in extensive assist with a	all activities of daily living, and for transfers, and was						
	dated 10/7/14, indicat purple bruise on the r buttock and that R39 bruising occurred. The been lowered to floor the bruise and indicat the injury. The incider anticoagulant medica clotting), other injurie unspecified times fram	· ·						
	DON)stated, when R3 floor it would be hard during that event but s due to use of anticoag therefore the injury wa reportable.	as not considered						
	unable to recall how t was no evidence that	oderately impaired and he bruise occurred, there a more in-depth npleted to determine the						

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	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		L 1	TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 225		s R39's injury of unknown	F 22	5		
	she was moderately of plan, dated 6/3/15, in extensive to total ass	ist for all activities of daily impaired, and at risk for				
	Report Forms indicate unknown origin. An in indicated R39 had a th hand that was dark po 8 cm x 8 cm. The rep was unable to state h blood thinners and de "minor." Another Soci dated 11/4/14, indicat to her left temple and was unable to state th third incident report d had a bruise of unknown knee, dark purple in of (unit of measurement report further indicate the cause of the injur- medications, and the	rate Social Services Incident ed R11 had injuries of incident form dated 10/21/15, pruise to the top of her right urple in color and measured ort further indicated R11 ow the injury occurred, used escribed the injury as fal Services Report Form, ted R11 had bruising noted above her left eyebrow, and he cause of the injury. A ated 12/18/14, indicated R11 own origin to her left inner color, measuring 1 x 1 3/4. was not indicated). The ed R11 was unable to report y, use of anticoagulant e injury was considered to be three bruises were reported				
	SW stated, R11 "had have ever known." Sh hand may have been	n 7/24/15, at 12:54 p.m., more bruising than anyone I ne stated the bruise on R11's caused by "recent trimming arding the bruise noted to				

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 08/10/2015 // APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER		-	5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	R11's nebulizer mask R11 who reported that way back from supper not ambulate, used a there were no records the bruising was likely nebulizer mask. During an interview of DON stated R11 could asked if bruising was she felt the injury was Although R11 was ide cognitively impaired, a different locations, an what happened, there investigation complete causes of R11's bruis was notified but none submitted to the state R66's quarterly MDS, was moderately cogn dated 2/9/15, indicate assist of two staff with transfers, at risk for de related to depression. During review of a So Referral Form, dated noted indicated R66 h from her hands to her indicated R66 was un the injury and that the	head, SW stated that ing was due to placement of , however, SW interviewed t she slipped and fell on her r. SW further stated R11 did Hoyer lift for transfer and of any falls and indicated r due to placement of R11's n 7/24/15, at 12:54 p.m., the d reliably answer when related to abuse, therefore, not reportable. Intified to be moderately and had multiple bruises at d were unable to determine e was no indepth ed to determine the actual es. The facility administrator of these incidents were agency. Indext 1/7/15, indicated she tively impaired. Care plan, d R66 required extensive n use of mechanical lift for elirium, and at risk for abuse	F	225				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/10/2015 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	- 19	F	225	5			
	SW stated, the bruise was reviewing a progr with nursing and dete assessed to be a min- reportable to to OHFC During an interview of DON stated, R66 use lift) and did not always occasionally "flailing h stated, R66 was confu "hard to say if R66 wo talk about how the bru time had passed." Although R66 had bila hands to her shoulder unwitnessed and the identify what happene immediately reported agency nor was a tho	n 7/24/15, at 12:54 p.m., the d a Hoyer lift (mechanical s cooperate in lift, her arms." She further used and that it would be build have been able to to uising occurred after any ateral bruising from her rs, the injury was resident was unable to ed. The facility had not the incident to the state rough investigation he if R66 was "flailing her						
	was severely cognitive dated 7/10/15, indicat assist with activities of for abuse related to sl impaired decision mat Review of Social Serve dated 6/15/15, indicat on her posterior forea	ated 6/9/15, indicated she ely impaired. Care plan, ed R44 required extensive f daily living, and was at risk nort term memory loss and king skills. vice Incident Referral Form, ed R44 had a purple bruise rm measuring 6.3 cm x 7 ring her bath. The incident						

Facility ID: 00374

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		D HUMAN SERVICES				FORM	0: 08/10/2015 APPROVED
STATEMENT C	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	
		245127	B. WING		_	07/2	23/2015
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page form indicated R66 di injury and that the inju "minor."The bruise wa During an interview of SW stated, on 8/18/14 bruise measuring 8.5 thumb and forefinger to her wrist. She state the initial evaluation a resulted from R8 wrin wringing of her hands She further stated the due to staff witness of Social Services Incide requested for this inju During an interview of SW stated when mak whether or not to repor refers to statutes, and also stated that she lo able to explain the inji it, and if there is a his and/or injuries. She fu indicated minor injury nature or location, it of reported.	e 20 d not state the cause of ury was determined to be as not reported to OHFC. n 7/24/15, at 12:54 p.m., 4, staff reported R8 had a cm in length between her from the base of the thumb ed the reporting nurse did and determined the bruising ging her hands, and the was witnessed by staff. injury was not reportable f the potential cause. A ent Referral form was ry but was not received. n 7/24/15, at 12:54 p.m., ing a determination of ort an injury to OHFC, she t uses a decision tree. SW boks at whether a resident is ury or if someone else saw tory of other recent falls urther stated, if the nurses or injury not suspicious in loes not need to be	F 225				
	DON stated, there was whether an injury was stated, the nurse findi evaluation to determin minor. The DON stat nurses judgement wh	n 7/24/15, at 12:54 p.m., the is no criteria for determining minor vs major. She further ing the injuries did initial he the above injuries to be ed she would use the en determining if an injury nd that the RN in charge					

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CENTER STATEMENT (AND PLAN OF NAME OF P MILLE LA	ROVIDER OR SUPPLIER	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245127	A. BUILDI B. WING	INGS	E CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORTH ELM STREET DNAMIA, MN 56359	FORM OMB NO (X3) DATE COMP	23/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	followed up on the injuthere was no charting would show evidence completed. Even though R44 was cognitively impaired, I origin, on the posterior indication the facility of investigation to determinjury, also the incident state agency. R8's quarterly minimuther to be severely cogrequiring assist of two living. CP dated 5/15/extensive assist for adwas at risk for abuse I dementia. A review of SSIRF da had a bruise measurinher thumb and forefin thumb to her wrist. The initial evaluation and or esulted from R8 wrinwringing of her hands. During an interview of SW stated, the injury staff witness of the point of the injury staff witness of the point of the injury are port was not made Social Services Incide	uries. However, she stated in the clinical record that is that follow up had been is assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her nt was not reported to the um data set (MDS) identified gnitively impaired and o staff for activities of daily (15 indicated R8 required ctivities of daily living and related to diagnosis of ted 8/18/14, indicated R8 ng 8.5 cm in length between uger from the base of her ne reporting nurse did the determined the bruising uging her hands, and the is was witnessed by staff. n 7/24/15, at 12:54 p.m., was not reportable due to otential cause. No further jury was completed. The was notified of the injury but e to the state agency. A	F	225			

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						<u>10. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			FE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 225	Although R8 had seve and had a bruise 8.5 forefinger from the ba There was no indicati thorough investigation her injury, also the indi- the state agency. Review of the facility revised 7/15, indicate (Mille Lacs Health Sy are vulnerable to abu physical, mental psyc sexual abuse)" The "protection will include individual abuse prev reporting of all cases neglect, or financial e reporting to the Comr substantiated inciden regard to investigation the policy stated: "All thoroughly investigate further potential abus progress." Under the Patient" section, the p alleged perpetrator (A situation. If the AP is suspended until the ir and further, "Disciplin up to and including di employee/employees defined Injury of Unkr the injury was not obs suspicious." The poli definition top include	ere cognitive impairment, cm between her thumb and use of her thumb to her wrist. on the facility completed an in to determine the source of cident was not reported to Vulnerable Adult Policy, d: "It is the policy of MLHS stem) to protect adults who se (including verbal, thosocial/emotional, and e policy further indicated: e abuse prevention plans, ention plans, internal of suspected abuse, xploitation, and external non Entry Point (CEP) of ts of maltreatment." In n of a reportable incident, I alleged violations are ed. The facility must prevent e while the investigation is in "Protection for Resident or policy directed that "The AP) will be removed from the an employee, they will be nvestigation is completed," ary action will be carried out smissal of as appropriate." The Policy nown Origin as "source of served and injury as cy did not expound on this CMS definitions. In regard tial employees, the policy	F 225			

Facility ID: 00374

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM) NORTH ELM STREET IAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 225	Continued From page	23	F 225			
F 226 SS=F	employers." 483.13(c) DEVELOP/ ABUSE/NEGLECT, E		F 226			
	policies and procedur	t, and abuse of residents				
	by: Based on observatio review, the facility fail Vulnerable Adult Polic abuse, neglect, mistre unknown origin were administrator and sta investigated, and res during the investigatio (R47, R12, R22, R39 allegations reviewed. to conduct reference policy for 4 of 5 newly NA-B, DA-A and RN- effect all 50 residents	is not met as evidenced n, interview and document ed to implement their cy to ensure all allegations of eatment and injuries of immediately reported to the te agency, were thoroughly idents were protected ons for 8 of 15 residents' , R11, R66, R44 and R8) In addition, the facility failed checks according to their v hired employees (NA-A, -B). This had the potential to who resided in the facility, andard quality of care under d facility practices.				
	indicated: "It is the po Health System) to pro	including verbal, physical,				

Facility ID: 00374

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/10/2015 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245127	B. WING				07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZI	IP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD B		(X5) COMPLETION DATE
F 226	will include abuse pre- abuse prevention plan cases of suspected al exploitation, and exter Common Entry Point incidents of maltreatm investigation of a repo- stated: "All alleged vii investigated. The fac potential abuse while progress." Under the Patient" section, the pp perpetrator (AP) will b situation. If the AP is suspended until the in and further, "Disciplin up to and including di- employee/employees INVESTIGATION AND During interview 7/23, worker (SW) stated th has been implicated in reports from February alleged abuse, and ne Review of facility Incid reports from 2/1/2015 identified the following R47's quarterly minim 2/17/15, indicated she intact and needed ext R47's care plan dated dementia and needs a grooming and bathing	further indicated: "protection vention plans, individual ns, internal reporting of all puse, neglect, or financial rnal reporting to the (CEP) of substantiated hent." In regard to ortable incident, the policy olations are thoroughly ility must prevent further the investigation is in "Protection for Resident or policy directed: "The alleged here removed from the an employee, they will be investigation is completed," ary action will be carried out smissal of as appropriate." D PROTECTION (15, at 5:09 p.m. with social hat nursing assistant (NA)-C in at least four incident 2015 to July 2015 of eglect. dent and Investigation to 7/20/2015 for NA-C g: um data set (MDS) dated was moderately cognitively ensive assistance in ADLs. 1 2/26/15, indicated she had	F	226				

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		MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:		G	· · · ·	IPLETED		
		245127	B. WING		07	7/23/2015		
NAME OF PI	AME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 226	Continued From page	e 25	F 22	26				
	related to dementia and that resident will continue to be oriented to person, place and time. A facility Social Service Incident Referral Form (SSIRF) indicated licensed practical nurse (LPN)-D verbally reported to the social worker							
	(SW) on 1/27/2014, a occurred during the n SSIRF, dated 1/27/15	at 4 p.m., an incident that ight shift on 1/24/2015. The 5, indicated: "Alleged						
	resulting in resident s didn't hit you, you hit	tween res [resident] & aides slapping aide and stating 'I me you liar.'" The SSIRF						
	investigation and/or nagency, and this was 1/28/15.	eporting" to the state signed by the SW on						
	Notes, dated 1/28/15	s Nursing Home Progress , written by LPN-D indicated: res. room, 5 rooms away						
	from where the incide distinct smack. Follo This nurse then got a	ent happened, but heard a wed by a woman's out cry. a call on the walkie						
	NA)." The [NA] state rounds, I went to che	e aide (nursing assistant, d (in her words) "On 2 a.m. ck resident in room 45-1 woke up resident in 45-2						
	[R47] in the process. said she should lay b some sleep until coffe	I told [R47] the time and ack down and try and get ee time." [R47] said "No, I						
	down" and NA went to bring them in bed and	ting." NA said "No lets lay o pick up [R47's] feet to d [R47] swung and hit me in I [NA] yelled out "ow" and						
	NA said "why did you	i hit me, [R47] said, 'I didn't, ien [NA] walked out and						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245127 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORTH ELM STREET MILLE LACS HEALTH SYSTEM **ONAMIA, MN 56359** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 226 Continued From page 26 F 226 walkie the nurse " This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." The nursing note did not identify the nursing assistant by name. A facility email. written by the SW. dated 1/28/2015, indicated the SW had been verbally informed by LPN-D of R47 being in a conflict with a nursing assistant. The email indicated there was a progress note of the incident, but no further "incident report form." The email indicated the SW further reviewed the progress notes, and because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency. An Incident Report submitted to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late afternoon 1/27/15..." and further that R47 had a conflict "this past weekend" with a nursing assistant. Following a review of the related progress notes by the "Stand Up Team" and "Behavior Management Team", it was originally determined incident was due to [R47's] "dementia symptoms..." The report referred to a nursing progress note which indicated that [R47] "claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified. A review of the SSIRF, the internal email, and the initial report submitted to the state agency indicated an incident occurred sometime during the night shift/early morning hours of 1/25/14.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Facility ID: 00374

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PRINTED: 08/10/2015

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (11) PROVIDERSUPPLIENCIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER MILLE LACS HEALTH SYSTEM OD PROVIDER OR SUPPLIER MILLE LACS HEALTH SYSTEM OD PROVIDER SPLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 226 Continued From page 27 The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 was thoroughly investigated for injuries; and F 226			ID HUMAN SERVICES				FORM	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245127 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORTH ELM STREET MILLE LACS HEALTH SYSTEM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 226 Continued From page 27 The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 F 226		S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0.0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MILLE LACS HEALTH SYSTEM STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORTH ELM STREET ONAMIA, MN 56359 200 NORTH ELM STREET ONAMIA, MN 56359 (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) COMPLETION DATE F 226 Continued From page 27 The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47	-							
MILLE LACS HEALTH SYSTEM 200 NORTH ELM STREET ONAMIA, MN 56359 (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 OCMPLETION DATE COMPLETION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) COMPLETION DATE F 226 Continued From page 27 The report also indicated the incident was first reported, and made known to the SW on late afternoon of 11/271/2014, (two days after the incident) and reported to the state agency on 11/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 F 200 NORTH ELM STREET ONAMIA, MN 56359			245127	B. WING			07/	23/2015
MILLE LACS HEALTH SYSTEM ONAMIA, MN 56359 (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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 226 Continued From page 27 The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 F 226	NAME OF P	ROVIDER OR SUPPLIER	• •		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ONAMIA, MN 56359 (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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE F 226 Continued From page 27 The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 F 226					2	00 NORTH ELM STREET		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F 226 Continued From page 27 The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 F 226		MILLE LACS HEALTH SYSTEM			c	DNAMIA, MN 56359		
The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
Iacked evidence of action to protect residents during the investigation. A final Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with R47 "on the a.m. of 1/28/15 and 1/30/15," and "Resident unable to recall any incidents of concern with any aides the previous weekend." The SW was unable to speak with NA-C, (identified as the nursing assistant involved) until 2/2/15 (7 days after the SW learned of the incident) "in part due to her work schedule not coinciding with the SW." SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C "acknowledged the incident happened as described" by LPN-D's note, and further, "[NA-C] saying she had not struck resident." The ray, but had merely tried to lift [R47's] legs to help her lay back down" The report indicated "There is no apparent evidence of NAR striking resident." The investigative report indicated the alleged perpetrator was NA-C. This report also included that NA-C had been implicated in a previous submitted report. During an interview 7/23/15, at 5:10 p.m., the SW	F 226	The report also indica reported, and made k afternoon of 1/27/201 incident) and reported 1/28/2015 (three days occurred). There was was reported immedia and state agency. Ac of this incident: lacke NA-C, and other invo affected residents; dia was thoroughly invest lacked evidence of ac during the investigative R state agency on 2/2/1 SW met with R47 "on 1/30/15," and "Reside incidents of concern w weekend." The SW w NA-C, (identified as the involved) until 2/2/15 learned of the incider schedule not coincidit with NA-C by phone of NA-C "acknowledged described" by LPN-D' saying she had not st had merely tried to lift back down" The re apparent evidence of investigative report in perpetrator was NA-C that NA-C had been i submitted report.	ated the incident was first snown to the SW on late 4, (two days after the d to the state agency on s after the incident allegedly s no indication this incident ately to the administrator dditionally, the investigation ed timely interviewing of lved staff, and potentially d not provide evidence R47 tigated for injuries; and ction to protect residents on. Report was submitted to the 15. The report indicated the the a.m. of 1/28/15 and ent unable to recall any with any aides the previous was unable to speak with the nursing assistant 6 (7 days after the SW et) "in part due to her work ing with the SW." SW spoke on 2/2/15, at 10:45 p.m. I the incident happened as 's note, and further, "[NA-C] truck resident in any way, but t [R47's] legs to help her lay port indicated "There is no NAR striking resident." The dicated the alleged C. This report also included mplicated in a previous	F	226			

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PRINTED: 08/10/2015 FORM APPROVED

						O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		L /	E SURVEY IPLETED
		245127	B. WING		07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 226	stated in the investiga recall if the incident h had dementia. The S suspended during he could not be proven t NA-C continued to be SW said NA-C was c cares for R47, and wa NA-C on how to keep Review of the facility' Schedule from Janua 2015, indicated NA-C	ation, R47 was unable to ad happened, and that R47 SW said NA-C was not r investigation because it hat NA-C abused R47, and e on the work schedule. The ounseled on how to provide as asked for ideas from o R47 safe. s MLHS-LTC NA/R iny 26, 2014 to February 8, c worked on the night shift on while the investigation of	F 224	6		
	Referral Form (SSIRI R47 was involved in a a.m., of possible abus The SSIRF indicated: (electronic progress r verbal statements an resident [R47]; possit maltreatment but jus resident's dementia." indicated the inciden Investigative Team or reported submitted to 3/3/2015 at 12:30 p.m	ble indication of t a likely symptoms of The SSIRF further t was discussed with n 3/3/15 at 8:30 a.m., and				
	state agency on 3/3/1 maltreatment of R47 referenced "two progr	port was submitted to the 15 regarding possible on 3/2/15. The report ress notes from NOC (night) f 3/2 that suggests either				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/10/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY
		245127	B. WING			07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE	_	
MILLE LA	CS HEALTH SYSTEM			0 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					(X5) COMPLETION DATE	
F 226	by resident [R47] at w maltreatment of residu indicated uncertainty maltreatment, and "S' submit the allegation A nursing progress not a.m., written by LPN-I "kicking at staff" and [going to report 'her' to indicated R47 told sta everyone I heard" O second progress note wipe dry blood off [R4 The note continued, t stated "I am going to Facility documentation was taken to protect F during this investigation Documentation of the did not include determ bloody lip, and there w with the nursing assiss R47. The SSRIF also immediate reporting of agency or administrat A final, Investigative F state agency on 3/06 The report indicated of interviewed by RN Ca this SW. Resident de happening this past w or the nighttime that u denied that anyone his her or that she has his	cerns/dementia symptoms york or possible ent by staff." The report by staff on whether this was W decided to go ahead and to [state agency]" ote, dated 3/2/215 at 4:03 B, indicated [R47] was [R47] told staff "she was of the nurse" The note also off "you go around hitting On 3/2/15 at 6:03 a.m., a ed indicated staff went to 47's] lip, and [R47] hit staff. hat after R47 hit staff, R47 report you for hitting me." In did not indicate any action R47 and other residents on of potential abuse. Investigation of this incident nination the cause of R47's was no evidence of interview stant who provided cares for o indicated there was no of this incident to the state	F 226				

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	S FOR MEDICARE &					10.0938-039
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 226	about progress notes shift, "indicating the N the EZ lift (mechanica bathroom per residen noticed resident's lip apparently cracked fr winter air. [NA-C] told the dried blood off, b causing NA's glasses The report indicated and assisted [R47] w same night, the NA w attempted to lift R47's resident kicked at NA referenced the allega was slapped. The re perpetrator in this inc R47's care plan was were made on how to cares. The report als coached by the SW a progress note chartin have been reminded reports. The report in not resting well with t maltreatment of resid particular incident, SV and ears open for par conduct, etc." Review of the facility Schedule from Febru 2015, indicated NA-C 3/2/15 (the night of th worked on 3/3/15.	from 3/2/15 during night JAR was situating resident in al lift) to help her to the at's request and the NAR had been bleeding om being chapped with dry, d [R47] she was going wipe but R47 struck out at NA, a to dismount from her face." NA-C re-approached later ithout incident. Later the vas doing rounds and a feet back in bed, and t-C. The report then tions made by R47, that she port did not confirm a ident. The report indicated reviewed, and suggestions o approach R47 during to indicated LPN-B was and DON on more thorough g, and further, that staff to submit timely incident neluded: "Something is just his, and although there is no ents 'substantiated' in this <i>N</i> will continue to keep eyes tterns and/or trends in 's MLHS-LTC NA/R ary 23, 2015 to March 8, C was assigned to work the alleged incident) and also	F 226			

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED	
		245127	B. WING		0	7/23/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 226	Continued From page	e 31	F 226	3			
	she had really done a felt they could not sub against NA-C, and the "suspension or discip investigation. There v	anything wrong. The facility ostantiate the allegations erefore did not warrant a					
	was moderately, cogr extensive assist with grooming. R12's care	tential for abuse from others					
	(SSIRF), signed by the indicated there was a early A.M.", which all was described as: "[I Res re some issues. want to go home, the lady with the ponytail up yesterday', and 'TI when she tried to mail 4p.m. resident [R12] concerns." The SSIR following: an internal on 2/18/15; that the re received by the SW in listed; the incident was "Investigative Team"	email report was completed eport of alleged abuse was n person, no date or time as discussed with on 2/18/15 at 0833; and that al report was submitted on					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 08/10/2015 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245127	B. WING		_	07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LACS HEALTH SYSTEM				00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	this morning while stather to take some med R12 had no apparent consistent with this cla The report also indication investigation is warrant perpetrator" on the re "unknown." A review of the SSIRF State Agency indicate occurred in the early of possibly earlier, no action or staff until it was dis on 2/18/15. There was was immediately report administrator. Further documentation of this R12 was slapped; and have R12 positively ic (possibly NA-C) who Although NA-C was in room without a colleast documentation offered were put in place for of assisted by NA-C dur incident, regardless of A final Investigative R state agency on 2/23/ indicated the "Initial R agency]at 4 p.m.," was made to local law indicated R12 had ma but the only allegation the one about someon	cheek by a staff person early ff person was trying to get licine." The report indicated injuries, and "has been aim throughout the day" ted "a full internal nted." The "alleged port form was listed as F, and the initial report to the id, that although this incident morning of 2/18/15, and ction was taken by the facility cussed later that morning as no indication the incident orted to state agency and r, the investigation incident did not indicate if d there was no follow up to lentify the nursing assistant, provided her cares that day. Instructed not to enter R12's gue present, the d no indication protections other residents who were ing the investigation of this f its outcome.	F 226				

Facility ID: 00374

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MEDICAID SERVICES				APPROVED 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	SURVEY
245127	B. WING		07/2	3/2015
		STREET ADDRESS, CITY, STATE, ZIP CODE		
		200 NORTH ELM STREET		
		ONAMIA, MN 56359		
ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	JLD BE	(X5) COMPLETION DATE
 33 uff)." The report indicated ded to seek more would have administered g. The report identified, dule, LPN-B and NA-C were Further, the report SW met with [NA-C], who given MOM upon the The report continued, didn't want the MOM, and and threw the MOM all ed to clean it up off the othing and her face, using rt indicated "[NA-C] denied hy way, but acknowledged with the wet ones." The possible this was perceived Next, the report indicated, og to resident's room to or would identify her as the and NA-C agreed to do so. oundly, however, so the report indicated the DON one on 2/23/15 at 3:20 p.m. tg NA-C to give MOM to ing occupied elsewhere dged that NA-C did report slapped by a "blonde lady." ted staff have been alerted s present" during cares with C was instructed not to enter gue present. 	F 22	26		
	IDENTIFICATION NUMBER: 245127 TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 33 ff)." The report indicated ded to seek more o would have administered g. The report identified, dule, LPN-B and NA-C were Further, the report SW met with [NA-C], who given MOM upon the The report continued, didn't want the MOM, and and threw the MOM all ed to clean it up off the othing and her face, using rt indicated "[NA-C] denied hy way, but acknowledged with the wet ones." The possible this was perceived Next, the report indicated, o go to resident's room to r would identify her as the and NA-C agreed to do so. oundly, however, so er." The report indicated go, however, leads SW to being truthful about not ne report indicated the DON one on 2/23/15 at 3:20 p.m. g NA-C to give MOM to ing occupied elsewhere dged that NA-C did report slapped by a "blonde lady." ted staff have been alerted s present" during cares with C was instructed not to enter gue present.	IDENTIFICATION NUMBER: A. BUILDIN 245127 B. WING	IDENTIFICATION NUMBER: A. BUILDING 245127 B. WING 200 NORTH ELM STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORTH ELM STREET INUST BE PRECEDED BY FULL D SCIENTIFYING INFORMATION) PREFIX 33 F 226 iff)." The report indicated Edit to seek more vould have administered jule, LPN-B and NA-C were Further, the report SW met with [NA-C], who given MOM upon the The report continued, didn't want the MOM, and and threw the MOM all do to clean it up off the othing and her face, using tri indicated "[NA-C] denied ny way, but acknowledged with the wet ones." The ropossible this was perceived Next, the report indicated go, however, so er." The report indicated go, bowever, leads SW to being truthful about not the report indicated the DON one on 2/23/15 at 3:20 p.m. g VA-C to give MOM to ing occupied elsewhere diged that NA-C did report solution to magnetize the staff have been alerted s present" during cares with Cowas instructed not to enter use present. 23/15, at 5:20 p.m. the SW pend NA-C Since "they SW	IDENTIFICATION NUMBER: A. BUILDING COMPL 245127 B. WING 07/2 STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORTH ELM STREET 0NAMIA, MN 56355 TEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED DI YULL SCIDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 33 F 226

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PRINTED: 08/10/2015 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/10/2015 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245127	B. WING			07	/23/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	[NA-C], but did not fee suspend" or provide of during this investigation Review of the facility's Schedule from Februa 2015, indicated NA-C 2/22/2015, that is on the incident, and during the There was no indication was completed for R1	had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on. s MLHS-LTC NA/R ary 9, 2015 to February 22, worked on 2/17/15 through the date of the alleged he subsequent investigation. on a thorough investigation 12.	F	226			
	she had depression a accident (CVA), and impaired and needed and extensive assist plan dated 5/3/15, ind with toileting and tran depression and sadne care plan further indic abuse from others rel weakness, aches and indicated "resident wi needs met in a safe e During observation or lifted her pant leg and right shin measuring a (centimeters) x 2 cm. be black, fading to da apparent swelling. In p.m. R22 stated that s "roughly by the staff"	ess/isolating self. R22's cated she had potential for ated to her general I pains. The care plan goal II remain safe and have nvironment." In 7/20/15 at 5:54 p.m., R22 I displayed a bruise on her approximately 8 cm R22's bruise was noted to rk purple in color, with no an interview 7/20/15, at 5:54					

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			0.00			IO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY IPLETED		
		245127	B. WING		0	7/23/2015		
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CO	DE			
MILLE LA	CS HEALTH SYSTEM) NORTH ELM STREET IAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 226	R22 went on to state "grabbed her arm who caused a large bruise also hit her leg into th bottom of her bed. The facility submitted state agency on 6/27 alleged mistreatment The report also identi right hand, measuring	this staff member had en transferring" which e and also stated she had e metal bar along the an Incident Report to the (15 regarding an incident of and physical abuse of R22. fied a bruise on R22 top g 5.5 cm x 5 cm, circular in	F 226					
	shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-C, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, after being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and							
	reported she is not st is not going to be treat explained that staff w night for getting up to times, and that a "girl into bed." R22 pointe said "this is where sh bruise on top of right (centimeters) x 5 cm reported when she th leg on something met	vhat happened: "Resident aying her again tonight and ated like this anymore." R22 as mad at her during the use the bathroom so many grabbed me and threw me ed out her hand hurt, and e grabbed me," noted a hand measures 5.5 cm circular is shape. R22 also rew me into bed, "I hit my tal" a bruise noted on right sures 2.5 cm x 2.5 cm						

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 08/10/2015 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	· · · ·	ATE SURVEY OMPLETED
		245127	B. WING				07/23/2015
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
				200 1	ORTH ELM STREET		
MILLE LA	CS HEALTH SYSTEM			ONA	MIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 226	during the night, and charge. No other inj reassured she will ren removed from workin An additional Inciden the state agency on 7 injury of unknown sou "8 x 5 cm, reddish pu shape." The date of in unknown. The report happened a few days An Investigative Reports state agency on 07/0 submitted incident ren 7/1/15. The report in nursing (DON) and so tried to investigate the been unable to subst perpetrator [AP] is for	stant working on that wing LPN-A was the nurse in uries noted, resident was main safe here, NA-C will be g with resident at this time. t Report was submitted to 7/1/15, which identified an urce on R22's right forearm rple in color and oval in ncident occurrence was t indicated R22 said "It s ago." ort was submitted to the 2/15, which combined two ports dated 6/27/15 and dicated the director of ocial worker (SW) "have is issue thoroughly and have antiate who the alleged r certain, but have reached a	F 2	226			
	may have occurred in hence submitting a re- enforcement, in acco Act." Further the rep our internal investigar are being submitted t agency." The Investi indicated on 7/1/15, t the AP, (NA-C) who s use the toilet 6-8 time report then indicated with the AP the numb involving this NAR, w her credibility, and sh defensive, face redde	rdance with Elder Justice ort indicated, "The details of tion to the limits of our ability o OHFC and the state					

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PRINTED: 08/10/2015 FORM APPROVED

						IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	E SURVEY IPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 226	don't, so I end up get further listed, that dur DON and SW meet w "reported having hea 6/30, that [R22] is afr hair and bangs, that s The blond hair with th NA-C. The report fur been "implicated in p 78740, and 79433 wi with residents, as she received coaching in also involved in repor specifically named as Although R22 had de member who had hur for her and received to incident documentation to protect residents d incidents. Also, there thorough investigation included other intervite During interview on 7 DON stated she "has be doing the accusati not certain." The DO during the night shift, on that do that." The were to report to her have concerns. In an interview on 7/2 stated she "did not ta staff regarding abuse	ting in trouble.' " The report ring an interview 7/2/15 the with NA-D, who stated she rd from resident (R22) on aid of the girl with the blonde she is not very nice, etc. The bangs fits description of ther included that NA-C had revious reports 75814, th possible "power struggles" these incidents. NA-C was rt 79866 but was not s AP." escribed NA-C as the staff rt her and NA-C was caring multiple large bruises, the on indicated no action taken uring investigation of these was no indication that a	F 226			

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		D HUMAN SERVICES				FORM): 08/10/2015 1 APPROVED
STATEMENT (S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245127	B. WING		_	07/:	23/2015
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET			
				DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	around "data privacy of further stated, when sa allegations come up of on duty initiates the C said the nurse would address any immedia NA-C, the SW stated several residents she but that does change the allegation is not si further stated, in rega allegation of abuse, " The SW also said the "not intensive, and the plan initiated and no c or mentoring done." During an interview of administrator said, "W working on nights, we enough staff." The ad feel the DON and SW During an interview of the DON stated NA-C facility policy following R22 . She stated, "If I would have had to su who would take care	b said there were issues and confidentiality." SW comething regarding abuse over the weekend, the nurse DHFC reporting. The SW talk to the resident, and te concerns. Regarding , "At times there have been is not allowed to care for, if, during the investigation ubstantiated." The SW rd to NA-C, after the first a lot of coaching was done." coaching for NA-C was ere was no improvement documentation of education n 7/23/15 at 5:10 p.m., the ke have three young people e can't suspend; there is not ministrator further stated, " I did the right thing." n 07/23/15, at 5:14 p.m., was not suspended per the g the allegation made by had suspended one, I spend all three staff, then of the residents?"	F 226		DEFICIENCY)		
	stated, " I don't work a am mandated, but I d stated, "I have heard wet and I have heard little rough, but I can't stated, one of the res	n 07/24/15 5:14 a.m., NA-E a lot of overnights unless I o hear a few things." NA-E about people being super that some of the girls are a tell you who." She further sident mentioned about a girl ing bruises. NA-E described					

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		D HUMAN SERVICES				FORM): 08/10/2015 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245127	B. WING		_	07/2	23/2015
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	the staff member as the resident and stated the threw me into the charber as the threw me into the charber of the nurse a lot on night bathroom again." NA-the nurse a lot on night During interview on 7, stated she works part LPN-H stated she harber of the stated she works part LPN-H stated she harber of the state of the cate of the cate of the cate of the cate of any certain readers on the night shift when she works on the night shift when she works on the night shift when she works on the North wing and because of the cate of any certain readers on the night shift prefer to work on each suspicious." The facility Vulnerable defined Injury of Unkrythe injury was not obstate assist with all activitie a mechanical stand for identified at risk for atterned to the state of the st	hey were described by the e resident said " the girl ir because I had to go to the E stated she does not see hts. /24/15, at 5:25 a.m. LPN-H time on the night shift. s heard from other NAs that e residents but had not LPN-H stated she is not nonitor any staff during the works. She further indicated ad reported that NA-C had that NA-C no longer works d thought the reason was t because she can not take sidents. She then stated the ft don't work together they h unit alone. DWN ORIGIN e Adult Policy, revised 7/15, nown Origin as "source of served and injury as cy did not expound on this riteria from the CMS ated 3/9/15, indicated she nitively impaired. The CP, ed R39 required extensive s of daily living (ADLs), used	F 226				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/10/2015 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/:	23/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	had a large, dark purp portion of her buttock injury, and R39 was " bruising occurred. Th "a few days ago had I not standing when tra Hoyer (a mechanical SSRIF further indicate that could explain bru chart contained "falls that could likely have SSIRF indicated R39 reported to the state a investigation was con though there was no any objects or the floo ground. During an interview o DON stated, when R3 floor "it would be hard during that event." Th easily due to use of a therefore the injury wa reportable." Although R39 was mo unable to recall how t was no evidence that investigation was con actual cause, nor was origin reported to the R11's quarterly MDS, she was moderately, CP, dated 6/3/15, ind	ble bruise on the right upper , and it was an "unknown" unaware" of how the e SSIRF also indicated R39 been lowered to floor due to insferring & then lifted with lift) Possible cause." The ed R39 used a medication ising, and also that R39's or other recent incidents produced the injury." The 's injury was "minor" and not agency. No further npleted for this incident even indication R39 had struck or as she was lowered to the to know if injury occurred he DON said R39 bruised nticoagulant medication, so as "not considered oderately impaired and he bruise occurred, there a more in-depth npleted to determine the s R39's injury of unknown state agency. dated 4/15/15, indicated cognitively impaired. The	F 226				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/10/2015 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245127	B. WING			07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	had a bruise to the top purple in color, and m SSIRF indicated R11 injury occurred, but R medication, and R11's "minor." The facility at no report was made to had bruising noted to her left eyebrow. The unable to state the ca facility administrator v was not reported to th A third SSIRF dated fa a bruise of unknown of dark purple in color, a inches. The SSIRF in "unknown", that R11 v cause of the injury, us indicated the injury was the facility administration cause of the injury was the facility administration puring an interview al unknown origin on 7/2 stated, R11 "had more have ever known." Th R11's hand "may have trimming of [R11's] na the bruise herself. Re R11's temple and fore nursing felt the bruisir [R11's] nebulizer mas	to depression. ted 10/21/15, indicated R39 p of her right hand, dark leasured 8 cm x 8 cm. The was unable to state how the 11 used anticoagulant is bruise was described as dministrator was notified but to the state agency. ed 11/4/14, indicated R11 her left temple and above a SSIRF indicated R11 was use of the injury. The vas notified, but the injury he state agency. 12/18/14, indicated R11 had origin to her left inner knee, and measuring 1 x 1 3/4 dicated the injury was was unable to report the sed anticoagulants; and also as considered to be "minor." ator was notified, but the d to the state agency. bout the three injuries of 24/15, at 12:54 p.m., the SW e bruising than anyone I he SW said the bruise on e been caused by recent tils," indicating R11 caused garding the bruise noted to behaad, the SW stated that ng "was due to placement of	F	226			

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/10/2015 // APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245127	B. WING				07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 226	she slipped and fell of SW further stated R1 ⁺ Hoyer lift [a mechanic there were no records bruising was "likely du nebulizer mask." No f completed for this inju During an interview of DON stated R11 "cou reporting nurse asked abuse, therefore, the reportable. Although R11 was ide cognitively impaired, a different locations, the investigation complete causes of R11's bruis was notified of the inju incidents were submit R66's quarterly MDS, was moderately, cogr dated 2/9/15, indicate assist of two staff, wit for transfers. The CP risk for delirium and p depression. A review of SSIRF da a review of R66's nurs 1/26/2015, there was bruises" on [R66] bott identified as bruising.	n her way back from supper. 1 did not ambulate, used a cal lift] for transferring, and s of any falls. SW added the ue to placement of [R11's] urther investigation was iry. n 7/24/15, at 12:54 p.m., the Id reliably answer" when the I if bruising was related to DON felt the injury was not entified to be moderately and had multiple bruises at ere was no indepth ed to determine the actual es. The facility administrator uries but none of these ted to the state agency. dated 1/7/15, indicated she hitively impaired. The CP, d R66 required extensive h use of a mechanical lift, also indicated R66 was at otential abuse, related to ted 2/3/15, indicated during sing progress note dated "presence of unknown n arms, the size was "from hands to shoulder."	F	226				

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		D HUMAN SERVICES				FORM	0: 08/10/2015 APPROVED
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	
		245127	B. WING		_	07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	was an "unknown inju state the cause, and t to be "minor." The inj facility administrator, the state agency. During an interview of SW stated, the bruise was reviewing R66's i said she "spoke with bruising was assesse therefore not reportate agency."During an int p.m., the DON said R (mechanical lift), and cooperate in lift, occa The DON further state that it would be "hard been able to to talk at occurred after any tim Although R66 had bila hands to her shoulder unwitnessed and the identify what happene immediately reported agency nor was a tho completed to determin arms" while using the R44's annual MDS, d was severely cognitiv 7/10/15, indicated R4	ry", that R66 was unable to hat the injury was assessed ury was reported to the but was not not reported to n 7/24/15, at 12:54 p.m., the s were noted while the DON progress notes. The SW nursing" and determined the d "to be a minor injury, and ble to the state erview on 7/24/15, at 12:54 66 used a Hoyer lift R66 did not always sionally "flailing her arms." ed R66 was confused, and to say if R66 would have bout how the bruising he had passed." ateral bruising from her rs, the injury was resident was unable to ed. The facility had not the incident to the state rough investigation he if R66 was "flailing her mechanical lift.	F 226				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 08/10/2015 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245127	B. WING			-	07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 226	had a purple bruise of forearm, measuring 6 found during her bath was an "unknown" inj the cause of injury. T be "minor". The facility but the injury was not agency.	ted 6/15/15, indicated R44 n her posterior (back side) .3 cm x 7 cm, that was . The SSIRF indicated this ury, and R66 could not state he injury was determined to y administrator was notified,	F	226				
	suspicious criteria. Th a need to report to th In an interview on 7/2 DON stated, "[R44] w	nor' and did not meet any he SW said she "did not see						
	cognitively impaired, I origin, on the posterio indication the facility of investigation to determ	as assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough nine the source of her nt was not reported to the						
	her to be severely coor requiring assist of two living. CP dated 5/15/ extensive assist for ac	im data set (MDS) identified gnitively impaired and o staff for activities of daily 15 indicated R8 required ctivities of daily living and related to diagnosis of						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 08/10/2015 1 APPROVED 2: 0938-0391
STATEMENT (MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER	-	s	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page) 45	F 226				
	had a bruise measuring her thumb and forefing thumb to her wrist. The initial evaluation and or resulted from R8 wring wringing of her hands During an interview of SW stated, the injury staff witness of the po- investigation of the inj facility administrator w a report was not made Social Services Incide requested for this injury Although R8 had seve and had a bruise 8.5c forefinger from the ba There was no indicati- thorough investigation her injury, also the ino- the state agency. During an interview of SW stated, when mak- whether or not to repo- agency, she "refers to decision tree." The S looks at whether a res- injury, or if someone of a history of other rece	Iry but was not received. ere cognitive impairment, cm between her thumb and use of her thumb to her wrist. on the facility completed an in to determine the source of cident was not reported to n 7/24/15, at 12:54 p.m., king a determination of ort an injury to the state o statutes, and uses a W also stated that she sident is able to explain the else saw it, and if there was ent falls and/or injuries. The the nurses indicated minor spicious in nature or					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/10/2015 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	DON said, minor injur state agency. She fur criteria or policy" the f determine whether an "major." The DON als the nurses judgement injury was minor or m charge "followed up o she stated there was	e 46 n 7/24/15, at 12:54 p.m., the ries are not reportable to the ther stated, there was "no facility has to identify and n injury was "minor" versus so stated she "would use t" when determining if an ajor, and that the RN in on the injuries." However, no charting on the clinical w evidence that follow-up	F 226				
	7/15, indicated as its who are vulnerable to policy included: "To a everything within its c occurrence of abuse of attempt to obtain infor employers and or/curr NA-A's personnel rec hired on 7/13/15. The evidence reference cl to employment at the NA-B's personnel rec hired on 6/30/15. The evidence reference cl to employment at the Dietary Aide (DA)-A's	revention Policy, revised purpose "to protect adults abuse" Further, the assure the facility was doing ontrol to prevent the or neglectthe facility would rmation from previous rent employers." cord identified they were personnel record lacked necks were completed prior facility.					

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		ID HUMAN SERVICES				FORM	D: 08/10/2015	
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE). 0938-0391 SURVEY 'LETED	
		245127	B. WING		_	07/23/2015		
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 226	Continued From page completed prior to em	e 47 nployment at the facility.	F 226					
	identified they were h personnel record lack	I)-B's personnel record ired on 5/11/15. The ted evidence reference ed prior to employment at						
F 241 SS=D	staff stated four of the did not have documer HR stated there was ' that reference checks facility used the applic about the position hel rehire and any feedba		F 241					
	manner and in an env	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.						
	by: Based on observation review, the facility fail rising and morning roi (R50 and R12),who re	is not met as evidenced n, interview and document ed to provide a dignified utines for 2 of 8 residents equired extensive staff te activities of daily living						
	(CP), reviewed 6/6/20 dementia, and aphasi	dentified on the care plan 015, included hemiplegia, ia. The quarterly Minimum ed 5/27/2015, indicated R50						

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		D HUMAN SERVICES				FORM): 08/10/2015 / APPROVED
	<u>S FOR MEDICARE & </u> DF DEFICIENCIES			E CONSTRUCTION		OMB NC	0. 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		-	I ` '	PLETED
		245127	B. WING		_	07/	23/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
0(0)15							(25)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page	2 48	F 241				
	had severely impaired						
	extensive, physical as						
		assist with bed mobility,					
	transfers, toileting, dro hygiene.	essing and personal					
	nygione.						
	l î	n 7/22/2015 at 7:11 a.m.,					
	, , ,	back, in her bed, with her					
		n top of her chest. R50's ot of the bed, pulled onto the					
		50's left leg, and one could					
		pants on as she lied in bed.					
		until 8:41, when NA-F and					
		th morning cares. R50 was pants, socks and shirt,					
		R50's covers and checked					
		F and NA-G assisted R50					
		ith use of a mechanical lift.					
		er hair, and NA-G assisted					
		splint and arm into the nd R50 was up for the day.					
	During an interview of	n 7/22/2015 at 8:38 a.m.,					
	NA-G said R50 was a						
		needed to get up, out of needed "total assistance"					
		as not able to verbalize her					
	needs to staff.						
	In on interview or 7/0						
		2/2015 at 9:18 a.m., NA-F as dressed this morning					
		50 to get up for the day.					
	NA-F did not know wh	no worked with R50, but said					
	"someone on nights [
		is typical for R50's routine.					
		ould not be dressed early se she gets a bath on that					
	day."						
	-						

Facility ID: 00374

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		D HUMAN SERVICES					FORM): 08/10/2015 // APPROVED	
STATEMENT	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY ILETED	
		245127	B. WING			_	07/23/2015		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 241	NA-H stated she work routinely got R50 "cle not removed from bed that." NA-H stated sh on her scheduled batt residents whom she h dressed, prior to the e said "I just need to ma and ready to go. I ge them back to bed; it h NA-H said if there wa want to get up, she w someone else up." N the residents she ass and there were some night anyway." During an interview of family member (FM)-/ were getting R50 dres bed. FM-A said that of was often awake late, restless, and they [sta than stated, "I would the she'd be getting out, a day." In an interview on 7/2 director of nursing (Du "to help the day shift s someone was trying t and keep [the resident and possibly fall." In social worker (SW) sa during the night was " aide. We should look	n 7/24/2015 at 6:00 a.m., as on the overnight shift, and aned up and dressed," but d, "the day shift would do be does not get R50 dressed in days. She has a list of helped get cleaned and end of the night shift. NA-H ake sure they are dressed t them dressed and then put elps out the morning shift." s a resident that did not	F	241					

Facility ID: 00374

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CENTER	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE			FORM	0: 08/10/2015 MAPPROVED 0: 0938-0391 SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				COMPLETED		
		245127	B. WING			-	07/	23/2015	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STA	ATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET DNAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 241	5/18/15, indicated she impaired and required transfers, dressing an (CP), dated 8/28/13, o opportunities to make including clothing, bed also indicated R12 ha related to insomnia, w hours of sleep at nigh morning routine prefe to get up. During observation or was noted fully dresse chair. R12 was positi television in the comn asleep in her wheelch jerking movements as in chair until 8:15 a.m approached, and awa R12 if if she wanted to breakfast. R12 replied During an interview of NA-E stated she was residents up, washed the over night shift. N shower, there was an up in their place. NA-f the residents up, was back to bed."	e was severely, cognitively l extensive assist for d grooming. The care plan directed staff to give R12 daily preferences choices, d time and bathing. The CP d an alteration in sleep, vith a goal of at least six t. The CP did not address a rence of when R12 wanted n 7/22/15 at 7:00 a.m., R12 ed and seated in her wheel oned in front of the non area on the east wing, air. R12 repeatedly made a she dozed. R12 remained ., (75 minutes) when staff kened her. The staff asked o go back to bed, or eat d "I don't care."	F	241					

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		D HUMAN SERVICES				FORM): 08/10/2015 1 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	-	(X3) DATE	0. 0938-0391 SURVEY LETED	
		245127	B. WING			07/:	23/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET			
				ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	e entimate a richnipage		F 24	1			
	of a mechanical lift to dressed and put back idea why they would o	in bed, I don't have any					
	director of nursing (Du people getting up and bed on the night shift. and care coordinators day shift. The DON fu this list are usually up like the night shift to h the day." She further the only nursing home that." The intent is to prevent falls. The DC if the rationale for wal to get them washed a plan or not. During an interview of registered nurse (RN) residents for the night dressed. She stated, who are trying to get people who want to g who are a "Hoyer lift." dress them in bed. RI prefers to get up early further stated, there is East unit that is care p to fall risk. RN-C state shift getting resident's due to the workload in Review of the facility's	n 7/24/15, at 1:16 p.m., the ON) stated, there are many I dressed and put back to She stated, The nurses a schedule them to help the or crawling out of bed," we help day shift "get a jump on stated, "I'm sure we are not e in the world that does help day shift out and ON stated she was not sure king a resident on night shift and dressed is on the care n 7/24/15, at 2:07 p.m., -C stated, We schedule t shift to get up, washed and We usually look at people up but if there aren't enough et up, we will pick people 'The aides will wash and N-C stated, "If someone y it is not care planned." She is no one currently on the oblanned to get up early due ed, The rationale for night is washed and dressed is in the morning.					
	sheet directed night s cares, oral cares, dre						

Facility ID: 00374

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			0(0) 100			IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	L 1	TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 241	Continued From page including R12.	9 52	F 24	11		
F 282 SS=D	4/15, indicated the fac promote care for [resi maintains and enhand full recognition of [a re 483.20(k)(3)(ii) SERV PERSONS/PER CAR The services provided must be provided by o	tients/Residents, dated cility "must, with courtesy, dents] in a manner that ces dignity and respect in esident's] individuality." (ICES BY QUALIFIED RE PLAN d or arranged by the facility	F 28	32		
	by: Based on observatio review, the facility fail					
	Findings include:					
	(CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascula Minimum Data Set (M indicated R50 had se and was unable to wa R50 required extension activities of daily living	dentified on the care plan 015, included hemiplegia de, dementia, and aphasia ar disease. The quarterly IDS), dated 5/27/2015, verely impaired cognition, alk. The MDS also identified ve, physical assistance for g (ADLs), including n bed mobility, transfers,				

Facility ID: 00374

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/10/2015 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVI COMPLETED		SURVEY
		245127	B. WING			07/23/2015		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZI	P CODE		
				2	200 NORTH ELM STREET			
	CS HEALTH SYSTEM			0	ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
F 282	alteration in skin integ alteration in elimination staff to follow the mote R50 "to turn and repo PRN" [as needed]. A staff to assist R50 "to hours and PRN" [as ne During continuous ob 7:55 a.m. to 11:12 a.r R50 was observed to upright in her wheel of seated in her wheel of from the north unit nu news program on TV. wheeled into the dinin breakfast, finishing at meal, and still seated moved from the table	I hygiene. identified the potential for prity, and also R50's on/toileting. The CP directed bility plan of care, and assist sition every 2 hours and dditionally, the CP directed check and change every 2 leeded]. servation on 7/23/2015 from n. (3 hours and 7 minutes) be dressed and seated hair. At 7:55 a.m., R50 was hair in the living area across rsing station and watching a At 8:33 a.m., R50 was ng room and assisted with 9:36 a.m. Following the in the wheel chair, R50 was where food was served to	F	282		INCY)		
	the activity area in the participated in the mo- the activity area until j staff member wheeled of the facility. R50 re her wheel chair, until member pushed R50 joining other residents a.m., R50 was returned aviary, and was appro- (NA)-F, who after gree signs. More than 2 1/ R50 was last toileted remained seated in he aviary until 11:12 a.m. back to her room. In	e same room. R50 rning activity, and stayed in just after 10:00 a.m., when a d her into the main entryway mained there, still seated in 10:19 a.m., when a staff outside of the building, s to get fresh air. At 10:37 ed into the building near the bached by nursing assistant eting R50, took her vital '2 hours had elapsed since or repositioned. R50 er wheel chair near the ., when NA-F assisted her						

Facility ID: 00374

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		245127	B. WING			07/	23/2015
NAME OF PF	ROVIDER OR SUPPLIER		·		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	care. RN-B assessed in color, free of any u there were no redden fully intact. RN-B also of urine. R50 was not from 7:55 a.m. to 11: and 7 minutes. During an interview o nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and that R for "urinary incontiner definitely ready to be In an interview on 7/2 registered nurse (RN work group on the flo repositioning complet today, "I'll say was a be honest, [R50] shou During an interview o the director of nursing interventions were ca	her bed. R50 was and NA-F provided perineal R50's skin, which was pink nusual warmth or swelling, ed areas, and her skin was o said R50 was incontinent toileted or repositioned 12 a.m., a total of 3 hours n 7/23/2015 at 11:16 a.m., .)-F stated R50 was last e was put in her wheel chair ight." NA-F then stated R50 hour repo [repositioning] .50 should also be checked nce." NA-F said R50 "Was repositioned." 3/2015 at 4:00 p.m.)-A said she "trusted the or to get toileting and ed," but what happened fluke." RN-A also stated, "I'll uld have been turned."	F	282			
F 314 SS=D	care plans was reque 483.25(c) TREATME		F	314			
	Based on the compre	hensive assessment of a					

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PRINTED: 08/10/2015 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 08/10/2015 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245127	B. WING			07	/23/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	200 NORTH ELM STREET		
MILLE LA	CS HEALTH SYSTEM			0	ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	resident, the facility m who enters the facility does not develop pre- individual's clinical co they were unavoidabl pressure sores receiv services to promote h prevent new sores fro This REQUIREMENT by: Based on observatio review, the facility fail repositioning for 1 of 1 in the sample identifie pressure ulcers. Findings include: R50's diagnoses, as i (CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascula Minimum Data Set (M indicated R50 had se and was unable to wa R50 required extensiv activities of daily living two-person assist with toileting, and persona Pressure Sore Risk A 5/26/2015, indicated I for development of pr comprehensive skin a 5/26/2015, identified I total assist with ADLs walk, and was on a tu	aust ensure that a resident without pressure sores ssure sores unless the indition demonstrates that e; and a resident having res necessary treatment and healing, prevent infection and om developing. T is not met as evidenced n, interview and document ed to provide timely 2 residents (R50) reviewed ed at risk for development of dentified on the care plan 015, included hemiplegia de, dementia, and aphasia ar disease. The quarterly 1DS), dated 5/27/2015, verely impaired cognition, alk. The MDS also identified ve, physical assistance for g (ADLs), including h bed mobility, transfers, al hygiene. A Braden issessment, dated R50 was at moderate risk	F	314			

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						<u>10. 0938-03</u>
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		· · · ·	TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 314	for pressure ulcers, d additional pressure ul including immobility, i and functional limitati R50's CP identified th skin integrity. The CF mobility plan of care, reposition every 2 hot The nursing assistant undated, directed for and reposition every 2 During continuous ob 7:55 a.m. to 11:12 a.r R50 was observed to upright in her wheel c wrist fitted with a splin was supported and st 7:55 a.m., R50 was s the living area across station and watching 8:33 a.m., R50 was w and assisted with bre Following the meal, a chair, R50 was move was served to the act R50 participated in th stayed in the activity a when a staff member entryway of the facilit seated in her wheel c a staff member pushe building, joining other At 10:37 a.m., R50 w near the aviary, and a	ated 2/25/2015, identified licer risk factors for R50 incontinence, cognitive loss on in range of motion. The potential for alteration in P directed staff to follow the and assist R50 "to turn and urs and PRN" [as needed]. It care sheet "North" unit, R50: T & R q 2 hrs [turn 2 hours]. Servation on 7/23/2015 from m. (3 hours and 7 minutes) be dressed and seated thair, with her right hand and nt device, and her right arm trapped into the arm rest. At eated in her wheel chair in from the north unit nursing a news program on TV. At wheeled into the dining room akfast, finishing at 9:36 a.m. and still seated in the wheel d from the table where food ivity area in the same room. the morning activity, and area until just after 10 a.m., wheeled her into the main y. R50 remained there, still thair, until 10:19 a.m., when ed R50 outside of the tresidents to get fresh air. as returned into the building approached by nursing o after greeting R50, took	F 314			

Facility ID: 00374

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 08/10/2015 1 APPROVED 2. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER	<u></u>	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	 wheel chair. R50 rem chair near the aviary of assisted her back to h NA-F and registered n mechanical lift, assist was incontinent of uri- cleansing cares for he surveyor, RN-B inspe skin. R50's skin was any unusual warmth of reddened areas, and RN-B also said R50 w had not been reposition 11:12 a.m., a total of 3 During an interview of nursing assistant (NA repositioned when sh "at about quarter to ei was on an "every two schedule," and R50, ' repositioned." A review of nursing an progress notes from 3 indicated R50 did not for a current pressure R50 did not develop a In an interview on 7/2 registered nurse (RN) consider any resident risk for pressure sore: would "look at everyth resident was at risk to RN stated R50 scored measure for predicting 	repositioned out of her nained seated in her wheel until 11:12 a.m., when NA-F her room. In her room, nurse (RN)-B, using the ed R50 into her bed. R50 ne, and NA-F provided er. In the presence of the cted and assessed R50's normal pink in color, free of or swelling, there were no her skin was fully intact. vas incontinent of urine. R50 oned from 7:55 a.m. to 3 hours and 7 minutes. n 7/23/2015 at 11:16 a.m.,)-F stated R50 was last e was put in her wheel chair ight." NA-F then stated R50 hour repo [repositioning] 'Was definitely ready to be and physician long-term care B/26/2015 to 7/14/2015, have, nor was being treated a ulcer. During this time, a pressure ulcer. 3/2015 at 4:00 p.m.)-A stated she would :"who had a stroke to be at s." RN-A also said she	F 314				

Facility ID: 00374

If continuation sheet Page 58 of 65

		D HUMAN SERVICES				FORM	: 08/10/2015 APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /	CONSTRUCTION	-	(X3) DATE COMP	
		245127	B. WING			07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314 F 315 SS=D	other risk factors" and RN-A said she trusted to get toileting and rep what happened today also stated, "I'll be hot turned." During an interview of the director of nursing manager had already when a resident is on and checked for incor this instance, "[R50] s breakfast into other at The DON said resider planned, and the facil residents' needs for ti A facility policy, Treat Breakdown and Ulcer "It is the policy to prop residents whose clinic risk for impaired skin preventive measures. directed, to "establish individualized turning if the resident is immo 483.25(d) NO CATHE RESTORE BLADDEF Based on the resident assessment, the facili resident who enters th indwelling catheter is resident's clinical con- catheterization was no	I was "at risk for pressure." I the work group on the floor positioning completed, but , "I'll say was a fluke." RN-A nest, she should have been n 7/27/2015 at 1:19 p.m., (DON) said the nurse taken steps to avoid issues a schedule to be turned ntinence. The DON said in should not go right from ctivities, that is too long." nt interventions were care ity takes "very seriously, mely assistance." ment and Prevention of Skin s, reviewed 3/14, indicated berly identify and assess cal conditions increase the integrity" and "implement " Further, the policy and record an and repositioning schedule obile." ETER, PREVENT UTI, S t's comprehensive ty must ensure that a ne facility without an not catheterized unless the dition demonstrates that ecessary; and a resident	F 314				
(X4) ID PREFIX TAG F 314	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page other risk factors" and RN-A said she trusted to get toileting and reg what happened today also stated, "I'll be hot turned." During an interview of the director of nursing manager had already when a resident is on and checked for incor this instance, "[R50] s breakfast into other ar The DON said residen planned, and the facil residents' needs for ti A facility policy, Treat Breakdown and Ulcer "It is the policy to prop residents whose clinic risk for impaired skin preventive measures. directed, to "establish individualized turning if the resident is immod 483.25(d) NO CATHE RESTORE BLADDEF Based on the resident assessment, the facili resident who enters th indwelling catheter is resident's clinical com- catheterization was new who is incontinent of the	A MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	F 314	DNAMIA, MN 56359 PROVIDER (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA		

Facility ID: 00374

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	O. 0938-039	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		245127	B. WING		0;	7/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 315	Continued From page	e 59	F 315				
f t r a u		ore as much normal bladder					
	by: Based on observatio review, the facility fail	is not met as evidenced n, interview and document ed to provide timely toileting residents (R50) who had					
	Findings include:						
	(CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascula Minimum Data Set (M indicated R50 had se and was unable to wa R50 required extensiv activities of daily living two-person assist with toileting, and persona bladder assessment, R50 was incontinent of also was not safe to u to poor trunk control. indicated R50 would of q 2hr [every 2 hours] each incontinence ep assessment (CAA) fo 3/11/2015, indicated R	h bed mobility, transfers, il hygiene. A bowel and dated 2/25/2015, indicated of bowel and bladder, and use a commode or toilet due Further, the assessment 'be checked for incontinence and peri care given after isode." The care area r urinary incontinence, dated R50 had dementia, and past cular accident (stroke), with a. The CAA also indicated					

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						10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		245127	B. WING		0	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET NAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 315	bowel and bladder, al using the bathroom d directed staff to assis every 2 hours and PF nursing assistant care undated, also directed change q 2hrs and PF needed]. During continuous ob 7:55 a.m. to 11:12 a.r R50 was observed to upright in her wheel c wrist fitted with a splin was supported and st 7:55 a.m., R50 was s the living area across station and watching 8:33 a.m., R50 was w and assisted with bre Following the meal, a chair, R50 was move was served to the act R50 participated in th stayed in the activity a when a staff member entryway of the facilit seated in her wheel c a staff member pushe building, joining other At 10:37 a.m., R50 w near the aviary, and a assistant (NA)-F, who her vital signs. More elapsed since the init was not off loaded, of wheel chair. R50 rem	nd also that R50 was not ue to safety. The CP t R50 "to check and change RN" [as needed]. The e sheet "North" unit, d for R50: Check and RN [every 2 hours and as servation on 7/23/2015 from m. (3 hours and 7 minutes) be dressed and seated thair, with her right hand and nt device, and her right arm trapped into the arm rest. At eated in her wheel chair in from the north unit nursing a news program on TV. At <i>v</i> heeled into the dining room akfast, finishing at 9:36 a.m. ind still seated in the wheel d from the table where food civity area in the same room. ie morning activity, and area until just after 10 a.m., wheeled her into the main y. R50 remained there, still thair, until 10:19 a.m., when ed R50 outside of the residents to get fresh air. as returned into the building approached by nursing o after greeting R50, took	F 315			

Facility ID: 00374

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		MEDICAID SERVICES		E CONSTRUCTION	(X3) DATE	. 0938-039
	F CORRECTION	IDENTIFICATION NUMBER:			L 1	LETED
		245127	B. WING		07/2	23/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 315	NA-F and registered mechanical lift, assist was incontinent of uri cleansing cares for he surveyor, RN-B inspe- skin, and also said RS R50 was not assisted to 11:12 a.m., a total During an interview o nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and that R for "urinary incontiner In an interview on 7/2 registered nurse (RN consider resident "wh for pressure sores." In the Braden" (a me pressure ulcer risk), b immobility, incontiner and was "at risk for p trusted the work grou be completed, but wh was a fluke." During an interview o the director of nursing manager had already when a resident is on and checked for inco this instance, "[R50] s breakfast into other a The DON said reside	nurse (RN)-B, using the ted R50 into her bed. R50 ine, and NA-F provided er. In the presence of the ected and assessed R50's 50 was incontinent of urine. d for toileting from 7:55 a.m. of 3 hours and 7 minutes. on 7/23/2015 at 11:16 a.m., A)-F stated R50 was last he was put in her wheel chair right." NA-F then stated R50 b hour repo [repositioning] R50 should also be checked nce." 23/2015 at 4:00 p.m.)-A stated she would ho had a stroke to be at risk RN stated R50 scored "a 13	F 31	5		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/10/2015 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	Continued From page	9 62	F 31	5			
F 465 SS=C	Policy, revised 3/14, i "Maintain resident's o continence and maint indicated individual ca to toilet based on indi checking for incontine 483.70(h) SAFE/FUNCTIONAL/ E ENVIRON The facility must prov sanitary, and comforta residents, staff and the This REQUIREMENT by: Based on observation review, the facility fail duct work, lights abov kitchen were clean of potential to affect all r who consumed food f Findings include: During the initial tour registered dietician (F six metal caged lights food is cooked, were thick dust and debris addition there was a window screen above completely covered in	SANITARY/COMFORTABL ide a safe, functional, able environment for ie public. T is not met as evidenced In, interview, and document ed to ensure exhaust fan re grill and screen in the dust and debris. This had esidents, staff and visitors from the kitchen. of the facility kitchen with RD) on 7/20/15, at 1:15 p.m.; above the grill where the covered with 1/4 inch visible from the light fixtures. In	F 46	5			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 08/10/2015 // APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	23/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 465	7:30 a.m. the lights ar observed to be cover debris. During interview 7/21, manager (DM) stated dust along with the so department was in ch items. The DM stated staff of 5 and 3 of the just are not getting do During interview 7/21, maintenance manage a contracted service t hood vent two times a director did inspect th stated "That doesn't of the expectation to cor Review of the facility of document form Fire P After Service Follow U indicated the kitchen cleaned but not to coo inaccessible. The reco "replacing box-style fa better access duct wo again on 3/2/15 and t Equipment Co. After S recommended "replace fan with upblast fan to Replace damaged filt During interview 7/22, stated the "fan blows air up to create a vac The MM-A stated the	And screen were still ed with visible dust and (15, at 8:15 a.m. dietary the lights were covered in creen; the maintenance arge of cleaning these the maintenance has a m are on light duty so things one. (15, at 8:30 a.m. the er (MM)-A stated they have hat cleans the overhead a year. The maintenance e lights and the screen and cut it" and expressed it is still mplete needed tasks. (20) Contracted cleaning service Protection Equipment Co. Up Report dated 9/22/14, exhaust system hood was de due to them being commendations indicated to an with upblast style to ork." The company was out he Fire Protection Service Follow Up Report cing box-style down blast o access fan and duct work.	F	465				

Facility ID: 00374

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/10/2015 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			-	(X3) DATE S COMPL	SURVEY
		245127	B. WING			07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		-	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 465	grandfathered until we some uncertain time. During phone intervie representative from th Equipment Co. stated inaccessible because down to the bare met which was probably n 70's, and recommend The facilities Nutrition Procedure Equipmen indicated 1. the inside and outs cleaned once per mod 2. clean the inside an 3. clean the light fixtu Remove the light fixtu 4. use a brush or clott grease and/or dust 5. wash hood with sou	e remodel the kitchen at w 7/22/15, at 2:15 p.m. with he Fire Protection If the fan and ducts are they were unable to see al. The system was very old, nanufactured in 1960's or led a new unit. The Services Cleaning t Hood policy undated side of the hood will be nth d outside of the hood res within the hood. ures and clean with soap h as needed to remove ap and water of the hood that extends to emi annually by a	F 46				

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		D HUMAN SERVICES			FORM APPROVED
		MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/27/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MILEIA	CS HEALTH SYSTEM		2	00 NORTH ELM STREET	
	SO HEALTH OTOTEM		C	DNAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
	as your allegation of o Department's accepta	nce. Your signature at the ge of the CMS-2567 form will			
	revisit of your facility i validate that substant	ceptable POC an on-site may be conducted to ial compliance with the attained in accordance with			
F 176 SS=D		nt of Health on 7/27/2015 SELF-ADMINISTER	F 176		8/13/15
	An individual resident the interdisciplinary te §483.20(d)(2)(ii), has practice is safe.				
	by:	is not met as evidenced			
	review, the facility fail self-administration of	medications (SAM) for 1 of erved for self-administration		 R-63 with the Potential to Affect all residents who have orders to receive nebulizer treatments. 1. On 7/28/15 TMA-A was coached on Self administered nebulizers vs not self administered nebulizers. 	
	Findings include:			She was also given the policy on Self-administered medication.	
	was observed alone i (a drug delivery devic	n 7/20/15, at 7:28 p.m. R63 n her room with a nebulizer e used to administer m of a mist inhaled into the		2. On 8/12/15 The MAR of all residents who have an order for Nebulizer treatment were updated to indicate if they have met the	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE
	cally Signed				08/21/2015

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

PRINTED: 09/04/2015

		MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLETIO TO THE APPROPRIATE IENCY)
F 176	lungs) running, with a medication aide (TMA the medication was o dining room passing r other residents in their mask off her nose and mask on her chest wi around the back of her R63's room while R63 and into the room new made no attempted to to R63's nose and mo medication. At 7:44 p room, turned off the n mask from R63's chear R63's diagnoses inclu behavioral disturband chronic obstructive pu and congestive heart plan dated 6/2/15, include disorientated to time a moderately impaired The Physician's Orde Administration Record Duoneb to be adminis hand written note on not like the nebulizer in front of her face an A Self Administration effective 7/21/15, indi cognitively able to pai	A)-A who had administered n the opposite side of the medications and assisting ir rooms. R63 removed the d mouth and placed the th the elastic strap still er neck. TMA-A walked past 3 had the mask on her chest at to R63 twice. TMA-A o check, or reapply the mask both for installation of the .m. TMA-A entered R63's nebulizer and removed the st. uded dementia with tes, depression, anxiety, JImonary disease (COPD) failure. A cognition care dicated R63 was and place and had cognition. rs and the Medication d (MAR) for 7/15, directed stered four times a day. A the MAR indicated R63 did mask and to hold the mask d let her breathe in that way. of Medication Assessment cated R63 was not	F 1		o self ter treatment. was sent to a administration dication. owed to ebulizers R, If this is st REMAIN the a placed on 8/15 ted on a who have ents every y week x 4 idents who self are being atment ON ported to the imittee.

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	S FOR MEDICARE &					<u>10. 0938-039</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			TE SURVEY MPLETED	
		245127	B. WING		0	7/27/2015	
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COE	DE		
MILLE LA	CS HEALTH SYSTEM			NORTH ELM STREET AMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 176		e 2 e it had been so hectic and	F 176				
	busy she left R63 alo						
	alone to SAM the net	as assessed to not to be left pulizer. In the past she would ask but now will allow staff to					
F 225 SS=E		DRT	F 225			8/21/15	
	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowl court of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a in employee, which would service as a nurse aide or ne State nurse aide registry s.					
	involving mistreatmen including injuries of u misappropriation of re immediately to the ac to other officials in ac	nknown source and esident property are reported Iministrator of the facility and cordance with State law procedures (including to the					

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	OF DEFICIENCIES					O. 0938-03
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	E SURVEY IPLETED
		245127	B. WING		07	7/27/2015
IAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 225	Continued From page	a 3	F 22	5		
1 220			F 22	5		
	to the administrator o	stigations must be reported				
		other officials in accordance				
		ing to the State survey and				
		within 5 working days of the				
	incident, and if the all	eged violation is verified				
	appropriate corrective	e action must be taken.				
		is not met as evidenced				
	by:	is not met as evidenced				
	-	n, interview and document		Investigation and Protection:		
		led to ensure all allegations		Affects residents R47, R12, R22) -,	
		streatment and injuries of		R39, R11, R66, R44, R8		
	unknown were imme	diately reported to the		with the Potential to affect		
		e agency, were thoroughly		All Residents.		
		idents were protected during		Injuries of Unknown Origin:		
	0	r 8 of 15 residents' (R47,		Affects residents R39, R11, R66	,	
	R12, R22, R39, R11,	-		R44, R8 with the Potential to		
	-	The facility failed to conduct		affect All Residents.	2	
	reference checks for	4 of 5 newly nired A-B, DA-A and RN-B).		Corrections support investigation protection and injuries of unknow	•	
	Chiployees (INA-A, IN	\neg - b , b , b , a and i i i i b .		7/24/15 @ 10:35 PM: A Perform		
	Findings include:			Improvement Plan was delivered		
				implemented effective immediate		
	Investigation and Pro	tection		with NA-C. (Attachment B). One said measurement included	1	
	During interview 7/23	/15, at 5:09 p.m. with social		NO complaints regarding care a		
		nat nursing assistant (NA)-C		during the shift. Failure to mee	t this	
		n four incident reports from		goal will result in further disciplin	lary	
		2015 as the potential		action up to termination.		
	alleged perpetrator (A	AP).		7/29/15 In order to ensure the		
		dent and investigation		protection and safety of R22 it w	as	
		dent and Investigation		decided that at this time 2 staff	han	
	reports indicated the	ionowing:		would be required in the room w providing care. This was discuss		
	R47's quarterly Minin	num Data Set (MDS) dated		at R22's Care Conference and v		
	INT S QUALCTLY WITHIN	IUIII DALA OCL (IVIDO) UALEU	1		200	1

Event ID: HJY511

Facility ID: 00374

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						<u>NO. 0938-03</u>		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED		
		245127	B. WING		0	07/27/2015		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	P CODE			
				200 NORTH ELM STREET				
MILLE LA	CS HEALTH SYSTEM			ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE		
F 225	Continued From page	۵ ک	F 22	25				
		tensive assistance in ADLs.	1 22	8/15/15 Existing VA track	ring log			
		d 2/26/15, indicated she had		revised to include identity				
	dementia and needs			perpetrators to better ide				
		g. The care plan further		occurring, including those				
		ght alteration in cognition		that have been ¿unable				
		nd that resident will continue		substantiate.¿	10			
	to be oriented to pers			The Log will be updated	at the time			
				investigation results are				
	Mille Lacs Nursing Ho	ome Progress Notes dated		to OHFC and again whe				
		indicated: "This nurse		investigation is closed.				
I		room, 5 rooms away from		Upon Closure of each ind	cident the			
		ppened, but heard a distinct		VA Log will be electronica				
		a woman's out cry. This		by LSW to administrator	-			
	nurse then got a call	on the walkie [walkie-talkie]		administrator is kept info	rmed of the			
	from the aide. The ai	de stated (in her words) On		FULL STATUS of the in	vestigations			
	2 a.m. rounds, I went	to check resident in room		with regards to timelines	s of report			
	45-1 and woke up res	sident in 45 -2 [R47] in the		submissions, final dispos	sition and			
		the time and said she		actions taken with regard	ls to			
		and try and get some sleep		alleged perpetrator.				
	-	7] said "No, I want to sit up		Person(s) responsible: L				
	-	aid "No lets lay down" and		On 8/17/15: Facility wide				
		[R47's] feet to bring them in		Adult Policy (Attachment				
		and hit me in the head,		delineate protections for				
		velled out "ow" and NA-C		This includes CMS lange				
		me, R47 said "I didn't, you		injuries of unknown sour				
		NA-C] walked out and		On 8/18/15: Administrato				
		This nurse [LPN-D] asked		Medical Director sent a l				
	-	ne aide. Res. [R47] stated		(Attachment D) to all resi				
	that the aide hit her."			their representatives rega	-			
	An Incident Papart a	ubmitted to the state agency		survey findings; how, whoften we educate staff ar				
		that R47 had a conflict with		facility¿s commitment to				
		n 1/24/15. Following a		vulnerable adults. A flier				
	review of the related			information on warning s				
		as originally determined		and neglect, and a copy				
		ue to her dementia. Further		education over the last 1				
		47 allegedly struck a nursing		were included with the le				
	-	t [R47] also alleged the		On 8/19/15 Social Servic				
		ick her. The report indicated		Reporting Form (Attachr				

Facility ID: 00374

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/27/2015
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
F 225	Continued From page	2 5	F 225	5	
	a further investigation A follow-up Investigat the state agency on 2 the SW met with the r 1/28/15 and 1/30/15 a recall any incidents o unable to speak with after the SW learned to her work schedule SW spoke with NA-C 10:45 p.m. NA-C ack happened as describe stated she had not sti had tried to lift R47's The investigative repor NA-C. This report als been implicated in a p During interview 7/23 stated the resident wa incident had happened dementia. The SW suspended during he could "not be proved" R47 continued to be o SW said NA-C was co cares for R47, and wa NA-C on how to keep	in needed to be completed. ive Report was submitted to 2/2/15. The report indicated resident R47 on the a.m. of and resident was unable to f concerns. The SW was NA-C until 2/2/15 (7 days of the situation) in part due not coinciding with the SW. by phone on 2/2/15, at nowledged the incident ed by LPN-D's note. NA-C ruck R47 in any way, but legs to help her lay down. ort indicated the AP was so included that NA-C had orevious submitted report. /15, at 5:10 p.m., the SW as unable to recall if the ed, and said R47 had said NA-C was not r investigation because it t that NA-C abused R47, and on the work schedule. The punseled on how to provide as asked for ideas from 0 R47 safe.		revised to provide documentation space that clearly identifies the in evaluators thoughts in regards to: 1) Reason for submission 2) Rationale for NOT submitting report beyond the facility 3) Action taken to Protect The Res The revision also provides the rev team a means to clearly docume their evaluation of the incident and any ACTION that they feel needs be taken on but not limited on the following items: (Attachment F) 1)Timeliness of the report 2) Was Protection of the resident appropriate 3) Reportability decisions were appropriate The vulnerable adult reporting process/guides located at each nurses' station will be updated by 8/25/15. Responsible Person: LSW 8/19/15: 4- separate staff meeting scheduled for 8/25/15 where the Administrator, DON and LSW will jointly provide nursing staff with training regarding the up to date changes that have been put into place to assist staff in identifying	sident iew ent d to
	pending the investiga	A-C was not suspended tion of the incident dated is scheduled to work 1/28/15		 potential abuse and neglect, protecting the resident, discerning reportable injuries of unknown ori and reporting requirements. This staff mtg will also cover the revisions to policies and available 	igin

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		MEDICAID SERVICES			
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/27/2015
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
F 225	Continued From page	6	F 225	5	
	on 1/24/15 but was no 1/27/15. The investig the R47 was actually suspend NA-C or take during the investigatio that a thorough invest R47. R47 had another facil Referral Form (SSIRF R47 was involved in a a.m., of possible abus The SSIRF indicated: (electronic progress no verbal statements and resident [R47]; possib maltreatment but just resident's dementia." indicated the incident Investigative Team or reported submitted to 3/3/2015 at 12:30 p.m NA-C was a person w the situation.	tereported to the SA until lation did not determine if abused. The facility did not e action to protect residents, on. There was no indication tigation was completed for ity Social Service Incident 5), signed by RN-C indicated an incident on "3/2/15 early se or resident aggression." RN-C noted PCC notes notes) by LPN-B questioning d other behaviors by ble indication of t a likely symptoms of The SSIRF further t was discussed with n 3/3/15 at 8:30 a.m., and	Γ 223	 and those staff unable to attend w be required to review materials presented and minutes of the meet A signature of completion will be required at the time of the review l no later than 9/1/15. Persons responsible: Administrato DON and LSW 8/20/15: Protection of the Residen After review of all final evidence in 2567 report NAR-C will be termina 8/21/15. (NAR -C has been off sin 8/10/15, earliest available meeting for NAR-C prior to next scheduled 8/21/15). (Attachment G) MONITORING Audit (Attachment H) of each S Service Incident Report Form will reviewed for: timeliness of reporti appropriateness of report, and ac taken to protect residents The audit will begin with any incide occurring after 8/21/15 and will in every incident reported for the ne 3 months (ending 11/21/15) Responsible person: DON and LS . Audit (Attachment I) of each Investigation Report will be completed for two performents 	eting. but or, the ated ce g date shift is ocial be ng, tions ent clude xt
	progress notes from N a.m. of 3/2 that sugge concerns/dementia sy at work or possible m staff." The report indi whether this was malt	e report referenced "two NOC (night) shift early that ests either some behavioral ymptoms by resident [R47] altreatment of resident by icated uncertainty by staff on treatment, and "SW decided nit the allegation to [state		to:Ensure thoroughness of investigations. The audit will begin with any incident occurring after 8/21/15 and will include every inci- reported for the next 3 months (en 11/21/15) Person(s) responsible: DON and I Both audit reports will be reported Quality Assurance Committee.	dent ids _SW

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	OF DEFICIENCIES	MEDICAID SERVICES			OMB NO. 0938-03 (X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED
		245127	B. WING		07/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETIC
F 225	Continued From page	e 7	F 22	25	
	a.m., written by LPN- "kicking at staff" and going to report 'her' to indicated R47 told sta everyone I heard" O second progress note wipe dry blood off [R4 The note continued, t stated "I am going to Facility documentatio was taken to protect I during this investigatii Documentation of the did not include determ bloody lip, and there with the nursing assis R47. The SSRIF also immediate reporting of agency or administration A final, Investigative F state agency on 3/06 The report indicated of interviewed by RN Ca this SW. Resident det happening this past w or the nighttime that u denied that anyone h her or that she has hi also indicated "SW c about progress notes shift, "indicating the N the EZ lift (mechanica bathroom per residen noticed resident's lip apparently cracked fr	B, indicated [R47] was [R47] told staff "she was of the nurse" The note also aff "you go around hitting On 3/2/15 at 6:03 a.m., a ed indicated staff went to 47's] lip, and [R47] hit staff. hat after R47 hit staff, R47 report you for hitting me." In did not indicate any action R47 and other residents on of potential abuse. Investigation of this incident nination the cause of R47's was no evidence of interview stant who provided cares for of this incident to the state tor. Report was submitted to the 6/15 regarding the incident. on 3/2/15 the "resident was are Coordinator (RN- A) and enied remembering anything veekend during the daytime upset her in any wayShe its her or has been mean to t anyone else." The report ommunicated with [LPN-B] from 3/2/15 during night JAR was situating resident in al lift) to help her to the t's request and the NAR		Reference Checks: F225 (comp 8/19/15) Affects Residents R47,R12,R22 R39, R11, R66, R44, R8 and the Potential to affect all Residents 1. 8/18/15 The VA policy was up (attachment C) indicating that HI would attempt to obtain informat from previous employers and /or current employers during the pre-employment screening proce including dates of employment, position held, and feedback on workplace performance 2. 8/18/19 A new Reference Che Form was developed (attachment J) which identifies documented reference checks w of employment, position held an feedback on workplace performa 3. 8/18/15 The VP of HR provide Training to the HR recruiter on th revised VA Policy, and the new Reference Check Form. The Reference Check Form was implemented on 8/19/15 and wil used on all new hires going forw Monitoring: (attachment K) Responsible Party: VP of HR 4. Biweekly audits will be comple by the VP of HR or designee for for all new hires. The audit will include verification that the Reference Check form was completed for all new hires prio their first day of employment. Audit reports will be reported to	e dated R nion r ess eck vith dates d ance. ed ne s I be vard eted

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		L` '	PLETED	
		245127	B. WING		07/27/2015		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
	F 225 Continued From page 8 causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff		F 225	(QA meets quarterly; Oct., Jan., April and July).			
	have been reminded reports. The report in not resting well with the maltreatment of resid particular incident, SV	g, and further, that staff to submit timely incident included: "Something is just his, and although there is no ents 'substantiated' in this V will continue to keep eyes iterns and/or trends in					
	2015, indicated NA-0	's MLHS-LTC NA/R ary 23, 2015 to March 8, C was assigned to work e alleged incident) and also					
	During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.						

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				CONSTRUCTION		10.0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	FE SURVEY MPLETED	
		245127	B. WING		0	7/27/2015	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 225	R12's quarterly MDS was moderately cogn extensive assist with grooming. R12's care indicated she had por related to cognitive in mobility. An initial Incident Reg agency on 2/18/15, ir was allegedly slapped person who was atter medicine. The AP or listed as unknown. A final Investigative F state agency on 2/23. The report indicated I allegations, but the or "tracked," was the on [R12] during the adm Magnesia (MOM) that indicated the SW and more information abo administered the MO schedule, LPN-B and duty. At 10:45 p.m. c SW met with NA-C, w given MOM to R12 u NA-C said "[R12] didu took the cup and thre [NA-C] tried to clean resident's clothing an The report indicated I any way, but acknow with the wet ones. Th possible this was per	dated 4/27/15 indicated she iitively intact and needed dressing, bathing and e plan dated 1/31/15, tential for abuse from others inpairment and limited bort submitted to the state indicated that on 2/18/15, R12 d, on her cheek, by a staff mpting to administer in the Incident Report was Report was submitted to the /15, regarding the incident. R12 had made numerous inly allegation that could be e about someone slapping inistration of Milk of t morning. Firstly, the report I DON proceeded to seek but who would have M that morning. Per I NA-C were the persons on on 2/19/15, the DON and who freely admitted having inder direction of LPN-B. in't want the MOM, and [R12] w the MOM all over."	F 225				

Facility ID: 00374

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CENTERS FOR MEDICARE & MEDICARD SERVICES OMB INC. 0989.05 AND FLAN OF CORRECTION (1) PROVINGENUME HEARCIAL UNITATIVEL CONSTRUCTION (22) MULTIPLE CONSTRUCTION A BUILDING (22) MULTIPLE CONSTRUCTION A BUILDING A BUILDING A BUILDING (22) MULTIPLE CONSTRUCT			ID HUMAN SERVICES					FORM	09/04/2015 APPROVED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, 2P CODE 200 NORTH ELM STREET MILLE LACS HEALTH SYSTEM STREET ADDRESS, CITY. STATE, 2P CODE 200 NORTH ELM STREET VMID PREDX TAG ISSUMMAYS STATEMENT OF DEPICIENCIES (CANDER CONTON VISIST TE PREDICTION BY USE (PREDX CODENTICY USE TO ENTICY USE TO ENTICATE BY UPLL REGULATORY OR LSC IDENTICY USE TO ENTICATE BY UPLL REGULATORY OR LSC IDENTICY USE INFORMATION) IP COVIDERS AND OR SCHOOD BETCH ON SENDLO BE CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY F 225 Continued From page 10 her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated TNA-CS willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident. The report indicated the DON spoke to LPN-B by phone on 2223/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being coccupied elsewhere LPN-C also acknowledged that NA-C duid report [R123] claim of being slapped by a "bone diady." The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present. During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation. The investigation of this incident by the facility did not determine if R12 was slapped, nor was there follow up to have R12 positively identify the nursing assistant who provide cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protectories were p	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY
MILLE LACS HEALTH SYSTEM 200 NORTH ELM STREET ONAMIA, NN 56359 PRETRY TAG SUMMARY STREMENT OF DEFICIENCIES (EACH DERICENCY MIST BE PRECEDED BY FULL RECULTORY OR LSC DERTRY NG INFORMATION) In PRETRY TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY) COMPLETE (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY) F 225 Continued From page 10 her as the lady who slapped her, and NA-C is append by a "Slonde lady." The report then indicated the DAN bork os LPM-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C due appent leady." The report then indicated she din to suspend NA-C since they could not prove NA-C slapped R12. The SW asknowledged NA-C had been involved in multiple incidents, and had "suspicions" with INA-C was instructed not to enter room without a colleague present. The investigation. The investigation. The investigation. The investigation. The investigation of this incident by the facility did not determine if R12 was slapped, nor was three follow up to have R12 positively identify the noring assis			245127	B. WING			_	07/	27/2015
MULE LACS HEALTH SYSTEM ONAMIA, NN 56359 (M) ID PHEFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFRECTION MUST DEFACEDED BY FULL RECORDERCIVE AND STORED TO FULL RECORDERCIVE AND SHOULD BE CACH OFRECTIVE AND SHOULD BE CACH OFRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT DEFICIENCY) COMMENT DEFICIENCY) COMMENT DEFICIENCY) COMMENT DEFICIENCY) COMMENT DEFICIENCY) COMMENT DEFICIENCY) F 225 Continued From page 10 her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated T(NA-C3) willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident. The report then indicated st[NA-C] due to LPN by hone on 22/3716 at 3:20 pm. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged occupied elsewhere LPN-C also acknowledged that NA-C was instructed not to enter room without a colleague present. During interview on 7/23/15, at 5:20 pm. the SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with IN [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation. The investigation of this incident by the facility did not determine if R12 was slapped, nor was three follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were guit in place for other residents who were assisted by NA-C during this investigation of this incident.	NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
(Majib) PREFX TVG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICENCY MIST BE PRECEDED bY FULL REGULTIONS OF DEFICIENCY MIST BE PRECEDED bY FULL REGULTIONS OF DEFICIENCY MIST BE PRECEDED bY FULL REGULTIONS OF DEFICIENCY MIST BE PRECEDED bY FULL PREFX PREVIDENT COMMENT MARKET REGULTIONS OF DEFICIENCY Deficiency Mist BE PRECEDED by FULL REGULTIONS OF DEFICIENCY Deficiency Mist BY BE PRECEDED by FULL REGULTIONS OF DEFICIENCY Deficiency Mist BY BE PRECEDED by FULL REGULTIONS OF DEFICIENCY Deficiency Mist BY BE PRECEDED by FULL REGULTIONS OF DEFICIENCY F 225 Continued From page 10 her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report Indicated TMA-C dispoint By By Dhone on 223/15 at 320 pm. LPN-C admitted asking NA-C C go with ND R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C direct [R125] claim of being slapped by a "blonde lady". The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present. During interview on 723/15, at 520 p.m. the SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with NA-C was instructed not the ref R12 was slapped, nor was three follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered		CS HEALTH SYSTEM							
Precisive TxG (EACH DEFICIENCY NUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TxG Celect Conference Action should be crossReferenceDecision Conference DEFICIENCY) F 225 Continued From page 10 her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated [TNA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 pm. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere. LPN-C admitted asking NA-C us nistructed not to enter room without a colleague present. During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation. The investigation of this incident, by the facility did not determine if R12 was slapped, nor was three follow up to have R12 positively identify the nursing assistant who provide cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C.					C	DNAMIA, MN 56359			
 her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12s] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present. During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they could not prove NA-C slapped R12. The SW acknowledged in for flapped in "suspicions" with [NA-C], but did not flap there was a reason to suspend" or provide disciplinary action to her during this investigation. The investigation of this incident by the facility did not determine if R12 was slapped, nor was there follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during this investigation of this incident. 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA		COMPLETION
during this investigation of this incident,		Continued From page her as the lady who s agreed to do so. [R12 however, so decided indicated "[NA-C's] wi leads SW to believe s about not slapping res indicated the DON sp 2/23/15 at 3:20 p.m. NA-C to give MOM to occupied elsewhere that NA-C did report [slapped by a "blonde indicated staff have b persons present durin and NA-C was instruct without a colleague p During interview on 7/ stated she did not sus could not prove NA-C acknowledged NA-C multiple incidents, and [NA-C], but did not fea suspend" or provide c during this investigation The investigation of th not determine if R12 y follow up to have R12 nursing assistant who NA-C was instructed without a colleague p offered no indication p	e 10 lapped her, and NA-C 2] was sleeping soundly, not awaken her. The report illingness to go, however, she [NA-C] is being truthful sident." The report then oke to LPN-B by phone on LPN-C admitted asking 0 R12 due to LPN being LPN-C also acknowledged R12's] claim of being lady." The report then een alerted to have two ng cares with this resident cted not to enter room resent. /23/15, at 5:20 p.m. the SW spend NA-C since they is slapped R12. The SW had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on. his incident by the facility did was slapped, nor was there 2 positively identify the o provided cares. Although not to enter R12's room resent, the documentation protections were put in place			1			
R22's admission MDS dated 4/24/15, indicated		regardless of its outco	ome.						

Facility ID: 00374

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 09/04/2015 APPROVED 0: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			-	(X3) DATE COMP	SURVEY LETED
		245127	B. WING			07/2	27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	she had depression a accident (CVA), was r impaired and needed and extensive assist v plan dated 5/3/15, ind with toileting and trans depression and sadne care plan further indic abuse from others rel- weakness, aches and indicated "resident wil needs met in a safe e During observation or lifted her pant leg and right shin measuring a (centimeters) x 2 cm fading to dark purple i swelling In an interview 7/20/1 that she had been tre- and there is a staff me shift that is rough with this staff member had transferring" which ca also stated she had a bar along the bottom The facility submitted state agency on 6/27/ alleged mistreatment The report also identifi right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm, report was submitted the initial reporter, NA	In d a cerebral vascular moderately cognitively limited assist with transfers with toileting. R22's care licated she needed assist sfers, had history of ess/isolating self. R22's cated she had potential for ated to her general I pains. The care plan goal II remain safe and have environment." h 7/20/15, at 5:54 p.m. R22 I displayed a bruise on her approximately 8 cm . R22's bruise was black, in color, with no apparent 5, at 5:54 p.m. R22 stated ated "roughly by the staff" ember who works the night h her. R22 went on to state I "grabbed her arm when iused a large bruise and Iso hit her leg into the metal	F 22	5			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245127	B. WING		07/	27/2015
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD	•	
			2	00 NORTH ELM STREET		
MILLE LA	CS HEALTH SYSTEM		c	DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 225	Continued From pag	e 12	F 225			
		A)-C reported at 5:15 a.m., , After being toileted, R22				
	that "some girl hurt h	not coming back tonight,and er." NA-C asked who, and				
	report then indicated	doesn't know who. The that registered nurse with R22 in the morning and				
	asked her to tell her	what happened: "Resident				
		taying here again tonight and ated like this anymore." R22				
		vas mad at her during the				
		o use the bathroom so many				
		I grabbed me and threw me				
		ed out her hand hurt, and ne grabbed me," noted a				
		hand measures 5.5 cm				
		circular is shape. R22 also				
		nrew me into bed, "I hit my				
		etal;" a bruise noted on right				
		sures 2.5 cm x 2.5 cm 22 could not recall who the				
		ne. R22 thought it was				
		eport further indicated NA-C				
	-	stant working on that wing				
		LPN-A was the nurse in				
		juries noted, resident was main safe here, NA-C will be				
		ng with resident at this time.				
		t Report was submitted to				
		7/1/15, which identified an ource on R22's right forearm				
		rple in color, and oval in				
		ncident occurrence was				
	unknown. The report happened a few days	t indicated R22 said, "It s ago."				
			1	1		1

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PRINTED: 09/04/2015 FORM APPROVED

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	I	10. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	6	CON	MPLETED
		245127	B. WING		0	7/27/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	Continued From page	e 13	F 22	25		
	two submitted incider					
		id social worker SW "have				
		s issue thoroughly and have				
		antiate who the alleged				
		certain, but have reached a asonable suspicion a crime				
		the form of assault, and are				
	hence submitting a re					
		rdance with Elder Justice				
	Act." Further, "The d					
		nits of our ability are being				
		Office of Health Facility agency." The Investigative				
		ed on 7/1/15, the DON and				
		(NA-C) who stated R22 had				
		toilet 6-8 times that night				
		then indicated [SW and				
		n the AP the number of nvolving this NAR, which				
		[regarding] her credibility,				
	÷	newhat defensive, face				
	reddening and voice					
		gs and others don't, so I end				
		" The report further listed,				
	-	ew 7/2/15 the DON and SW				
		stated she "reported having R22) on 6/30, that [R22] is				
	,	the blonde hair and bangs,				
	•	ice, etc. The blond hair with				
	•	tion of NA-C. The report				
		NA-C had been "implicated				
		5814, 78740, and 79433 with				
		gles" with residents, as she ; received coaching in these				
		also involved in report				
		pecifically named as AP."				
		scribed NA-C as the staff ther and NA-C was caring				
	member who had hur	t her and NA-C was caring				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/04/2015 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	27/2015
NAME OF PF	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MULEIA	CS HEALTH SYSTEM			20	00 NORTH ELM STREET			
	STEALINGTOLEM			0	NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	disciplinary action was suspended pending the was no indication that was completed by the interviews with staff a During interview on 7/ DON stated she has of be doing the accusation certain. The DON said during the night shift," that do that." The DOC report if they notice ar In an interview on 7/2 stated she did not talk regarding abuse alleg stated, "I don't generat hunt." The DON said, keeps coming up doe The DON also said the "data privacy and con stated when somethin allegations come up of on duty initiates the O said the nurse would the address any immediat NA-C, the SW stated several residents she but that does change the allegation is not su further stated, in rega allegation of abuse, "a The SW also said the "not intensive, and the	nultiple large bruises, no s taken, NA-C was not he investigation. Also, there a thorough investigation facility to include other nd residents. (23/15, at 4:50 p.m. the concerns that NA-C might ons, but stated she was not id, "Staff monitor [NA-C] and "we have nurses on N stated the nurses were to nything and have concerns. (3/15, at 5:03 p.m. the SW with other residents or staff ations by R22. The DON ally do that, it's not a witch "Just because their name s not make them guilty." ere were issues around fidentiality." SW further	F 2	225		DEFICIENCY)		
		documentation of education						

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		D HUMAN SERVICES				FORM	: 09/04/2015 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	
		245127	B. WING		_	07/2	27/2015
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET			
				-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	: 15	F 225				
	During an interview o administrator said, "W working on nights, we enough staff." The ad feel the DON and SW During an interview o	n 7/23/15 at 5:10 p.m., the /e have three young people can't suspend; there is not ministrator further stated, " I					
	facility policy following R22 . She stated, "If I	the allegation made by had suspended one, I spend all three staff, then					
	stated, " I don't work a am mandated, but I d stated, "I have heard wet and I have heard little rough, but I can't stated one of the resid being rough and leave the staff member as the resident and stated the threw me into the char	n 07/24/15, 5:14 a.m., NA-E a lot of overnights unless I o hear a few things." NA-E about people being super that some of the girls are a tell you who." She further dents mentioned about a girl ng bruises. NA-E described hey were described by the e resident said " the girl ir because I had to go to the -E stated she does not see hts.					
	stated she works part LPN-H stated she has NA-C is rough with th witnessed it directly. aware that she was to the night shift when s indicated she had hea NA-C had slapped he works on the North wi was because of the c	24/15, at 5:25 a.m. LPN-H time on the night shift. s heard from other NAs that e residents but had not LPN-H stated she was not o monitor any staff during he works. She further ard R12 had reported that r and that NA-C no longer ing and thought the reason at; not because she can not in residents. She then					

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/04/2015 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245127	B. WING			-	07/	27/2015
NAME OF PF	ROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
	CS HEALTH SYSTEM				00 NORTH ELM STREET			
				0	NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	: 16	F 2	25				
		e night shift don't work o work on each unit alone.						
	INJURIES OF UNKNO	OWN ORIGIN						
	was moderately cogn plan, dated 3/30/15, in extensive assist with a	all activities of daily living, and for transfers, and was						
	dated 10/7/14, indicat purple bruise on the r buttock and that R39 bruising occurred. The been lowered to floor the bruise and indicat the injury. The incider anticoagulant medica clotting), other injurie unspecified times fram							
	DON)stated, when R3 floor it would be hard during that event but s due to use of anticoag therefore the injury wa reportable.	as not considered						
	unable to recall how t was no evidence that	oderately impaired and he bruise occurred, there a more in-depth npleted to determine the						

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			0.00	E AONOTRUOTION		IO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	TE SURVEY MPLETED		
		245127	B. WING		0	7/27/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
actu origi R11 she plan exte livin		s R39's injury of unknown	F 22	5				
	she was moderately of plan, dated 6/3/15, in extensive to total ass	ist for all activities of daily / impaired, and at risk for						
	Report Forms indicate unknown origin. An in indicated R39 had a th hand that was dark po 8 cm x 8 cm. The rep was unable to state h blood thinners and de "minor." Another Soci dated 11/4/14, indicat to her left temple and was unable to state th third incident report d had a bruise of unknown knee, dark purple in of (unit of measurement report further indicate the cause of the injur- medications, and the	rate Social Services Incident ed R11 had injuries of ncident form dated 10/21/15, pruise to the top of her right urple in color and measured ort further indicated R11 ow the injury occurred, used escribed the injury as ial Services Report Form, ted R11 had bruising noted above her left eyebrow, and ne cause of the injury. A ated 12/18/14, indicated R11 own origin to her left inner color, measuring 1 x 1 3/4. was not indicated). The ed R11 was unable to report y, use of anticoagulant injury was considered to be three bruises were reported						
	SW stated, R11 "had have ever known." Sh hand may have been	n 7/24/15, at 12:54 p.m., more bruising than anyone I ne stated the bruise on R11's caused by "recent trimming arding the bruise noted to						

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If continuation sheet Page 18 of 65

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 09/04/2015 // APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	27/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	R11's nebulizer mask R11 who reported that way back from supper not ambulate, used a there were no records the bruising was likely nebulizer mask. During an interview of DON stated R11 could asked if bruising was she felt the injury was Although R11 was ide cognitively impaired, a different locations, an what happened, there investigation complete causes of R11's bruis was notified but none submitted to the state R66's quarterly MDS, was moderately cogn dated 2/9/15, indicate assist of two staff with transfers, at risk for de related to depression. During review of a So Referral Form, dated noted indicated R66 h from her hands to her indicated R66 was un the injury and that the	head, SW stated that ing was due to placement of , however, SW interviewed t she slipped and fell on her r. SW further stated R11 did Hoyer lift for transfer and of any falls and indicated r due to placement of R11's n 7/24/15, at 12:54 p.m., the d reliably answer when related to abuse, therefore, not reportable. Intified to be moderately and had multiple bruises at d were unable to determine e was no indepth ed to determine the actual es. The facility administrator of these incidents were agency. Indext 1/7/15, indicated she tively impaired. Care plan, d R66 required extensive n use of mechanical lift for elirium, and at risk for abuse	F	225				

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If continuation sheet Page 19 of 65

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 09/04/2015 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	27/2015
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	: 19	F	225	5			
	SW stated, the bruise was reviewing a progr with nursing and dete assessed to be a min- reportable to to OHFC During an interview of DON stated, R66 use lift) and did not always occasionally "flailing h stated, R66 was confu "hard to say if R66 wo talk about how the bru time had passed." Although R66 had bila hands to her shoulder unwitnessed and the identify what happene immediately reported agency nor was a tho completed to determin	n 7/24/15, at 12:54 p.m., the ed a Hoyer lift (mechanical s cooperate in lift, ner arms." She further used and that it would be build have been able to to uising occurred after any ateral bruising from her rs, the injury was resident was unable to ed. The facility had not the incident to the state rough investigation ne if R66 was "flailing her						
	was severely cognitive dated 7/10/15, indicat assist with activities of for abuse related to sl impaired decision mat Review of Social Serve dated 6/15/15, indicat on her posterior forea	ated 6/9/15, indicated she ely impaired. Care plan, ted R44 required extensive of daily living, and was at risk hort term memory loss and						

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		D HUMAN SERVICES				FORM): 09/04/2015 1 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245127	B. WING		_	07/:	27/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET			
			I	DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	form indicated R66 di injury and that the inju "minor."The bruise wa During an interview of SW stated, on 8/18/14 bruise measuring 8.5 thumb and forefinger to her wrist. She state the initial evaluation a resulted from R8 wrin wringing of her hands She further stated the due to staff witness of Social Services Incide requested for this inju During an interview of SW stated when mak	d not state the cause of ury was determined to be as not reported to OHFC. n 7/24/15, at 12:54 p.m., 4, staff reported R8 had a cm in length between her from the base of the thumb ed the reporting nurse did und determined the bruising ging her hands, and the was witnessed by staff. e injury was not reportable f the potential cause. A	F 225		DEFICIENCY)		
	also stated that she lo able to explain the inji it, and if there is a his and/or injuries. She fu indicated minor injury nature or location, it d reported. During an interview of DON stated, there was whether an injury was stated, the nurse findi evaluation to determin minor. The DON staten nurses judgement wh	n 7/24/15, at 12:54 p.m., the is no criteria for determining minor vs major. She further ing the injuries did initial he the above injuries to be					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/04/2015 APPROVED D: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245127	B. WING			07/	27/2015
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	followed up on the injuthere was no charting would show evidence completed. Even though R44 was cognitively impaired, I origin, on the posterior indication the facility of investigation to determinjury, also the incider state agency. R8's quarterly minimuther to be severely cogrequiring assist of two living. CP dated 5/15/ extensive assist for adwas at risk for abuse I dementia. A review of SSIRF da had a bruise measurinher thumb and forefin thumb to her wrist. The initial evaluation and or esulted from R8 wrinwringing of her hands. During an interview of SW stated, the injury staff witness of the point of the injury staff witness of the point of the injury are port was not made Social Services Incider	uries. However, she stated in the clinical record that that follow up had been s assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her nt was not reported to the um data set (MDS) identified gnitively impaired and o staff for activities of daily (15 indicated R8 required ctivities of daily living and related to diagnosis of ted 8/18/14, indicated R8 ng 8.5 cm in length between iger from the base of her ne reporting nurse did the determined the bruising ging her hands, and the s was witnessed by staff. n 7/24/15, at 12:54 p.m., was not reportable due to otential cause. No further jury was completed. The was notified of the injury but e to the state agency. A	F	225			

Facility ID: 00374

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						<u>10. 0938-039</u>		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED		
		245127	B. WING		0	7/27/2015		
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE				
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 225	Although R8 had seve and had a bruise 8.5 forefinger from the ba There was no indicati thorough investigation her injury, also the indi- the state agency. Review of the facility revised 7/15, indicate (Mille Lacs Health Sy are vulnerable to abu physical, mental psyc sexual abuse)" The "protection will include individual abuse prev reporting of all cases neglect, or financial e reporting to the Comr substantiated inciden regard to investigation the policy stated: "All thoroughly investigate further potential abus progress." Under the Patient" section, the p alleged perpetrator (A situation. If the AP is suspended until the ir and further, "Disciplin up to and including di employee/employees defined Injury of Unkr the injury was not obs suspicious." The poli definition top include	ere cognitive impairment, cm between her thumb and use of her thumb to her wrist. on the facility completed an in to determine the source of cident was not reported to Vulnerable Adult Policy, d: "It is the policy of MLHS stem) to protect adults who se (including verbal, thosocial/emotional, and e policy further indicated: e abuse prevention plans, ention plans, internal of suspected abuse, xploitation, and external non Entry Point (CEP) of ts of maltreatment." In n of a reportable incident, I alleged violations are ed. The facility must prevent e while the investigation is in "Protection for Resident or policy directed that "The AP) will be removed from the an employee, they will be nvestigation is completed," ary action will be carried out smissal of as appropriate." The Policy nown Origin as "source of served and injury as cy did not expound on this CMS definitions. In regard tial employees, the policy	F 225					

Facility ID: 00374

If continuation sheet Page 23 of 65

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/27/2015
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
AILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLE
F 225	Continued From page	23	F 225	5	
F 226 SS=F	employers." 483.13(c) DEVELOP/ ABUSE/NEGLECT, E		F 226		8/21/15
	policies and procedur	, and abuse of residents			
	by: Based on observatio review, the facility fail Vulnerable Adult Polic abuse, neglect, mistre unknown origin were administrator and stat investigated, and res during the investigatio (R47, R12, R22, R39 allegations reviewed. to conduct reference policy for 4 of 5 newly NA-B, DA-A and RN- effect all 50 residents and resulted in substa resident behavior and	cy to ensure all allegations of eatment and injuries of immediately reported to the te agency, were thoroughly idents were protected ons for 8 of 15 residents' , R11, R66, R44 and R8) In addition, the facility failed checks according to their hired employees (NA-A, B). This had the potential to who resided in the facility, andard quality of care under		Investigation and Protection: Affects residents R47, R12, R22, R39, R11, R66, R44, R8 with the Potential to affect All Residents. Injuries of Unknown Origin: Affects residents R39, R11, R66, R44, R8 with the Potential to affect All Residents. Corrections support investigation, protection and injuries of unknown o 7/24/15 @ 10:15 PM: A Performance Improvement Plan was delivered an implemented effective immediately with NA-C. (Attachment B). One said measurement included NO complaints regarding care action during the shift. Failure to meet this	d
	indicated: "It is the po Health System) to pro vulnerable to abuse (i	e Adult Policy, revised 7/15, licy of MLHS (Mille Lacs otect adults who are including verbal, physical, emotional, and sexual		 goal will result in further disciplinary action up to termination. 7/29/15 In order to ensure the protection and safety of R22 it was decided that at this time 2 staff would be required in the room when providing care. This was discussed 	

Event ID: HJY511

Facility ID: 00374

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						0.0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245127	B. WING		07/	27/2015
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
/ILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET		
				ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 226	Continued From page	> 24	F 22	6		
	-	further indicated: "protection		at R22's Care Conference and wa	26	
		evention plans, individual		approved by both R22 and her fa		
		ns, internal reporting of all		8/15/15 Existing VA tracking log		
		buse, neglect, or financial		revised to include identity of alleg	ed	
	exploitation, and exte			perpetrators to better identify tree		
	-	(CEP) of substantiated		occurring, including those inciden		
	incidents of maltreatn			that have been ¿unable to		
		ortable incident, the policy		substantiate.¿		
	stated: "All alleged v	iolations are thoroughly		The Log will be updated at the tin	ne	
	investigated. The fac	ility must prevent further		investigation results are submitted	d	
	potential abuse while	the investigation is in		to OHFC and again when the		
		"Protection for Resident or		investigation is closed.		
		oolicy directed: "The alleged		Upon Closure of each incident the		
	perpetrator (AP) will t			VA Log will be electronically forwa		
		an employee, they will be		by LSW to administrator to assur		
		nvestigation is completed,"		administrator is kept informed of		
		ary action will be carried out		FULL STATUS of the investigation		
	up to and including di			with regards to timeliness of repo		
	employee/employees	as appropriate.		submissions, final disposition and actions taken with regards to	I	
	INVESTIGATION AN			alleged perpetrator.		
		BIROTECTION		Person(s) responsible: LSW		
	During interview 7/23	/15, at 5:09 p.m. with social		On 8/17/15: Facility wide Vulnera	ble	
		nat nursing assistant (NA)-C		Adult Policy (Attachment C) revis		
		n at least four incident		delineate protections for residents		
		y 2015 to July 2015 of		This includes CMS language def		
	alleged abuse, and n			injuries of unknown source.	-	
				On 8/18/15: Administrator and		
		dent and Investigation		Medical Director sent a letter		
		5 to 7/20/2015 for NA-C		(Attachment D) to all residents an	id/or	
	identified the following	g:		their representatives regarding		
				survey findings; how, what and h	WO	
		num data set (MDS) dated		often we educate staff and the		
		e was moderately cognitively		facility¿s commitment to protectin	ıg	
		tensive assistance in ADLs.		vulnerable adults. A flier with	h	
	-	d 2/26/15, indicated she had		information on warning signs of a		
	dementia and needs	-		and neglect, and a copy of the st		
		g. The care plan further ght alteration in cognition		education over the last 12 month were included with the letter.	S	

Facility ID: 00374

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIOI	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		245127	B. WING		07/27/2015
IAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
/ILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 226	Continued From page	25	F 226	5	
	related to dementia a	nd that resident will continue		On 8/19/15 Social Service Incider	
	to be oriented to pers	on, place and time.		Reporting Form (Attachment E) w revised to provide documentation	as
	A facility Social Servi	ce Incident Referral Form		space that clearly identifies the in	itial
	(SSIRF) indicated lice			evaluators thoughts in regards to:	
		orted to the social worker		1) Reason for submission	
		t 4 p.m., an incident that		2) Rationale for NOT submitting	
		ight shift on 1/24/2015. The		report beyond the facility	
	SSIRF, dated 1/27/15			3) Action taken to Protect The Res	
		tween res [resident] & aides lapping aide and stating 'I		The revision also provides the rev team a means to clearly docume	
		me you liar." The SSIRF		their evaluation of the incident and	
		separated aide & resident,		any ACTION that they feel needs	
		scorted aide to hallway to		be taken on but not limited on the	
	inquire what happene			following items: (Attachment F)	
	indicated the incident	•		1)Timeliness of the report	
	investigation and/or re	eporting" to the state signed by the SW on		2) Was Protection of the resident appropriate	
	1/28/15.	signed by the Sw on		3) Reportability decisions were	
	1/20/10.			appropriate	
	A review of Mille Lacs	Nursing Home Progress		The vulnerable adult reporting	
		, written by LPN-D indicated:		process/guides located at each	
		res. room, 5 rooms away		nurses' station will be updated	
		ent happened, but heard a		by 8/25/15.	
	This nurse then got a	wed by a woman's out cry.		Responsible Person: LSW 8/19/15: 4- separate staff meeting	woro
		e aide (nursing assistant,		scheduled for 8/25/15 where the	were
		d (in her words) "On 2 a.m.		Administrator, DON and LSW will	
		ck resident in room 45-1		jointly provide nursing staff with	
		woke up resident in 45-2		training regarding the changes that	
		I told [R47] the time and		have been put into place to assis	t
	-	ack down and try and get		staff in identifying potential abuse	at
		ee time." [R47] said "No, I ting." NA said "No lets lay		and neglect, protecting the resider discerning reportable injuries of	π,
		o pick up [R47's] feet to		unknown origin and reporting	
		d [R47] swung and hit me in		requirements.	
	the head, fairly hard.	I [NA] yelled out "ow" and		This staff mtg will also cover the	
		hit me, [R47] said, 'I didn't,		revisions to policies and available	
	you hit me you liar' th	on [NIA] walked out and		tools. All Nurses and NA-R staff w	30

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		MEDICAID SERVICES			OMB NO. 0938
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/27/201
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPL
F 226	Continued From page	e 26	F 226	6	
F 220	walkie the nurse" T the res. why she hit th that the aide hit her." identify the nursing as A facility email, writte 1/28/2015, indicated informed by LPN-D of a nursing assistant. Was a progress note of "incident report form." SW further reviewed because the notes ind allegedly struck a NA also that the resident NAR struck her, the in reported" to the state An Incident Report su on 1/28/15, indicated reported to this SW ir 1/27/15" and furthe past weekend" with a Following a review of by the "Stand Up Tea Management Team", incident was due to [F symptoms" The rep progress note which i "claimed at the time to thus requiring a report "an internal investigat policy." The alleged punidentified.	This nurse [LPN-D] asked the aide. Res. [R47] stated The nursing note did not ssistant by name. In by the SW, dated the SW had been verbally f R47 being in a conflict with The email indicated there of the incident, but no further " The email indicated the the progress notes, and dicated "the resident R [nursing assistant] and claimed at the time that the noident DOES need to be agency. "An incident was verbally in the late afternoon r that R47 had a conflict "this nursing assistant. the related progress notes am" and "Behavior it was originally determined R47's] "dementia port referred to a nursing indicated that [R47] hat the NAR struck her," t to the state agency, and tion done accordingly as per perpetrator (AP) was	F 226	 be strongly encouraged to atter an attendance record will be ke and those staff unable to attend be required to review materials presented and minutes of the m A signature of completion will b required at the time of the revie no later than 9/1/15. Persons responsible: Administr DON and LSW 9/20/15: Protection of the Resice After review of all final evidence 2567 report NAR-C will be term 8/21/15. (NAR-C has been off s 8/10/15, earliest available meet for NAR-C prior to next schedul 8/21/15. (Attachment G) MONITORING Audit (Attachment H) of each Service Incident Report Form w reviewed for: timeliness of report appropriateness of report, and taken to protect residents The audit will begin with any into occurring after 8/21/15 and will every incident reported for the 3 months (ending 11/21/15) Responsible person: DON and 2. Audit (Attachment I) of each Investigation Report will be com to:Assure thoroughness of investigations. The audit will be with any incident occurring after 8/21/15 and will include every incident reported for the next 3 months (ending 11/21/15) 	pt d will seeting. be w but ator, dents in the since ing date led shift o Social <i>i</i> be porting, actions cident l include next LSW pleted
	indicated an incident	occurred sometime during orning hours of 1/25/14.		Person(s) responsible: DON an Both audit reports will be report	

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE	0. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,		<u> </u>	LETED
		245127	B. WING		07/2	27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 226	Continued From page	e 27	F 22	6		
		ated the incident was first		the Quality Assurance Committe	e.	
		known to the SW on late		(QA meets quarterly; Oct., Jan.,		
		4, (two days after the		April and July).		
		d to the state agency on				
		s after the incident allegedly		Reference Checks: F225 Correct	ed	
		s no indication this incident ately to the administrator		8/19/15 Affects Posidents P47 P12 P22		
		dditionally, the investigation		Affects Residents R47,R12,R22 R39, R11, R66, R44, R8 and the		
		ed timely interviewing of		Potential to affect all Residents		
		lved staff, and potentially		1. 8/18/15 The VA policy was upo	dated	
		d not provide evidence R47		(Attachment C) indicating that HF		
		tigated for injuries; and		would attempt to obtain informati	on	
		ction to protect residents		from previous employers and /or		
	during the investigation	on.		current employers during the		
				pre-employment screening proce including dates of employment,	:55	
	A final Investigative F	Report was submitted to the		position held, and feedback on		
		15. The report indicated the		workplace performance		
		the a.m. of 1/28/15 and		2. 8/18/19 A new Reference Che	ck	
		ent unable to recall any		Form was developed		
		with any aides the previous		(Attachment J) which identifies		
		was unable to speak with		documented reference checks w		
	NA-C, (identified as t	6 (7 days after the SW		dates of employment, position he and feedback on workplace	eld	
		nt) "in part due to her work		performance.		
		ng with the SW." SW spoke		3. 8/18/15 The VP of HR provide	d	
		on 2/2/15, at 10:45 p.m.		Training to the HR recruiter on th		
		I the incident happened as		revised VA Policy, and the new		
		's note, and further, "[NA-C]		Reference Check Form.		
		truck resident in any way, but		The Reference Check Form was		
		t [R47's] legs to help her lay		implemented on 8/19/15 and will		
		port indicated "There is no NAR striking resident." The		used on all new hires going forwat Monitoring: (attachment K)	DIR	
	investigative report in			Responsible Party: VP of HR		
		C. This report also included		4. Biweekly audits will be comple	ted	
		mplicated in a previous		by the VP of HR or designee for		
	submitted report.	-		for all new hires. The audit will		
				include verification that the		
	During an interview 7	/23/15, at 5:10 p.m., the SW	1	Reference Check form was		

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		MEDICAID SERVICES				O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · · ·	E SURVEY IPLETED	
		245127	B. WING		0	7/27/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 226	 F 226 Continued From page 28 stated in the investigation, R47 was unable to recall if the incident had happened, and that R47 had dementia. The SW said NA-C was not suspended during her investigation because it could not be proven that NA-C abused R47, and NA-C continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe. Review of the facility's MLHS-LTC NA/R Schedule from January 26, 2014 to February 8, 2015, indicated NA-C worked on the night shift on 1/28/15 and 1/29/15, while the investigation of this incident was in progress. 		F 226	completed for all new hires prio the first day of employment. Audit reports will be reported to Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).			
	Referral Form (SSIRF R47 was involved in a a.m., of possible abus The SSIRF indicated: (electronic progress r verbal statements and resident [R47]; possit maltreatment but just resident's dementia." indicated the inciden Investigative Team or reported submitted to 3/3/2015 at 12:30 p.m NA-C was a person w the situation.	ble indication of t a likely symptoms of The SSIRF further t was discussed with a 3/3/15 at 8:30 a.m., and the state agency on a. The report also indicated with credible knowledge of					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 09/04/2015 1 APPROVED 2. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY
		245127	B. WING			07/2	27/2015
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT	TE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			0 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 226	by resident [R47] at w maltreatment of residu indicated uncertainty maltreatment, and "S' submit the allegation A nursing progress not a.m., written by LPN-I "kicking at staff" and [going to report 'her' to indicated R47 told sta everyone I heard" O second progress note wipe dry blood off [R4 The note continued, t stated "I am going to Facility documentation was taken to protect F during this investigation Documentation of the did not include determ bloody lip, and there w with the nursing assiss R47. The SSRIF also immediate reporting of agency or administrat A final, Investigative F state agency on 3/06 The report indicated of interviewed by RN Ca this SW. Resident de happening this past w or the nighttime that u denied that anyone hi her or that she has hi	cerns/dementia symptoms york or possible ent by staff." The report by staff on whether this was W decided to go ahead and to [state agency]" ote, dated 3/2/215 at 4:03 B, indicated [R47] was [R47] told staff "she was of the nurse" The note also off "you go around hitting On 3/2/15 at 6:03 a.m., a ed indicated staff went to 47's] lip, and [R47] hit staff. hat after R47 hit staff, R47 report you for hitting me." In did not indicate any action R47 and other residents on of potential abuse. Investigation of this incident nination the cause of R47's was no evidence of interview stant who provided cares for o indicated there was no of this incident to the state	F 226				

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	S FOR MEDICARE &					10.0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED
		245127	B. WING		0	7/27/2015
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 226	shift, "indicating the N the EZ lift (mechanication bathroom per resident noticed resident's lip apparently cracked fr winter air. [NA-C] told the dried blood off, b causing NA's glasses The report indicated and assisted [R47] with same night, the NA w attempted to lift R47's resident kicked at NA referenced the allega was slapped. The rep perpetrator in this inc R47's care plan was to were made on how to cares. The report als coached by the SW ap progress note chartin have been reminded reports. The report in not resting well with the maltreatment of resid particular incident, SV and ears open for pat conduct, etc." Review of the facility Schedule from Febru 2015, indicated NA-C 3/2/15 (the night of the worked on 3/3/15.	from 3/2/15 during night JAR was situating resident in al lift) to help her to the at's request and the NAR had been bleeding om being chapped with dry, d [R47] she was going wipe out R47 struck out at NA, to dismount from her face." NA-C re-approached later ithout incident. Later the vas doing rounds and s feet back in bed, and t-C. The report then tions made by R47, that she port did not confirm a ident. The report indicated reviewed, and suggestions to approach R47 during to indicated LPN-B was and DON on more thorough g, and further, that staff to submit timely incident his, and although there is no ents 'substantiated' in this <i>N</i> will continue to keep eyes tterns and/or trends in	F 226			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	ECONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		245127	B. WING		0.	7/27/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 226	she had really done a felt they could not sub against NA-C, and the "suspension or discip investigation. There w	nything wrong. The facility ostantiate the allegations erefore did not warrant a	F 226			
was modera extensive as grooming. F indicated sh related to co mobility. A facility Soc (SSIRF), sig indicated the early A.M.", was describ Res re some want to go h lady with the up yesterday when she tri 4p.m. reside concerns." following: a on 2/18/15; received by listed; the in "Investigativ the state age	was moderately, cogr extensive assist with grooming. R12's care indicated she had pot related to cognitive im	e plan dated 1/31/15, tential for abuse from others				
	A facility Social Service Incident Referral Form (SSIRF), signed by the SW 2/18/15 at 4:15 p.m., indicated there was an incident on "2/18/2015 early A.M.", which alleged "Abuse." The incident was described as: "[NA)-I] asked SW to meet w/ Res re some issues. 9:30 a.m. Res told SW 'I want to go home, they're mean to me here.' 'The lady with the ponytail hurt me when she clean me up yesterday', and 'The other lady slapped me when she tried to make me drink white stuff.' At 4p.m. resident [R12] was still claiming similar concerns." The SSIRF also indicated the following: an internal email report was completed on 2/18/15; that the report of alleged abuse was received by the SW in person, no date or time listed; the incident was discussed with "Investigative Team" on 2/18/15 at 0833; and that the state agency initial report was submitted on 2/18/15 (no time indicated).					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/04/2015 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245127	B. WING		_	07/	27/2015
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	this morning while stather to take some med R12 had no apparent consistent with this cli The report also indication investigation is warrant perpetrator" on the re- "unknown." A review of the SSIRF State Agency indicate occurred in the early of possibly earlier, no action or staff until it was dis on 2/18/15. There was was immediately report administrator. Further documentation of this R12 was slapped; and have R12 positively id (possibly NA-C) who Although NA-C was in room without a collea documentation offerent were put in place for of assisted by NA-C dur incident, regardless of A final Investigative R state agency on 2/23/ indicated the "Initial R agency]at 4 p.m.," was made to local law indicated R12 had ma but the only allegation the one about someon	cheek by a staff person early iff person was trying to get licine." The report indicated injuries, and "has been aim throughout the day" ted "a full internal nted." The "alleged port form was listed as F, and the initial report to the ed, that although this incident morning of 2/18/15, and ction was taken by the facility cussed later that morning as no indication the incident orted to state agency and r, the investigation incident did not indicate if d there was no follow up to dentify the nursing assistant, provided her cares that day. nstructed not to enter R12's gue present, the d no indication protections other residents who were ing the investigation of this f its outcome.	F 226				

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			FOR	D: 09/04/2015 MAPPROVED O. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	E SURVEY IPLETED
245127	B. WING		07	//27/2015
1		STREET ADDRESS, CITY, STATE, ZIP CODE		
	2	200 NORTH ELM STREET		
		DNAMIA, MN 56359		
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE
uff)." The report indicated aded to seek more o would have administered ag. The report identified, adule, LPN-B and NA-C were Further, the report SW met with [NA-C], who g given MOM upon the The report continued, a didn't want the MOM, and and threw the MOM all ed to clean it up off the lothing and her face, using ort indicated "[NA-C] denied any way, but acknowledged f with the wet ones." The possible this was perceived Next, the report indicated, to go to resident's room to or would identify her as the r, and NA-C agreed to do so. soundly, however, so her." The report indicated o go, however, leads SW to a being truthful about not the report indicated the DON hone on 2/23/15 at 3:20 p.m. ng NA-C to give MOM to eing occupied elsewhere edged that NA-C did report g slapped by a "blonde lady." ated staff have been alerted ns present" during cares with C was instructed not to enter ague present.	F 226			
	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 33 tuff)." The report indicated aded to seek more to would have administered ag. The report identified, edule, LPN-B and NA-C were Further, the report SW met with [NA-C], who g given MOM upon the "The report continued, t didn't want the MOM, and and threw the MOM all ied to clean it up off the lothing and her face, using out indicated "[NA-C] denied any way, but acknowledged f with the wet ones." The possible this was perceived Next, the report indicated, to go to resident's room to or would identify her as the r, and NA-C agreed to do so. soundly, however, so her." The report indicated o go, however, leads SW to a being truthful about not The report indicated the DON hone on 2/23/15 at 3:20 p.m. ng NA-C to give MOM to eing occupied elsewhere edged that NA-C did report g slapped by a "blonde lady." ated staff have been alerted ns present" during cares with -C was instructed not to enter ague present. 7/23/15, at 5:20 p.m. the SW spend NA-C since "they	MEDICAID SERVICES (X2) MULTIPLIA (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLIA IDENTIFICATION NUMBER: A. BUILDING 245127 B. WING 2 2 CATEMENT OF DEFICIENCIES ID YMUST BE PRECEDED BY FULL PREFIX LSC IDENTIFYING INFORMATION) PREFIX e 33 F 226 tuff)." The report indicated eded to seek more oo would have administered ng. The report indicated edule, LPN-B and NA-C were Further, the report SW met with [NA-C], who g given MOM upon the ' The report continued, t didn't want the MOM, and o and threw the MOM all ied to clean it up off the lothing and her face, using ort indicated "[NA-C] denied any way, but acknowledged f with the wet ones." The possible this was perceived Next, the report indicated, to g or esident's room to or would identify her as the r, and NA-C agreed to do so. soundly, however, so her." The report indicated	MEDICAID SERVICES (x1) PROVIDERSUPPLERICLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 245127 B. WING 245127 B. WING 20 NORTH ELM STREET ONAMIA, MN 56359 INTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S) PREFIX e 33 F 226 Uff)." The report indicated side to seek more to would have administered go the seek more further, the report SW met with [NA-C], who g given MOM upon the "The report continued, didint want the MOM, and and threw the MOM all led to clean it up off the lothing and her face, using ort indicated "[NA-C] denied any way, but acknowledged fwith the wores." The possible this was perceived Next, the report indicated to go to resident's room to or would identify her as the r, and NA-C agreed to do so. soundly, however, so her." The report indicated to go to resident's room to or would identify her as the r, and NA-C agreed to do so. soundly, however, so her." The report indicated the DON hone on 2/23/15 at 3:20 p.m. ng NA-C to give MOM to ing occupied elsewhere edged that NA-C did report g slapped by a "blonde lady." ated staft have been alerted hs present. Her SW spend NA-C Since "they	ND HUMAN SERVICES FOR MEDICAID SERVICES OMB N MEDICAID SERVICES OMB N (n1) PROVIEERSUPPLIERCLA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BUILDING (x0) DATA 245127 B. WING go 200 NORTH ELM STREET ONAMA, MN 56339 ATEMENT OF DEFICIENCIES TYMUST EE PRECEDED BY PULL LSC. IDENTIFYING INFORMATION) p. PREPRX e 33 F 226 e 33 F 226 utif)." The report indicated ded to seek more to would have administered ig. The report indicated didule, LPN-B and NA-C were Further, the report of the report indicated didule, LPN-B and NA-C were Further, the report indicated ided to clean it up off the lothing and her face, using or indicated "[NA-C] denied nay way, but acknowledged f with the wotones." The possible this was perceived Next, the report indicated, to go to resident's room to or would ident's nom to or sourd ident's nom to or would ident's nom to or sourd ident's nom to her. The report indicated o go, however, leads SW to is being truth'nd-C did report g slapped by a "blonde lady." ated staff have been alerted ns present." 72315, at 5:20 p.m. the SW spen NA-C Since "th

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/04/2015 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245127	B. WING			07	/27/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	[NA-C], but did not fee suspend" or provide of during this investigation Review of the facility's Schedule from Februa 2015, indicated NA-C 2/22/2015, that is on the incident, and during the There was no indication was completed for R1	had been involved in d had "suspicions" with el "there was a reason to lisciplinary action to her on. S MLHS-LTC NA/R ary 9, 2015 to February 22, worked on 2/17/15 through the date of the alleged ne subsequent investigation. on a thorough investigation 2.	F	226			
	she had depression a accident (CVA), and impaired and needed and extensive assist plan dated 5/3/15, ind with toileting and tran depression and sadne care plan further indic abuse from others rel weakness, aches and indicated "resident wi needs met in a safe e During observation or lifted her pant leg and right shin measuring a (centimeters) x 2 cm. be black, fading to da apparent swelling. In p.m. R22 stated that s "roughly by the staff"	ess/isolating self. R22's ated she had potential for ated to her general pains. The care plan goal Il remain safe and have nvironment." A 7/20/15 at 5:54 p.m., R22 displayed a bruise on her approximately 8 cm R22's bruise was noted to rk purple in color, with no an interview 7/20/15, at 5:54					

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						<u>10. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				FE SURVEY MPLETED
		245127	B. WING		0	7/27/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	E	
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	R22 went on to state "grabbed her arm who caused a large bruise also hit her leg into th bottom of her bed. The facility submitted state agency on 6/27/ alleged mistreatment The report also identi right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm, report was submitted the initial reporter, NA perpetrator in this inci nursing assistant (NA she had toileted R22, told [NA-C] she was r that "some girl hurt he she [R22] stated she report then indicated (RN)-A, followed up v asked her to tell her v reported she is not sta is not going to be treat explained that staff w night for getting up to times, and that a "girl	this staff member had en transferring" which a and also stated she had e metal bar along the an Incident Report to the (15 regarding an incident of and physical abuse of R22. fied a bruise on R22 top g 5.5 cm x 5 cm, circular in bruise on R22's lower right circular in shape. The by RN-D, and indicated that A-C, was also the alleged ident. The report indicated, .)-C reported at 5:15 a.m., after being toileted, R22 not coming back tonight,and er." NA-C asked who, and doesn't know who. The	F 226			
	bruise on top of right (centimeters) x 5 cm reported when she th leg on something met outer lower shin meas circular in shape. R2 girl was, nor her name	e grabbed me," noted a hand measures 5.5 cm circular is shape. R22 also rew me into bed, "I hit my tal" a bruise noted on right sures 2.5 cm x 2.5 cm 2 could not recall who the e. R22 thought it was eport further indicated NA-C				

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If continuation sheet Page 36 of 65

		ND HUMAN SERVICES MEDICAID SERVICES			F	TED: 09/04/2015 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION		DATE SURVEY OMPLETED
		245127	B. WING			07/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
				200 NORTH ELM STREET		
	CS HEALTH SYSTEM			ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 226	was the nursing assist during the night, and charge. No other inj reassured she will re- removed from workin An additional Inciden the state agency on T injury of unknown sou "8 x 5 cm, reddish put shape." The date of i unknown. The report happened a few days An Investigative Rep state agency on 07/0 submitted incident re 7/1/15. The report in nursing (DON) and s tried to investigate th been unable to subst perpetrator [AP] is fo conclusion there is re may have occurred in hence submitting a re enforcement, in acco Act." Further the rep our internal investiga are being submitted to agency." The Investi indicated on 7/1/15, t the AP, (NA-C) who s use the toilet 6-8 time report then indicated	stant working on that wing LPN-A was the nurse in uries noted, resident was main safe here, NA-C will be g with resident at this time. t Report was submitted to 7/1/15, which identified an urce on R22's right forearm irple in color and oval in ncident occurrence was t indicated R22 said "It s ago." ort was submitted to the 2/15, which combined two ports dated 6/27/15 and dicated the director of ocial worker (SW) "have is issue thoroughly and have antiate who the alleged r certain, but have reached a easonable suspicion a crime in the form of assault, and are	F 2	226	JENCY)	
	involving this NAR, w her credibility, and sh defensive, face redde	which can raise red flags re ne became somewhat ening and voice tightening, report things and others				
						1

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PRINTED: 09/04/2015 FORM APPROVED

			()(0) 1 () () () () ()			10.0938-039	
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	· · · ·	TE SURVEY MPLETED	
		245127	B. WING		07/27/2015		
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 226	don't, so I end up get further listed, that dur DON and SW meet w "reported having heat 6/30, that [R22] is afri- hair and bangs, that s The blond hair with th NA-C. The report fur been "implicated in pr 78740, and 79433 wi with residents, as she received coaching in also involved in repor specifically named as Although R22 had de member who had hur for her and received r incident documentation to protect residents d incidents. Also, there thorough investigation included other intervie During interview on 7 DON stated she "has be doing the accusati not certain." The DO during the night shift, on that do that." The were to report to her have concerns. In an interview on 7/2 stated she "did not ta staff regarding abuse	ting in trouble.' " The report ring an interview 7/2/15 the vith NA-D, who stated she rd from resident (R22) on aid of the girl with the blonde she is not very nice, etc. The bangs fits description of ther included that NA-C had revious reports 75814, th possible "power struggles" these incidents. NA-C was rt 79866 but was not s AP." escribed NA-C as the staff rt her and NA-C was caring multiple large bruises, the on indicated no action taken uring investigation of these was no indication that a	F 226				

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		D HUMAN SERVICES				FORM): 09/04/2015 1 APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	
		245127	B. WING		_	07/2	27/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET			
			C	NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	guilty." The DON also around "data privacy" further stated, when s allegations come up of on duty initiates the C said the nurse would address any immedia NA-C, the SW stated several residents she but that does change the allegation is not s further stated, in rega allegation of abuse, " The SW also said the "not intensive, and the plan initiated and no c or mentoring done." During an interview o administrator said, "W working on nights, we enough staff." The ad feel the DON and SW During an interview o the DON stated NA-C facility policy following R22 . She stated, "If I would have had to su who would take care During an interview o stated, "I have heard little rough, but I can't stated, one of the res	b said there were issues and confidentiality." SW comething regarding abuse over the weekend, the nurse WHFC reporting. The SW talk to the resident, and te concerns. Regarding , "At times there have been is not allowed to care for, if, during the investigation ubstantiated." The SW rd to NA-C, after the first a lot of coaching was done." coaching for NA-C was ere was no improvement documentation of education h 7/23/15 at 5:10 p.m., the /e have three young people can't suspend; there is not ministrator further stated, " I did the right thing." h 07/23/15, at 5:14 p.m., was not suspended per the g the allegation made by had suspended one, I spend all three staff, then	F 226				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/04/2015 // APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245127	B. WING				07/	27/2015
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 226	resident and stated the threw me into the char bathroom again." NA- the nurse a lot on night During interview on 7/ stated she works part LPN-H stated she has NA-C is rough with the witnessed it directly. aware that she is to me night shift when she we she had heard R12 has slapped her and also on the North wing and because of the cat no care of any certain rest aides on the night shift prefer to work on each INJURIES OF UNKNO The facility Vulnerabled defined Injury of Unkr the injury was not obst suspicious." The politi definition to include cat interpretive guidance. R39's annual MDS, dat was moderately, cogre dated 3/30/15, indicat assist with all activitie a mechanical stand for identified at risk for at	hey were described by the re resident said " the girl ir because I had to go to the E stated she does not see hts. /24/15, at 5:25 a.m. LPN-H time on the night shift. s heard from other NAs that e residents but had not LPN-H stated she is not nonitor any staff during the works. She further indicated ad reported that NA-C had that NA-C no longer works d thought the reason was t because she can not take sidents. She then stated the ft don't work together they h unit alone. OWN ORIGIN e Adult Policy, revised 7/15, nown Origin as "source of served and injury as cy did not expound on this riteria from the CMS ated 3/9/15, indicated she hitively impaired. The CP, red R39 required extensive s of daily living (ADLs), used or transfers, and was puse, because of dementia.	F	226				
	A review of SSIRF da	ated 10/7/14, indicated R39						

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/04/2015 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/:	27/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	had a large, dark purp portion of her buttock injury, and R39 was " bruising occurred. Th "a few days ago had I not standing when tra Hoyer (a mechanical SSRIF further indicate that could explain bru chart contained "falls that could likely have SSIRF indicated R39 reported to the state a investigation was con though there was no any objects or the floo ground. During an interview o DON stated, when R3 floor "it would be hard during that event." Th easily due to use of a therefore the injury wa reportable." Although R39 was mo unable to recall how t was no evidence that investigation was con actual cause, nor was origin reported to the R11's quarterly MDS, she was moderately, CP, dated 6/3/15, ind	ble bruise on the right upper , and it was an "unknown" unaware" of how the e SSIRF also indicated R39 been lowered to floor due to unsferring & then lifted with lift) Possible cause." The ed R39 used a medication ising, and also that R39's or other recent incidents produced the injury." The 's injury was "minor" and not agency. No further npleted for this incident even indication R39 had struck or as she was lowered to the a to know if injury occurred he DON said R39 bruised nticoagulant medication, so as "not considered oderately impaired and he bruise occurred, there a more in-depth npleted to determine the s R39's injury of unknown state agency. dated 4/15/15, indicated cognitively impaired. The	F 226				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/04/2015 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245127	B. WING				07/	27/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET DNAMIA, MN 56359			
					-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page risk for abuse related		F	226				
	A review of SSIRF dat had a bruise to the top purple in color, and m SSIRF indicated R11 injury occurred, but R medication, and R11's "minor." The facility at no report was made to A second SSIRF, date had bruising noted to her left eyebrow. The unable to state the ca facility administrator v was not reported to th A third SSIRF dated fa a bruise of unknown of dark purple in color, a inches. The SSIRF in "unknown", that R11 v cause of the injury wa The facility administration injury was not reported During an interview al unknown origin on 7/2 stated, R11 "had more have ever known." Th R11's hand "may have trimming of [R11's] na the bruise herself. Re R11's temple and fore nursing felt the bruisir [R11's] nebulizer mas	ted 10/21/15, indicated R39 p of her right hand, dark easured 8 cm x 8 cm. The was unable to state how the 11 used anticoagulant s bruise was described as dministrator was notified but to the state agency. ed 11/4/14, indicated R11 her left temple and above e SSIRF indicated R11 was use of the injury. The vas notified, but the injury re state agency. 2/18/14, indicated R11 had origin to her left inner knee, and measuring 1 x 1 3/4 dicated the injury was was unable to report the sed anticoagulants; and also as considered to be "minor." tor was notified, but the d to the state agency. bout the three injuries of 24/15, at 12:54 p.m., the SW e bruising than anyone I is SW said the bruise on e been caused by recent iils," indicating R11 caused garding the bruise noted to the ad, the SW stated that ng "was due to placement of						

Facility ID: 00374

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 09/04/2015 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245127	B. WING				07/	27/2015
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE,	ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 226	she slipped and fell of SW further stated R1 ⁺ Hoyer lift [a mechanic there were no records bruising was "likely du nebulizer mask." No f completed for this inju During an interview of DON stated R11 "cou reporting nurse asked abuse, therefore, the reportable. Although R11 was ide cognitively impaired, a different locations, the investigation complete causes of R11's bruis was notified of the inju incidents were submit R66's quarterly MDS, was moderately, cogr dated 2/9/15, indicate assist of two staff, wit for transfers. The CP risk for delirium and p depression. A review of SSIRF da a review of R66's nurs 1/26/2015, there was bruises" on [R66] bott identified as bruising.	n her way back from supper. 1 did not ambulate, used a cal lift] for transferring, and s of any falls. SW added the ue to placement of [R11's] urther investigation was iry. n 7/24/15, at 12:54 p.m., the Id reliably answer" when the I if bruising was related to DON felt the injury was not entified to be moderately and had multiple bruises at ere was no indepth ed to determine the actual es. The facility administrator uries but none of these ted to the state agency. dated 1/7/15, indicated she hitively impaired. The CP, d R66 required extensive h use of a mechanical lift, also indicated R66 was at otential abuse, related to ted 2/3/15, indicated during sing progress note dated "presence of unknown n arms, the size was "from hands to shoulder."	F	226				

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		D HUMAN SERVICES				FORM	0: 09/04/2015
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	
		245127	B. WING		_	07/2	27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	was an "unknown inju state the cause, and t to be "minor." The inj facility administrator, I the state agency. During an interview of SW stated, the bruise was reviewing R66's I said she "spoke with I bruising was assesse therefore not reportab agency."During an int p.m., the DON said R (mechanical lift), and cooperate in lift, occa The DON further state that it would be "hard been able to to talk at occurred after any tim Although R66 had bila hands to her shoulder unwitnessed and the identify what happene immediately reported agency nor was a tho completed to determin arms" while using the R44's annual MDS, d was severely cognitive 7/10/15, indicated R4	ry", that R66 was unable to hat the injury was assessed ury was reported to the but was not not reported to n 7/24/15, at 12:54 p.m., the s were noted while the DON progress notes. The SW hursing" and determined the d "to be a minor injury, and ble to the state erview on 7/24/15, at 12:54 66 used a Hoyer lift R66 did not always sionally "flailing her arms." ed R66 was confused, and to say if R66 would have bout how the bruising he had passed." ateral bruising from her rs, the injury was resident was unable to ed. The facility had not the incident to the state rough investigation he if R66 was "flailing her mechanical lift.	F 226				

Facility ID: 00374

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/04/2015 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	27/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	had a purple bruise of forearm, measuring 6 found during her bath was an "unknown" inj the cause of injury. T be "minor". The facility but the injury was not agency.	ted 6/15/15, indicated R44 n her posterior (back side) .3 cm x 7 cm, that was . The SSIRF indicated this ury, and R66 could not state he injury was determined to y administrator was notified,	F	226				
	SW stated, "The injur nursing staff to be 'mi suspicious criteria. The a need to report" to the In an interview on 7/2 DON stated, "[R44] w	y was determined by nor' and did not meet any he SW said she "did not see						
	cognitively impaired, l origin, on the posterio indication the facility o investigation to determ	assessed to be severely nad an injury of "unknown" or of her arm. There was no completed an thorough nine the source of her nt was not reported to the						
	her to be severely coor requiring assist of two living. CP dated 5/15/ extensive assist for ad	Im data set (MDS) identified gnitively impaired and o staff for activities of daily 15 indicated R8 required ctivities of daily living and related to diagnosis of						

Facility ID: 00374

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	2: 09/04/2015 1 APPROVED 2: 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/2	27/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page	e 45	F 226				
	had a bruise measuring her thumb and forefing thumb to her wrist. The initial evaluation and or resulted from R8 wring wringing of her hands During an interview of SW stated, the injury staff witness of the po- investigation of the inj facility administrator w a report was not made Social Services Incide requested for this injury Although R8 had seve and had a bruise 8.5c forefinger from the ba There was no indicati- thorough investigation her injury, also the ino- the state agency. During an interview of SW stated, when mak- whether or not to repo- agency, she "refers to decision tree." The S looks at whether a res- injury, or if someone of a history of other rece	ry but was not received. ere cognitive impairment, em between her thumb and se of her thumb to her wrist. on the facility completed an it to determine the source of cident was not reported to n 7/24/15, at 12:54 p.m., king a determination of ort an injury to the state o statutes, and uses a W also stated that she sident is able to explain the else saw it, and if there was ent falls and/or injuries. The the nurses indicated minor spicious in nature or					

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	MENT OF HEALTH AN					FORM	2: 09/04/2015 1 APPROVED 2: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		245127	B. WING		_	07/2	27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	DON said, minor injur state agency. She fur criteria or policy" the f determine whether an "major." The DON als the nurses judgement injury was minor or m charge "followed up o she stated there was	e 46 In 7/24/15, at 12:54 p.m., the ies are not reportable to the ther stated, there was "no acility has to identify and injury was "minor" versus so stated she "would use " when determining if an ajor, and that the RN in in the injuries." However, no charting on the clinical w evidence that follow-up	F 226				
	7/15, indicated as its who are vulnerable to policy included: "To a everything within its c occurrence of abuse of attempt to obtain infor employers and or/curr NA-A's personnel rec hired on 7/13/15. The evidence reference ch to employment at the NA-B's personnel rec hired on 6/30/15. The evidence reference ch to employment at the Dietary Aide (DA)-A's	revention Policy, revised burpose "to protect adults abuse" Further, the assure the facility was doing ontrol to prevent the or neglectthe facility would mation from previous rent employers." Ford identified they were personnel record lacked necks were completed prior facility.					

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 09/04/2015 M APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245127	B. WING		07	/27/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	Registered nurse (RN identified they were h personnel record lack checks were complete the facility. On 7/23/15, at 8:45 a. staff stated four of the did not have documer HR stated there was ' that reference checks facility used the applie	aployment at the facility. I)-B's personnel record ired on 5/11/15. The ed evidence reference ed prior to employment at 	F 226		,	
F 241 SS=D	483.15(a) DIGNITY A INDIVIDUALITY The facility must prom manner and in an env enhances each reside full recognition of his of This REQUIREMENT by: Based on observation review, the facility fail- rising and morning roo (R50 and R12),who re assistance to complet (ADL's). R50's diagnoses, as i (CP), reviewed 6/6/20 dementia, and aphasi	ND RESPECT OF note care for residents in a rironment that maintains or ent's dignity and respect in	F 241	F241 Affects R50 &R12. Pe to affect all residents 1. 8/11/15:Dignity & respect relationship to cares was dia at the nsg staff meeting 8/1 2. 8/14/15: NAR night duty assignment sheet was revis (Attachment L) 3.8/14/15: an email to all NA regarding dignity & respect cares was sent by the DON	t & it's scussed 1/15. sed ARs and AM	8/14/15

Facility ID: 00374

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED
		245127	B. WING		07/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 241	Continued From page	e 48	F 241		
	transfers, toileting, dra hygiene. During observation or R50 was lying on her left hand positioned of blanket was at the foor resident, exposing R5 see she already had p R50 remained in bed NA-G assisted her wi already dressed, with when NA-F removed for incontinence, NA- into her wheel chair w NA-F then brushed her in placing R50's hand wheel chair armrest a During an interview o NA-G said R50 was a morning, and we "just bed." NA-G said R50 dressing, and R50 was needs to staff.	ssistance for ADL's, assist with bed mobility, essing and personal n 7/22/2015 at 7:11 a.m., back, in her bed, with her n top of her chest. R50's of of the bed, pulled onto the 50's left leg, and one could pants on as she lied in bed. until 8:41, when NA-F and th morning cares. R50 was pants, socks and shirt, R50's covers and checked F and NA-G assisted R50 <i>i</i> th use of a mechanical lift. er hair, and NA-G assisted splint and arm into the and R50 was up for the day. n 7/22/2015 at 8:38 a.m., already dressed this t needed to get up, out of 0 needed "total assistance" as not able to verbalize her		"No resident should be gotten up on the noc shift for the convenien of staff. Only Residents who are a & choose to get up or if they are re & attempting to get out of bed and written in their care plan that they at a specific time". Monitoring 8/24/15- 9/28/15 An audit will be performed every of x1 week, then every week x4 wee ensure dignity & respect of all resi with their AM cares. The day nurs who arrives @0600 will round on the scheduled wing. They will observed document the residents who are up or dressed and back in bed. The re will be given to the RN Care Coord for review if Dignity & Respect wa provided. The Care Coordinator w forward the review form to the DO their review. (Attachment M) Responsibility: Nurses/TMA, Care Coordinators & DON Audit reports will be reported to th Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	awake estless l or it is get up day ks to idents e/TMA their e and up and report dinator s rill W after
	acknowledged R50 w when she assisted R5 NA-F did not know w "someone on nights [dressed," and that wa NA-F also said R50 w	2/2015 at 9:18 a.m., NA-F ras dressed this morning 50 to get up for the day. no worked with R50, but said the night shift] got her as typical for R50's routine. yould not be dressed early se she gets a bath on that			

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		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245127	B. WING			07/	27/2015
NAME OF PI	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MILEIA	CS HEALTH SYSTEM			20	00 NORTH ELM STREET		
	SO HEALTH OTOTEM			0	NAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	NA-H stated she work routinely got R50 "cle not removed from bed that." NA-H stated sh on her scheduled bat residents whom she h dressed, prior to the e said "I just need to ma and ready to go. I ge them back to bed; it h NA-H said if there wa want to get up, she w someone else up." N the residents she ass and there were some night anyway." During an interview o family member (FM)-/ were getting R50 dres bed. FM-A said that of was often awake late restless, and they [sta than stated, "I would the she'd be getting out, a day." In an interview on 7/2 director of nursing (D "to help the day shift s someone was trying the and keep [the resider and possibly fall." In social worker (SW) sa during the night was ' aide. We should look	n 7/24/2015 at 6:00 a.m., ks on the overnight shift, and aned up and dressed," but d, "the day shift would do be does not get R50 dressed h days. She has a list of helped get cleaned and end of the night shift. NA-H ake sure they are dressed t them dressed and then put helps out the morning shift." s a resident that did not as instructed "to get IA-H did add that some of isted "liked to get up early," who simply "were up all n 7/24/2015 at 1:06 p.m., A said he was unaware staff ssed, then having her stay in depending on the night, R50 , or was "up at 3:00 a.m. and aff] will get her up." FM-A think if [R50] got dressed, and up to breakfast for the P4/2015 at 1:17 p.m., the ON) stated the night shift try staff." The DON said "If o get up, then get them up, ht] from getting out of bed the same interview, the aid getting a resident up 'not just a decision for the x into this some more."	F	241			
		num data set (MDS), dated					

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PRINTED: 09/04/2015 FORM APPROVED

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 09/04/2015 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		(X3) DATE	
		245127	B. WING			_	07/	27/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				200 NORTH ELM STREET DNAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	5/18/15, indicated she impaired and required transfers, dressing an (CP), dated 8/28/13, o opportunities to make including clothing, bed also indicated R12 ha related to insomnia, w hours of sleep at nigh morning routine prefe to get up. During observation or was noted fully dresse chair. R12 was positi television in the comn asleep in her wheelch jerking movements as in chair until 8:15 a.m approached, and awa R12 if if she wanted to breakfast. R12 replied During an interview of NA-E stated she was residents up, washed the over night shift. N shower, there was an up in their place. NA-f the residents up, was back to bed."	e was severely, cognitively l extensive assist for d grooming. The care plan directed staff to give R12 daily preferences choices, d time and bathing. The CP d an alteration in sleep, vith a goal of at least six t. The CP did not address a rence of when R12 wanted n 7/22/15 at 7:00 a.m., R12 ed and seated in her wheel oned in front of the non area on the east wing, air. R12 repeatedly made a she dozed. R12 remained ., (75 minutes) when staff kened her. The staff asked o go back to bed, or eat d "I don't care."	F	241				

Facility ID: 00374

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		D HUMAN SERVICES				FORM): 09/04/2015 1 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	_	(X3) DATE	0. 0938-0391 SURVEY LETED
		245127	B. WING			07/:	27/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE	-	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET	т		
	oo neaenn o roreim			ONAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page of a mechanical lift to		F 24	11			
	dressed and put back idea why they would o	in bed, I don't have any do that."					
	director of nursing (Du people getting up and bed on the night shift. and care coordinators day shift. The DON fu this list are usually up like the night shift to h the day." She further the only nursing home that." The intent is to prevent falls. The DO if the rationale for wal to get them washed a plan or not.	n 7/24/15, at 1:16 p.m., the ON) stated, there are many I dressed and put back to She stated, The nurses a schedule them to help the or crawling out of bed," we help day shift "get a jump on stated, "I'm sure we are not e in the world that does help day shift out and ON stated she was not sure king a resident on night shift and dressed is on the care					
	residents for the night dressed. She stated, who are trying to get i people who want to g who are a "Hoyer lift." dress them in bed. RI prefers to get up early further stated, there is East unit that is care i to fall risk. RN-C state shift getting resident's due to the workload in Review of the facility's sheet directed night s cares, oral cares, dress	t shift to get up, washed and We usually look at people up but if there aren't enough et up, we will pick people ' The aides will wash and N- C stated, "If someone y it is not care planned." She is no one currently on the planned to get up early due ed, The rationale for night is washed and dressed is					

Facility ID: 00374

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		245127	B. WING		07/27/2015		
NAME OF P	ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
MILLE LA	CS HEALTH SYSTEM		200 NORTH ELM STREET ONAMIA, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
F 241	Continued From page including R12.	e 52	F 241				
F 282 SS=D	4/15, indicated the fa promote care for [res maintains and enhan full recognition of [a r 483.20(k)(3)(ii) SERV PERSONS/PER CAR The services provide must be provided by	atients/Residents, dated cility "must, with courtesy, idents] in a manner that ces dignity and respect in esident's] individuality." /ICES BY QUALIFIED RE PLAN d or arranged by the facility	F 282		8/20/15		
	by: Based on observatio review, the facility fail for timely repositionin for 1 of 1 residents (F incontinence, and at development. Findings include: R50's diagnoses, as (CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascul Minimum Data Set (N indicated R50 had se and was unable to wa R50 required extensi activities of daily livin	identified on the care plan 015, included hemiplegia de, dementia, and aphasia ar disease. The quarterly MDS), dated 5/27/2015, verely impaired cognition, alk. The MDS also identified ve, physical assistance for		 F282: Affects R50 with the Potential to Affect All Residents requiring reposition and toileting. 1. On 7/23/15: an email was sent to all LTC staff, including Activity staff, by the Care Coordinator. indicating the following: "Make sure resident's are be toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted the care plan. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NA three ring binder @ each nurses' statio Staff will document each time that they assist the resident with repositioning an or toileting. Monitoring An audit of the toileting/repositioning/sl 	ning of in NR n. nd		

Event ID: HJY511

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		MEDICAID SERVICES			CONSTRUCTION		NO. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					MPLETED
		245127	B. WING			0	7/27/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM				0 NORTH ELM STREET NAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 282	Continued From page	e 53	F 28	82			
	toileting, and persona	Il hygiene.			worksheet will be completed by nursi 1x/shift for 1 week then weekly x4 we		
	alteration in skin integ				(8/26/15-9/30/15) (Attachment O)		
	staff to follow the mot	on/toileting. The CP directed bility plan of care, and assist bition every 2 hours and			Responsibility: DON, Care Coordinat Nursing Staff. Audit reports will be reported to the	ors,	
	PRN" [as needed]. A staff to assist R50 "to	dditionally, the CP directed check and change every 2			Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).		
	hours and PRN" [as r	-			April and July).		
	-	servation on 7/23/2015 from n. (3 hours and 7 minutes)					
		be dressed and seated					
		hair. At 7:55 a.m., R50 was					
		hair in the living area across					
		irsing station and watching a					
	1 0	. At 8:33 a.m., R50 was					
		ng room and assisted with					
		9:36 a.m. Following the					
		in the wheel chair, R50 was where food was served to					
	the activity area in the						
		prning activity, and stayed in					
		just after 10:00 a.m., when a					
		d her into the main entryway					
		mained there, still seated in					
	her wheel chair, until	10:19 a.m., when a staff					
	member pushed R50	outside of the building,					
		s to get fresh air. At 10:37					
		ed into the building near the					
		bached by nursing assistant					
		eting R50, took her vital					
	R50 was last toileted	/2 hours had elapsed since					
		er wheel chair near the					
		., when NA-F assisted her					
	back to her room. In						
)-B, using the mechanical					

Facility ID: 00374

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		MEDICAID SERVICES	0.00		OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/27/2015
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
IILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 282	Continued From pag	e 54	F 28	32	
	lift, assisted R50 into			-	
		and NA-F provided perineal			
	care. RN-B assessed	d R50's skin, which was pink			
		unusual warmth or swelling,			
		ned areas, and her skin was			
		so said R50 was incontinent t toileted or repositioned			
		12 a.m., a total of 3 hours			
	and 7 minutes.				
		on 7/23/2015 at 11:16 a.m.,			
		A)-F stated R50 was last			
		ne was put in her wheel chair eight." NA-F then stated R50			
		o hour repo [repositioning]			
	-	R50 should also be checked			
		nce." NA-F said R50 "Was			
	definitely ready to be	e repositioned."			
	In an interview on 7/2	•			
	-	I)-A said she "trusted the			
		por to get toileting and			
		ted," but what happened fluke." RN-A also stated, "I'll			
		ould have been turned."			
	During an interview of	on 7/27/2015 at 1:19 p.m.,			
	-	g (DON) said resident			
		are planned, and the facility			
	takes "very seriously assistance."	, residents' needs for timely			
	A facility policy regar	ding the implementation of			
		ested, but none provided.			
F 314			F 31	4	8/20/15
SS=D	PREVENT/HEAL PR	ESSURE SORES			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/04/2 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/27/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	• • • •
MILLEIA	CS HEALTH SYSTEM		2	200 NORTH ELM STREET	
	CS HEALTH STOTEM		(DNAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETIO
F 314	resident, the facility n who enters the facility does not develop pre- individual's clinical co they were unavoidabl pressure sores receiv services to promote h prevent new sores fro This REQUIREMENT by: Based on observatio review, the facility fail repositioning for 1 of	hust ensure that a resident y without pressure sores ssure sores unless the ondition demonstrates that le; and a resident having yes necessary treatment and healing, prevent infection and om developing.	F 314	F314 affects R50 and has the potential to affect all residents requiring physical assistance w ADL's and are at a risk for deve pressure ulcers. 1. On 7/23/15: an email was se LTC	eloping nt to all
	(CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascul Minimum Data Set (M indicated R50 had se and was unable to wa R50 required extensit activities of daily livin two-person assist wit toileting, and persona Pressure Sore Risk A 5/26/2015, indicated for development of pr comprehensive skin a 5/26/2015, identified total assist with ADLs walk, and was on a tu	h bed mobility, transfers, al hygiene. A Braden Issessment, dated R50 was at moderate risk		 staff, including Activity staff, by Care Coordinator. indicating the following: "Make sure resident's toileted and repositioned @ mir every 2 hrs. or more frequently the care plan. 2. A toileting/reposition/skin woi (Attachment N) will be placed in three ring binder @ each nurse Staff will document each time th assist the resident with repositio or toileting. Monitoring An audit of the toileting/repositio worksheet will be completed by 1x/shift for 1 week then weekly (8/26/15-9/30/15) (Attachment O) Responsibility: DON, Care Coo 	e s are being nimum of if noted in rksheet n the NAR s' station. nat they oning and oning/skin nursing x4 weeks

Facility ID: 00374

If continuation sheet Page 56 of 65

		MEDICAID SERVICES	(X2) MULT		ONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
		245127	B. WING _			07	//27/2015
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MULEIA	CS HEALTH SYSTEM			200	NORTH ELM STREET		
	CS REALTH STSTEM			ON	AMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 314	Continued From page	e 56	F 3	14			
		lated 2/25/2015, identified	1.5		Nursing Staff		
		lcer risk factors for R50			Nursing Staff. Audit reports will be reported to the		
		incontinence, cognitive loss			Quality Assurance Committee.		
	and functional limitati			(QA meets quarterly; Oct., Jan.,			
		-			April and July).		
		ne potential for alteration in					
		P directed staff to follow the					
		and assist R50 "to turn and					
		urs and PRN" [as needed].					
	-	t care sheet "North" unit, R50: T & R q 2 hrs [turn					
	and reposition every	· ·					
		2 10013].					
	Durina continuous ob	oservation on 7/23/2015 from					
		m. (3 hours and 7 minutes)					
	R50 was observed to	be dressed and seated					
		chair, with her right hand and					
		nt device, and her right arm					
		trapped into the arm rest. At					
		eated in her wheel chair in					
	U U	s from the north unit nursing					
	•	a news program on TV. At vheeled into the dining room					
		akfast, finishing at 9:36 a.m.					
		and still seated in the wheel					
	-	d from the table where food					
		tivity area in the same room.					
	R50 participated in th	ne morning activity, and					
		area until just after 10 a.m.,					
		wheeled her into the main					
		y. R50 remained there, still					
		chair, until 10:19 a.m., when					
		ed R50 outside of the r residents to get fresh air.					
		as returned into the building					
		approached by nursing					
		o after greeting R50, took					
		than 2 1/2 hours had					
	elabsed since the init	ial observation, and still R50					

Facility ID: 00374

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PRINTED: 09/04/2015 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/04/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY
		245127	B. WING		_	07/2	27/2015
NAME OF P	ROVIDER OR SUPPLIER	L	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			00 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	wheel chair. R50 rem chair near the aviary if assisted her back to h NA-F and registered if mechanical lift, assist was incontinent of uri- cleansing cares for he surveyor, RN-B inspe skin. R50's skin was any unusual warmth of reddened areas, and RN-B also said R50 v had not been repositin 11:12 a.m., a total of if During an interview of nursing assistant (NA- repositioned when sh "at about quarter to e was on an "every two schedule," and R50, ' repositioned." A review of nursing an progress notes from if indicated R50 did not for a current pressure R50 did not develop a In an interview on 7/2 registered nurse (RN) consider any resident risk for pressure sore would "look at everyth resident was at risk to RN stated R50 scored measure for predictin	r repositioned out of her nained seated in her wheel until 11:12 a.m., when NA-F her room. In her room, nurse (RN)-B, using the ed R50 into her bed. R50 ne, and NA-F provided er. In the presence of the sected and assessed R50's normal pink in color, free of or swelling, there were no her skin was fully intact. vas incontinent of urine. R50 oned from 7:55 a.m. to 3 hours and 7 minutes. n 7/23/2015 at 11:16 a.m., t)-F stated R50 was last e was put in her wheel chair ight." NA-F then stated R50 hour repo [repositioning] 'Was definitely ready to be and physician long-term care B/26/2015 to 7/14/2015, have, nor was being treated e ulcer. During this time, a pressure ulcer. B/2015 at 4:00 p.m.)-A stated she would to who had a stroke to be at s." RN-A also said she	F 314				

Facility ID: 00374

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 09/04/2015 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245127	B. WING _				07/	27/2015
NAME OF P	ROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET NAMIA, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 314 F 315 SS=D	other risk factors" and RN-A said she trusted to get toileting and rep what happened today also stated, "I'll be hot turned." During an interview of the director of nursing manager had already when a resident is on and checked for incor this instance, "[R50] s breakfast into other ad The DON said resider planned, and the facil residents' needs for ti A facility policy, Treatt Breakdown and Ulcer "It is the policy to prop residents whose clinic risk for impaired skin i preventive measures. directed, to "establish individualized turning if the resident is immo 483.25(d) NO CATHE RESTORE BLADDEF Based on the resident assessment, the facili resident's clinical com catheterization was ne who is incontinent of the	A was "at risk for pressure." I the work group on the floor positioning completed, but , "I'll say was a fluke." RN-A nest, she should have been n 7/27/2015 at 1:19 p.m., (DON) said the nurse taken steps to avoid issues a schedule to be turned thinence. The DON said in should not go right from ctivities, that is too long." nt interventions were care ity takes "very seriously, mely assistance." ment and Prevention of Skin s, reviewed 3/14, indicated berly identify and assess cal conditions increase the integrity" and "implement " Further, the policy and record an and repositioning schedule obile." TER, PREVENT UTI, t's comprehensive ty must ensure that a	F3					8/20/15

Facility ID: 00374

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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE			TE SURVEY
RRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		CO	MPLETED
	245127	B. WING			07/27/2015	
/IDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HEALTH SYSTEM						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIZ TAG	×			(X5) COMPLETIO DATE
ontinued From page	9 59	F	315			
fections and to resto						
y: Based on observation eview, the facility fail ssistance for 1 or 1 r rinary incontinence. Indings include: 50's diagnoses, as i CP), reviewed 6/6/20 fecting dominant sic ue to cerebrovascula inimum Data Set (N dicated R50 had se nd was unable to wa 50 required extensive ctivities of daily living vo-person assist with illeting, and personal adder assessment, 50 was incontinent of so was not safe to u poor trunk control. dicated R50 would ' 2hr [every 2 hours] ach incontinence ep ssessment (CAA) fo ('11/2015, indicated F story of cardio-vaso ght-sided hemiplegia	n, interview and document ed to provide timely toileting residents (R50) who had dentified on the care plan 015, included hemiplegia de, dementia, and aphasia ar disease. The quarterly IDS), dated 5/27/2015, verely impaired cognition, alk. The MDS also identified ve, physical assistance for g (ADLs), including n bed mobility, transfers, il hygiene. A bowel and dated 2/25/2015, indicated of bowel and bladder, and use a commode or toilet due Further, the assessment 'be checked for incontinence and peri care given after isode." The care area r urinary incontinence, dated R50 had dementia, and past cular accident (stroke), with a. The CAA also indicated			toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted the care plan. 2. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NA three ring binder @ each nurses' statio Staff will document each time that they assist the resident with repositioning ar or toileting. Monitoring An audit of the toileting/repositioning/sk worksheet will be completed by nursing 1x/shift for 1 week then weekly x4 weet (8/26/15-9/30/15) (Attachment O)	ing of in AR n. nd ks	
	DEFICIENCIES DRRECTION VIDER OR SUPPLIER HEALTH SYSTEM SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I ontinued From page fections and to rester inction as possible. his REQUIREMENT y: Based on observation eview, the facility fail ssistance for 1 or 1 m rinary incontinence. indings include: 50's diagnoses, as in CP), reviewed 6/6/20 ffecting dominant sid ue to cerebrovascular linimum Data Set (M dicated R50 had see nd was unable to wa 50 required extensive ctivities of daily living vo-person assist with illeting, and personal adder assessment, 50 was incontinent of so was not safe to u o poor trunk control. dicated R50 would ' 2hr [every 2 hours] ach incontinence ep ssessment (CAA) fo (11/2015, indicated R50 bitsory of cardio-vasc ght-sided hemiplegia	DRRECTION IDENTIFICATION NUMBER: IDENTIFICATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 59 (fections and to restore as much normal bladder unction as possible. his REQUIREMENT is not met as evidenced y: Based on observation, interview and document eview, the facility failed to provide timely toileting ssistance for 1 or 1 residents (R50) who had rinary incontinence.	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 245127 IDER OR SUPPLIER HEALTH SYSTEM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFICIENCY ontinued From page 59 FC fections and to restore as much normal bladder unction as possible. FC his REQUIREMENT is not met as evidenced ty: Based on observation, interview and document eview, the facility failed to provide timely toileting sistance for 1 or 1 residents (R50) who had rinary incontinence. FC indings include: 50's diagnoses, as identified on the care plan CP), reviewed 6/6/2015, included hemiplegia ffecting dominant side, dementia, and aphasia ue to cerebrovascular disease. The quarterly linimum Data Set (MDS), dated 5/27/2015, dicated R50 had severely impaired cognition, nd was unable to walk. The MDS also identified 50 required extensive, physical assistance for ctivities of daily living (ADLs), including wo-person assist with bed mobility, transfers, ilideting, and personal hygiene. A bowel and ladder assessment, dated 2/25/2015, included 50 was incontinent of bowel and bladder, and so was not safe to use a commode or toilet due o poor trunk control. Further, the assessment (CAA) for urinary incontinence, dated 11/2015, indicated R50 would "be checked for incontinence 2hr [every 2 hours] and peri care given after ach incontinence episode." The care area sessesment (CAA) for urinary incontinence, dated 11/2015, indicated R50 had dementia, and past story of cardio-vascular acc	beFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE JUDER OR SUPPLIER 245127 B. WING HEALTH SYSTEM D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ontinued From page 59 fections and to restore as much normal bladder inction as possible. F 315 his REQUIREMENT is not met as evidenced y: Based on observation, interview and document view, the facility failed to provide timely toileting ssistance for 1 or 1 residents (R50) who had rinary incontinence. F 315 for diagnoses, as identified on the care plan CP), reviewed 6/6/2015, included hemiplegia ffecting dominant side, dementia, and aphasia ue to cerebrovascular disease. The quarterly linimum Data Set (MDS), dated 5/27/2015, dicated R50 had severely impaired cognition, nd was unable to walk. The MDS also identified 50 required extensive, physical assistance for ctivities of daily living (ADLs), including vo-person assist with bed mobility, transfers, illeting, and personal hygiene. A bowel and adder assesment, dated 2/25/2015, indicated 50 was incontinent of bowel and bladder, and iso was not safe to use a commode or toilet due poor trunk control. Further, the assessment dicated R50 would "be checked for incontinence 2hr [every 2 hours] and peri care given after ach incontinence episode." The care area assessment (CAA) for urinary incontinence, dated (11/2015, indicated R50 had dementia, and past istory of cardio-vascular accident (stroke), with ght-sided hemiplegia. The CAA also indicated	percension [X1] PROVIDERSUPPLIERQUA IDENTIFICATION NUMBER: [X2] MULTIPLE CONSTRUCTION A BUILING	percicicNOES [X1] PROVIDERSUPPLERCIAL (X2] MULTIPLE CONSTRUCTION (X3] DX INPRECTION 245127 (X2) MULTIPLE CONSTRUCTION (X3] DX INDER OR SUPPLER INVING (X3) DX HEALTH SYSTEM INTEGRATION DEPROPENDENT OF DEFICIENCIES (X4) DX (X4) DX IEACH DEPROPENDENT MUST BE PRECEDED BY FULL REDUTATORY OR LSD DEMTIPYING INFORMATION) (X5) DX (X6) DX Ontinued From page 59 (X6) DX (X6) DX (X6) DX fectors and to restore as much normal bladder incroin as possible. (X6) DX (X6) DX (X6) DX Notice for 1 or 1 residents (R50) who had tinary incontinence. (X6) DX (X6) DX (X6) DX D/D (X6) DX (X6) DX (X6) DX (X6) DX (X6) DX D/D (X6) DX (X6) DX (X6) DX (X6) DX (X6) DX (X6) DX ontinued From page 59 (X6) DX (X6) DX </td

Facility ID: 00374

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OTATEMENT -	OF DEFICIENCIES			CONSTRUCTION		O. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	E SURVEY IPLETED
		245127	B. WING		0	7/27/2015
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET DNAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 315	bowel and bladder, a using the bathroom d directed staff to assis every 2 hours and PF nursing assistant care undated, also directe change q 2hrs and Pf needed]. During continuous ob 7:55 a.m. to 11:12 a.r R50 was observed to upright in her wheel c wrist fitted with a split was supported and si 7:55 a.m., R50 was s the living area across station and watching 8:33 a.m., R50 was w and assisted with bre Following the meal, a chair, R50 was move was served to the act	nd also that R50 was not ue to safety. The CP t R50 "to check and change RN" [as needed]. The	F 315			
	when a staff member entryway of the facilit seated in her wheel of a staff member pushe building, joining other At 10:37 a.m., R50 w near the aviary, and a assistant (NA)-F, who her vital signs. More elapsed since the init was not off loaded, of wheel chair. R50 rem chair near the aviary	residents to get fresh air. as returned into the building approached by nursing o after greeting R50, took				

Facility ID: 00374

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		B	I ` '	PLETED
		245127	B. WING		07	/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 315	NA-F and registered in mechanical lift, assist was incontinent of uri- cleansing cares for he surveyor, RN-B inspe- skin, and also said R R50 was not assisted to 11:12 a.m., a total	nurse (RN)-B, using the ted R50 into her bed. R50 ine, and NA-F provided er. In the presence of the ected and assessed R50's 50 was incontinent of urine. I for toileting from 7:55 a.m. of 3 hours and 7 minutes.	F 31			
	nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two	 A)-F stated R50 was last a was put in her wheel chair a ight." NA-F then stated R50 b hour repo [repositioning] C should also be checked 				
	for pressure sores." I on the Braden" (a me pressure ulcer risk), b immobility, incontiner and was "at risk for p trusted the work grou)-A stated she would no had a stroke to be at risk RN stated R50 scored "a 13				
	the director of nursing manager had already when a resident is on and checked for incor this instance, "[R50] s breakfast into other a The DON said reside	n 7/27/2015 at 1:19 p.m., g (DON) said the nurse taken steps to avoid issues a schedule to be turned ntinence. The DON said in should not go right from ctivities, that is too long." nt interventions were care lity takes "very seriously, imely assistance."				

Facility ID: 00374

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		MEDICAID SERVICES			
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245127	B. WING		07/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 315	Continued From page	62	F 31	5	
F 465 SS=C	Policy, revised 3/14, i "Maintain resident's of continence and maint indicated individual ca to toilet based on indi checking for incontine 483.70(h) SAFE/FUNCTIONAL E ENVIRON The facility must prov	'SANITARY/COMFORTABL ide a safe, functional,	F 46	5	8/18/15
	by: Based on observatio review, the facility fail duct work, lights above kitchen were clean of potential to affect all r who consumed food f Findings include: During the initial tour registered dietician (F six metal caged lights food is cooked, were thick dust and debris addition there was a window screen above completely covered in	e public. is not met as evidenced n, interview, and document ed to ensure exhaust fan ve grill and screen in the dust and debris. This had residents, staff and visitors		Potential to Affect All Residents, Staff, and Visitors who consume food from the Kitchen 1. Small window was cleaned on 7/21/15 2. Light in hood system was cleaned on 7/21/15 3. Nutrition Services staff was notified of POC at department meeting on 8/18/15 4. Cleaning of hood box will occur monthly. 5. Cleaning of small window will occur monthly. 6. Cleaning procedure for hood box was developed. (Attachment P) Nutrition services staff will be in-serviced on this cleaning procedure at the	4

Event ID: HJY511

Facility ID: 00374

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED
		245127	B. WING		07/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE
MILLE LA	CS HEALTH SYSTEM			200 NORTH ELM STREET ONAMIA, MN 56359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	A OF CORRECTION (X5) ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE IENCY)
F 465	Continued From page	e 63	F 46	55	
	7:30 a.m. the lights an observed to be cover debris. During interview 7/21 manager (DM) stated dust along with the so department was in ch items. The DM stated staff of 5 and 3 of the just are not getting do During interview 7/21 maintenance manage a contracted service to hood vent two times a director did inspect th stated "That doesn't of the expectation to con Review of the facility document form Fire F After Service Follow I indicated the kitchen cleaned but not to con inaccessible. The rec "replacing box-style fa better access duct wo again on 3/2/15 and t Equipment Co. After 3 recommended "replace fan with upblast fan to Replace damaged filt During interview 7/22	nd screen were still ed with visible dust and /15, at 8:15 a.m. dietary the lights were covered in creen; the maintenance arge of cleaning these the maintenance has a m are on light duty so things one. /15, at 8:30 a.m. the er (MM)-A stated they have that cleans the overhead a year. The maintenance he lights and the screen and cut it" and expressed it is still mplete needed tasks. contracted cleaning service Protection Equipment Co. Jp Report dated 9/22/14, exhaust system hood was de due to them being ommendations indicated to an with upblast style to ork." The company was out he Fire Protection Service Follow Up Report cing box-style down blast o access fan and duct work.		Department Meeting he Monitoring Nutrition Services Mana conduct an audit on the starting in Aug. & for ne to ensure this system i followed and is adequa the equipment clean. (Responsibility: Dietary Audit reports will be rep Quality Assurance Com (QA meets quarterly; O April and July).	ager will 4th Monday ext six months s being te for keeping Attachment Q) Manager ported to the umittee.
	During interview 7/22 stated the "fan blows air up to create a vac The MM-A stated the	/15, at 2:00 p.m. the MM-A			

If continuation sheet Page 64 of 65

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/04/2015 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245127	B. WING			07	/27/2015
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MILLE LA	CS HEALTH SYSTEM				00 NORTH ELM STREET NAMIA, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	some uncertain time. During phone intervie representative from the Equipment Co. stated inaccessible because down to the bare met which was probably in 70's, and recommend The facilities Nutrition Procedure Equipmen indicated 1. the inside and outs cleaned once per mo 2. clean the inside an 3. clean the light fixtu Remove the light fixtu 4. use a brush or clot grease and/or dust 5. wash hood with so	e remodel the kitchen at ew 7/22/15, at 2:15 p.m. with he Fire Protection d the fan and ducts are e they were unable to see al. The system was very old, nanufactured in 1960's or ded a new unit. The Services Cleaning t Hood policy undated side of the hood will be nth d outside of the hood res within the hood. ures and clean with soap h as needed to remove ap and water of the hood that extends to remi annually by a	F 4	65			

If continuation sheet Page 65 of 65



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted August 10, 2015

Ms. Kim Kucera, Administrator Mille Lacs Health System 200 North Elm Street Onamia, Minnesota 56359

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5127025

Dear Ms. Kucera:

The above facility was surveyed on July 20, 2015 through July 23, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule

Mille Lacs Health System August 10, 2015 Page 2

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

ate Comston

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE COMF	SURVEY
			B. WING			
		00374		7/0 0005	07	/23/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, RTH ELM STREET	ZIP CODE		
ILLE LA	CS HEALTH SYSTEM		A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 000	Initial Comments		2 000			
	*****ATTEN	ITION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this correct pursuant to a survey, found that the deficie herein are not correct not corrected shall be with a schedule of fin the Minnesota Depar Determination of whe corrected requires co	ther a violation has been				
	number and MN Rule When a rule contains comply with any of th lack of compliance. I re-inspection with an result in the assessm	and provided at the tag e number indicated below. a several items, failure to be items will be considered Lack of compliance upon y item of multi-part rule will thent of a fine even if the item ing the initial inspection was				
	that may result from orders provided that	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.				
	receipt of State licens the Minnesota Depar Informational Bulletin	participate in the electronic sure orders consistent with tment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf licensing orders are				

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

TITLE

(X6) DATE

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		00374		7/0.0005	07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From page	e 1	2 000			
	you electronically. Al is necessary for State enter the word "corre text. You must then in State licensure proce completion date, the corrected prior to elec Minnesota Departme On July 20-24 and Ju this Department's sta and the following corr Please indicate in you correction that you ha and identify the date Minnesota Departme the State Licensing O federal software. Tag	Ily 27th, 2015 surveyors of ff, visited the above provider rection orders are issued. ur electronic plan of ave reviewed these orders, when they will be completed. Int of Health is documenting Correction Orders using				
	column entitled "ID F statute/rule out of cor "Summary Statement and replaces the "To correction order. This findings which are in after the statement, " evidence by." Followi are the Suggested M Time period for Correct PLEASE DISREGAR FOURTH COLUMN V "PROVIDER'S PLAN	D THE HEADING OF THE				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING		07	/23/2015
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
2 000	Continued From page	2	2 000			
		IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.				
2 302	MN State Statute 144 or related disorder tra	.6503 Alzheimer's disease in	2 302			
	ALZHEIMER'S DISE/ DISORDER TRAININ MN St. Statute 144.65	IG:				
	care staff					
	related disorders; (2) assistance with ac (3) problem solving w and	Alzheimer's disease and ctivities of daily living; ith challenging behaviors;				
	written or electronic for training program, the trained, the frequency topics covered.	ills. rovide to consumers in orm a description of the categories of employees y of training, and the basic ocument compliance with				
	This MN Requiremen by:	t is not met as evidenced				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00374	B. WING		07	//23/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		07	123/2015
	CS HEALTH SYSTEM		RTH ELM STREET			
		ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From page	e 3	2 302			
	facility failed to ensur information regarding dementia training, ind training program, the trained, the frequency topics covered in the electronic form. This all residents and their Findings include: During a review of the training program, the documentation that in	nd document review, the re consumers were provided g Alzheimer's disease and cluding a description of the categories of employees y of training and the basic training in a written or had the potential to affect r families.				
	Alzheimer's training p employees trained, fr basic topics covered. During an interview o social worker stated,	orogram, categories of requency of training and the on 7/21/15, at 4:07 p.m., the dementia training was ducare. She stated she not				
	information. The direct no family education w	ctor of nursing (DON) stated, vas provided regarding and she was unaware that it				
	DON or designee coustaff training to the reconsumers were awa	IOD OF CORRECTION: The uld add information regarding esident admission packet so are of this information. The uld educate staff about this duct audits to ensure				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				

TATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00374	B. WING		07/	23/2015
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		TH ELM STREET , MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565			
		nprehensive plan of care ersonnel involved in the				
	by: Based on observatior review, the facility fail for timely repositionin for 1 of 1 residents (F	t is not met as evidenced n, interview and document led to follow the plan of care g and toileting assistance R50) with urinary risk for pressure ulcer				
	Findings include:					
	(CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascula Minimum Data Set (M indicated R50 had se and was unable to wa R50 required extension activities of daily living	h bed mobility, transfers,				
	alteration in skin integ alteration in elimination staff to follow the mot R50 "to turn and repo PRN" [as needed]. A	identified the potential for grity, and also R50's on/toileting. The CP directed bility plan of care, and assist osition every 2 hours and diditionally, the CP directed o check and change every 2				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	/23/2015
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		120,2010
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
	CS REALTH STSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
2 565	Continued From page	e 5	2 565			
	hours and PRN" [as r	needed].				
	7:55 a.m. to 11:12 a.r. R50 was observed to upright in her wheel of from the north unit nu- news program on TV wheeled into the dinin breakfast, finishing at meal, and still seated moved from the table the activity area in the participated in the mo- the activity area until staff member wheele of the facility. R50 re- her wheel chair, until member pushed R50 joining other resident a.m., R50 was return aviary, and was appre- (NA)-F, who after gree signs. More than 2 1 R50 was last toileted remained seated in h aviary until 11:12 a.m. back to her room. In registered nurse (RN lift, assisted R50 into incontinent of urine, a care. RN-B assessed in color, free of any u there were no redder fully intact. RN-B als of urine. R50 was not	orning activity, and stayed in just after 10:00 a.m., when a d her into the main entryway emained there, still seated in 10:19 a.m., when a staff outside of the building, s to get fresh air. At 10:37 ed into the building near the oached by nursing assistant eting R50, took her vital /2 hours had elapsed since or repositioned. R50 er wheel chair near the h., when NA-F assisted her her room, NA-F and)-B, using the mechanical				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	//23/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, RTH ELM STREET	ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From page	e 6	2 565			
	nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and that F for "urinary incontinent definitely ready to be In an interview on 7/2 registered nurse (RN work group on the flo repositioning complet today, "I'll say was a be honest, [R50] sho During an interview of the director of nursing interventions were ca	23/2015 at 4:00 p.m.)-A said she "trusted the				
	care plans was reque	ding the implementation of ested, but none provided. OD OF CORRECTION:				
	The Director of Nursi review the importance	ng and / or designee could				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
2 905	MN Rule 4658.0525	Subp. 4 Rehab - Positioning	2 905			
		. Residents must be ody alignment. The position o change their own position				

HJY511

6899

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	//23/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	123/2015
MULEIA	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
	C3 HEALTH STSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From page	e 7	2 905			
	including periods of t been put to bed for th has documented that hours during this time	east every two hours, ime after the resident has ne night, unless the physician t repositioning every two e period is unnecessary or dered a different interval.				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R50) reviewed in the sample identified at risk for development of pressure ulcers.					
	Findings include:					
	(CP), reviewed 6/6/2 affecting dominant si due to cerebrovascul Minimum Data Set (M indicated R50 had se and was unable to w R50 required extensi activities of daily livin two-person assist wit toileting, and persona Pressure Sore Risk A 5/26/2015, indicated for development of p comprehensive skin 5/26/2015, identified	th bed mobility, transfers, al hygiene. A Braden Assessment, dated R50 was at moderate risk ressure sores. A assessment summary, dated R50 required extensive to				
	walk, and was on a to every 2 hours. The co for pressure ulcers, co additional pressure u	s, that she was unable to urn-and-reposition schedule care area assessment (CAA) lated 2/25/2015, identified lcer risk factors for R50 incontinence, cognitive loss				

Minnesota Department of Health STATE FORM

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
				B. WING		
		00374	B. WING		07/23/201	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
AILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE	(X5) COMPLE DATE
2 905	Continued From pag	e 8	2 905			
	and functional limitat	ion in range of motion.				
	skin integrity. The C mobility plan of care, reposition every 2 ho The nursing assistant	he potential for alteration in P directed staff to follow the and assist R50 "to turn and burs and PRN" [as needed]. It care sheet "North" unit, R50: T & R q 2 hrs [turn 2 hours].				
	7:55 a.m. to 11:12 a. R50 was observed to upright in her wheel wrist fitted with a spli was supported and s 7:55 a.m., R50 was s the living area across station and watching 8:33 a.m., R50 was s and assisted with bre Following the meal, a chair, R50 was move was served to the ac R50 participated in th stayed in the activity when a staff member	oservation on 7/23/2015 from m. (3 hours and 7 minutes) o be dressed and seated chair, with her right hand and int device, and her right arm strapped into the arm rest. At seated in her wheel chair in s from the north unit nursing a news program on TV. At wheeled into the dining room eakfast, finishing at 9:36 a.m. and still seated in the wheel ed from the table where food tivity area in the same room. ne morning activity, and area until just after 10 a.m., r wheeled her into the main				
	seated in her wheel of a staff member push building, joining othe At 10:37 a.m., R50 w near the aviary, and assistant (NA)-F, wh her vital signs. More elapsed since the ini was not off loaded, of wheel chair. R50 ref	ty. R50 remained there, still chair, until 10:19 a.m., when ed R50 outside of the r residents to get fresh air. vas returned into the building approached by nursing o after greeting R50, took e than 2 1/2 hours had tial observation, and still R50 or repositioned out of her mained seated in her wheel until 11:12 a.m., when NA-F				

STATE FORM

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
	00374	B. WING		07	//23/2015
IAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	, , , , , , , , , , , , , , , , , , ,	
AILLE LACS HEALTH SYSTEM	200 NOI	RTH ELM STREET			
	ONAMIA	A, MN 56359			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 905 Continued From pag	e 9	2 905			
 mechanical lift, assis was incontinent of un cleansing cares for h surveyor, RN-B inspession. R50's skin was any unusual warmth reddened areas, and RN-B also said R50 whad not been reposit 11:12 a.m., a total of During an interview of nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and R50, repositioned." A review of nursing a progress notes from indicated R50 did not develop In an interview on 7/2 registered nurse (RN consider any resident was at risk for pressure sore would "look at everyt resident was at risk to RN stated R50 score measure for predictir that also R50 "had in other risk factors" an RN-A said she truste to get toileting and resident was at risk for state and resident was at risk for state and resident was at risk factors. 	23/2015 at 4:00 p.m.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/23/2015
IAME OF PR	OVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		120/2010
AILLE LAC	S HEALTH SYSTEM		RTH ELM STREET			
		ONAMIA	A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
	Continued From page turned."	e 10	2 905			
	the director of nursing manager had already when a resident is on and checked for incor this instance, "[R50] s breakfast into other a The DON said reside planned, and the faci residents' needs for ti A facility policy, Treat Breakdown and Ulcer "It is the policy to pro- residents whose clinic risk for impaired skin preventive measures directed, to "establish individualized turning if the resident is immo- SUGGESTED METH The Director of Nursin review with care staff	ment and Prevention of Skin rs, reviewed 3/14, indicated perly identify and assess cal conditions increase the integrity" and "implement " Further, the policy and record an and repositioning schedule obile." OD OF CORRECTION: ng and / designee could				
	healing, and monitor TIME PERIOD FOR ((14) days.	CORRECTION: Fourteen				
	MN Rule 4658.0525 S Incontinence	Subp. 5 A.B Rehab -	2 910			
	have a continuous pr	e. A nursing home must ogram of bowel and bladder ce incontinence and the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00374			07	/23/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
AILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From pag	e 11	2 910			
	comprehensive resid home must ensure th A. a resident wh without an indwelling unless the resident's that catheterization v B. a resident who receives appropriate prevent urinary tract	o enters a nursing home catheter is not catheterized clinical condition indicates				
	by: Based on observatio review, the facility fa	nt is not met as evidenced n, interview and document iled to provide timely toileting residents (R50) who had				
	(CP), reviewed 6/6/2 affecting dominant si due to cerebrovascu Minimum Data Set (Minimum Set	identified on the care plan 015, included hemiplegia de, dementia, and aphasia lar disease. The quarterly MDS), dated 5/27/2015, everely impaired cognition,				
	R50 required extensi activities of daily livin two-person assist win toileting, and person bladder assessment, R50 was incontinent also was not safe to to poor trunk control.	alk. The MDS also identified ive, physical assistance for ig (ADLs), including th bed mobility, transfers, al hygiene. A bowel and , dated 2/25/2015, indicated of bowel and bladder, and use a commode or toilet due Further, the assessment "be checked for incontinence				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		00374	B. WING		07	/23/2015
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From page	e 12	2 910			
	 2 910 Continued From page 12 q 2hr [every 2 hours] and peri care given after each incontinence episode." The care area assessment (CAA) for urinary incontinence, dated 3/11/2015, indicated R50 had dementia, and past history of cardio-vascular accident (stroke), with right-sided hemiplegia. The CAA also indicated R50 was not a candidate for retraining. R50's CP identified alteration in elimination/toileting, that she was incontinent of bowel and bladder, and also that R50 was not using the bathroom due to safety. The CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, also directed for R50: Check and change q 2hrs and PRN [every 2 hours and as needed]. 					
	7:55 a.m. to 11:12 a. R50 was observed to upright in her wheel of wrist fitted with a spli was supported and s 7:55 a.m., R50 was s the living area across station and watching 8:33 a.m., R50 was w and assisted with bree Following the meal, a chair, R50 was move was served to the ac R50 participated in the stayed in the activity when a staff member entryway of the faciliti seated in her wheel of	oservation on 7/23/2015 from m. (3 hours and 7 minutes) o be dressed and seated chair, with her right hand and nt device, and her right arm trapped into the arm rest. At seated in her wheel chair in s from the north unit nursing a news program on TV. At wheeled into the dining room eakfast, finishing at 9:36 a.m. and still seated in the wheel ed from the table where food tivity area in the same room. ne morning activity, and area until just after 10 a.m., r wheeled her into the main ty. R50 remained there, still chair, until 10:19 a.m., when ed R50 outside of the				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING:			
		00374	B. WING	7/0.0005	07	/23/2015
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 910	Continued From page	e 13	2 910			
	near the aviary, and a assistant (NA)-F, who her vital signs. More elapsed since the init was not off loaded, or wheel chair. R50 rem chair near the aviary assisted her back to H NA-F and registered mechanical lift, assist was incontinent of uri cleansing cares for he surveyor, RN-B inspe skin, and also said R8 R50 was not assisted to 11:12 a.m., a total During an interview o nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and that R for "urinary incontiner In an interview on 7/2 registered nurse (RN consider resident "wh for pressure sores." If on the Braden" (a me pressure ulcer risk), b immobility, incontiner and was "at risk for put trusted the work grou	ial observation, and still R50 r repositioned out of her ained seated in her wheel until 11:12 a.m., when NA-F her room. In her room, nurse (RN)-B, using the ed R50 into her bed. R50 ne, and NA-F provided er. In the presence of the acted and assessed R50's 50 was incontinent of urine. I for toileting from 7:55 a.m. of 3 hours and 7 minutes. n 7/23/2015 at 11:16 a.m., .)-F stated R50 was last e was put in her wheel chair ight." NA-F then stated R50 hour repo [repositioning] 50 should also be checked nce."				
	was a fluke." During an interview o	n 7/27/2015 at 1:19 p.m., g (DON) said the nurse				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00274	B WING		07/00/00/5		
NAME OF PI	ROVIDER OR SUPPLIER	00374 STREET A	B. WING				
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	manager had already when a resident is on and checked for inco- this instance, "[R50] s breakfast into other a The DON said reside planned, and the faci residents' needs for t A facility policy, Bowe Policy, revised 3/14, 1 "Maintain resident's c continence and main" indicated individual c to toilet based on indi checking for incontine SUGGESTED METH The Director of Nursi review with care staff assistance with toileti compliance.	A taken steps to avoid issues a a schedule to be turned intinence. The DON said in should not go right from ctivities, that is too long." int interventions were care lity takes "very seriously, imely assistance." A and bladder Program indicated as its purpose to optimal bowel and bladder tain skin integrity The policy are plan will address "Times ividual schedule and/or ence." OD OF CORRECTION: ing and / designee could residents requiring	2 910				
21565	MN Rule 4658.1325 Medications Self Adm	Subp. 4 Administration of nin	21565				
	self-administer medic resident assessment care as required in pa 4658.0405 indicate th	istration. A resident may cations if the comprehensive and comprehensive plan of arts 4658.0400 and his practice is safe and there in the attending physician.					
	This MN Requiremen	t is not met as evidenced					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING			
	ROVIDER OR SUPPLIER	00374 STREET A	DDRESS, CITY, STATE		07	/23/2015
			RTH ELM STREET	,		
AILLE LA	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From page	e 15	21565			
	review, the facility fail self-administration of	medications (SAM) for 1 of served for self-administration				
	Findings include:					
	During observation on 7/20/15, at 7:28 p.m. R63 was observed alone in her room with a nebulizer (a drug delivery device used to administer medications in the form of a mist inhaled into the lungs) running, with a face mask. The trained medication aide (TMA)-A who had administered the medicaiton was on the opposite side of the dining room passing medications and assisting other residents in their rooms. R63 remove the mask off her nose and mouth and placed the mask on her chest with the elastic strap still around the back of her neck. The TMA-A walked past R63's room while R63 had the mask on her chest and into the room next to R63 twice. TMA-A made no attempted to check, or reapply the mask to R63's nose and mouth for installation of the medication. At 7:44 p.m. TMA-A entered R63's room turned off the nebulizer and removed the mask from R63's chest.					
	chronic obstructive pu	es, depression, anxiety, ulmonary disease (COPD) failure. A cognition care licated R63 was and place and had				
	Administration Record Duoneb to be administration	rs and the Medication d (MAR) for 7/15, directed stered four times a day. A the MAR indicated R63 did				

STATEMEN	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	//23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE	•	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
21565	in front of her face an A Self Administration effective 7/21/15, indi cognitively able to pa During interview on 7 stated she did not knowith the nebulizer. Sh residents alone with thad been so hectic an On 7/23/15, at 11:20 (RN)-A stated R63 wa alone to SAM the net not even allow the mat	mask and to hold the mask ad let her breathe in that way. of Medication Assessment icated R63 was not rticipate in a SAM. 7/20/15, at 7:50 p.m. TMA-A ow if R63 could be left alone he usually does not leave their nebulizer but because it nd busy she left R63 alone. a.m. registered nurse as assessed to not to be left pulizer. In the past she would ask but now will allow staff to	21565			
21685	The Director of Nursi review the facility's por residents for the abili medications, with the TIME PERIOD FOR ((14) days. MN Rule 4658.1415 3 Housekeeping, Opera Subp. 2. Physical pla including walls, floors systems, and equipm continuous state of g with regard to the hea	OD OF CORRECTION: ng and/or designee could blicy for assessment of ty for self administration of facility staff responsible. CORRECTION: Fourteen Subp. 2 Plant	21685			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From page	e 17	21685			
	routine maintenance and repair program. This MN Requirement is not met as evidenced					
	by: Based on observation	n, interview, and document				
		led to ensure exhaust fan				
		ve grill and screen in the				
		f dust and debris. This had residents, staff and visitors				
	who consumed food					
	Findings include:					
	During the initial tour	of the facility kitchen with				
	registered dietician (RD) on 7/20/15, at 1:15 p.m.;					
		s above the grill where the				
		covered with 1/4 inch visible from the light fixtures. In				
		12 inch long by 6 inch				
		e the kitchen sink was n a black dust and debris.				
	An additional tour wa 7:30 a.m. the lights a	is completed on 7/21/15, at				
		red with visible dust and				
	debris.					
	During interview 7/21	/15, at 8:15 a.m. dietary				
		the lights were covered in				
		creen and the maintenance				
		narge of cleaning those. The enance has a staff of 5 and 3				
		luty so things just are not				
	getting done.					
	During interview 7/21	/15, at 8:30 a.m. the				
	maintenance manage	er (MM)-A stated they have				
		that cleans the overhead				
	hood vent two times	a year. The maintenance				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	00374 B. WING		07	07/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	07	123/2013	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
21685	Continued From page	e 18	21685				
	director did inspect the lights and the screen and stated "That doesn't cut it" and expressed it is still the expectation to complete needed tasks.						
	document form Fire F After Service Follow I indicated the kitchen cleaned but not to coo inaccessible. The rec "replacing box-style fa better access duct we again on 3/2/15 and t Equipment Co. After recommended "replace fan with upblast fan to Replace damaged filt During interview 7/22 stated the "fan blows	Service Follow Up Report cing box-style down blast o access fan and duct work. ers." /15, at 2:00 p.m. the MM-A down and then diverts the					
	The MM then stated t but that is how this st	uum up and out of the roof". he fans should be cleaned, yle exhaust fan works and it we remodel the kitchen at					
	representative from the Equipment Co. stated inaccessible because down to the bare met	d the fan and ducts are they were unable to see al. The system was very old, nanufactured in 1960's or					
	indicated	t Hood policy undated side of the hood will be nth					

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STATEMEN	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00374	B. WING		07	/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21685	4. use a brush or cloth grease and/or dust 5. wash hood with soa 7. the interior section the roof is cleansed s commercial hood-clea SUGGESTED METH The Administrator and the cleaning schedule determine the frequer be cleaned.	res within the hood. Ires and clean with soap In as needed to remove ap and water of the hood that extends to emi annually by a	21685			
21805	residents have the rig courtesy and respect employees of or perso health care facility. This MN Requiremen by: Based on observation review, the facility fail rising and morning ro (R50 and R12),who re	Bill of Rights treatment. Patients and	21805			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00074	B. WING				
	ROVIDER OR SUPPLIER	00374	B. WING 07/23/2015 ET ADDRESS, CITY, STATE, ZIP CODE				
			RTH ELM STREET	, 0002			
	CS HEALTH SYSTEM	ONAMIA	, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE	
21805	Continued From pag	e 20	21805				
	(CP), reviewed 6/6/2 dementia, and aphas Data Set (MDS), date had severely impaire extensive, physical a	ssistance for ADL's, assist with bed mobility,					
	R50 was lying on her left hand positioned of blanket was at the for resident, exposing R see she already had R50 remained in bed NA-G assisted her w already dressed, with when NA-F removed for incontinence, NA- into her wheel chair w NA-F then brushed h in placing R50's hand wheel chair armrest a During an interview of NA-G said R50 was	n 7/22/2015 at 7:11 a.m., r back, in her bed, with her on top of her chest. R50's ot of the bed, pulled onto the 50's left leg, and one could pants on as she lied in bed. I until 8:41, when NA-F and ith morning cares. R50 was n pants, socks and shirt, R50's covers and checked -F and NA-G assisted R50 with use of a mechanical lift. her hair, and NA-G assisted d splint and arm into the and R50 was up for the day.					
	dressing, and R50 w needs to staff. In an interview on 7/2 acknowledged R50 v when she assisted R NA-F did not know w "someone on nights	0 needed "total assistance" as not able to verbalize her 22/2015 at 9:18 a.m., NA-F vas dressed this morning 50 to get up for the day. 'ho worked with R50, but said [the night shift] got her as typical for R50's routine.					

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00374	B. WING			7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1 .	
	CS HEALTH SYSTEM		TH ELM STREET			
			, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page	e 21	21805			
	on Tuesdays, "because she gets a bath on that day."					
	NA-H stated she wor routinely got R50 "cle not removed from be that." NA-H stated sl on her scheduled bat residents whom she dressed, prior to the said "I just need to m and ready to go. I ge them back to bed; it H NA-H said if there wa want to get up, she w someone else up." N the residents she ass and there were some night anyway." During an interview of family member (FM)- were getting R50 dre bed. FM-A said that was often awake late restless, and they [st than stated, "I would	on 7/24/2015 at 6:00 a.m., its on the overnight shift, and eaned up and dressed," but id, "the day shift would do he does not get R50 dressed th days. She has a list of helped get cleaned and end of the night shift. NA-H the ake sure they are dressed et them dressed and then put helps out the morning shift." as a resident that did not vas instructed "to get NA-H did add that some of sisted "liked to get up early," e who simply "were up all on 7/24/2015 at 1:06 p.m., A said he was unaware staff essed, then having her stay in depending on the night, R50 e, or was "up at 3:00 a.m. and taff] will get her up." FM-A think if [R50] got dressed, and up to breakfast for the				
	director of nursing (D "to help the day shift someone was trying and keep [the residen	24/2015 at 1:17 p.m., the DON) stated the night shift try staff." The DON said "If to get up, then get them up, nt] from getting out of bed				
	social worker (SW) s during the night was	the same interview, the aid getting a resident up "not just a decision for the k into this some more."				

Minnesota Department of Health STATE FORM

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00074	B. WING				
	ROVIDER OR SUPPLIER	00374		WING 07/23/201 SS, CITY, STATE, ZIP CODE 07/23/201			
			RTH ELM STREET	,			
MILLE LA	CS HEALTH SYSTEM	ONAMIA	A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From page	e 22	21805				
	5/18/15, indicated shi impaired and required transfers, dressing ar (CP), dated 8/28/13, opportunities to make including clothing, be also indicated R12 ha related to insomnia, w hours of sleep at nigh	num data set (MDS), dated e was severely, cognitively d extensive assist for nd grooming. The care plan directed staff to give R12 e daily preferences choices, d time and bathing. The CP ad an alteration in sleep, with a goal of at least six nt. The CP did not address a erence of when R12 wanted					
	was noted fully dress chair. R12 was posit television in the comr asleep in her wheelch jerking movements as in chair until 8:15 a.m approached, and awa R12 if if she wanted t breakfast. R12 replier During an interview o NA-E stated she was residents up, washed	mon area on the east wing, hair. R12 repeatedly made s she dozed. R12 remained h., (75 minutes) when staff akened her. The staff asked to go back to bed, or eat d "I don't care." on 7/24/15, at 5:59 a.m., instructed to get four I and dressed when working					
	shower, there was ar up in their place. NA- the residents up, was back to bed."	IA-E stated if a resident had nother one assigned to get E stated she will usually "get shed, dressed and put them on 7/24/15 12:24 p.m.,					
	licensed practical nur the over night shift is she stated they are n	rse (LPN)-C stated, " usually getting up the early risers, ot getting up anyone that in. LPN-C further stated,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00374		07/23/20			
			ADDRESS, CITY, STATE RTH ELM STREET	, ZIF GODE			
	CS HEALTH SYSTEM	ONAMIA	A, MN 56359				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From page	e 23	21805				
	"Some of the Hoyers [residents who require use of a mechanical lift to transfer] get washed, dressed and put back in bed, I don't have any idea why they would do that."						
	director of nursing (D people getting up and bed on the night shift and care coordinators day shift. The DON fu this list are usually up like the night shift to h the day." She further the only nursing hom that." The intent is to prevent falls. The DO if the rationale for wa	In 7/24/15, at 1:16 p.m., the ON) stated, there are many d dressed and put back to . She stated, The nurses is schedule them to help the urther stated, "the people on o or crawling out of bed," we help day shift "get a jump on is stated, "I'm sure we are not e in the world that does help day shift out and DN stated she was not sure king a resident on night shift and dressed is on the care					
	registered nurse (RN residents for the nigh dressed. She stated, who are trying to get people who want to g who are a "Hoyer lift. dress them in bed. RI prefers to get up early further stated, there is East unit that is care to fall risk. RN-C state	n 7/24/15, at 2:07 p.m.,)-C stated, We schedule t shift to get up, washed and We usually look at people up but if there aren't enough tet up, we will pick people " The aides will wash and N- C stated, "If someone y it is not care planned." She s no one currently on the planned to get up early due ed, The rationale for night s washed and dressed is n the morning.					
	sheet directed night s cares, oral cares, dre	s undated East night group shift to complete morning ssing, making bed and five residents on the unit,					

STATEMEN	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		00374	B. WING		07	//23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		TH ELM STREET MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	4/15, indicated the fa promote care for [res maintains and enhan full recognition of [a r SUGGESTED METH The Administrator and inservice facility staff care in a dignified ma auditing system to en treated with dignity.	y policy, Rights and atients/Residents, dated cility "must, with courtesy, idents] in a manner that ces dignity and respect in esident's] individuality." OD OF CORRECTION:	21805			
21990	Maltreatment of Vulne Subd. 4. Reporting, immediately make an entry point. Use of a for the deaf or other s considered an oral re point may not require extent possible, the r content to identify the caregiver, the nature maltreatment, any ev maltreatment, the native reporter, the time, da incident, and any other reporter believes mig the suspected maltre	A mandated reporter shall oral report to the common telecommunications device similar device shall be port. The common entry written reports. To the eport must be of sufficient avulnerable adult, the and extent of the suspected idence of previous me and address of the te, and location of the er information that the ht be helpful in investigating	21990			

STATEMEN	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
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21990	Continued From page	e 25	21990			
		medical records under ne extent necessary to division.				
	by: Based on observation review, the facility fai of abuse, neglect, mi unknown were imme adminstrator and stat investigated, and res their investigations for R12, R22, R39, R11, allegations reviewed reference checks for employees (NA-A, NA Findings include: Investigation and Pro- During interview 7/23 worker (SW) stated th has been implicated	The facility failed to conduct 4 of 5 newly hired A-B, DA-A and RN-B). Detection B/15, at 5:09 p.m. with social hat nursing assistant (NA)-C in four incident reports from 2015 as the potential				
	Review of facility Inci reports indicated the	dent and Investigation following:				
	2/17/15, indicated sh intact and needed ex R47's care plan date dementia and needs grooming and bathing indicated she had slig	g. The care plan further ght alteration in cognition and that resident will continue				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
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	1/24/15, at 3:49 a.m. [LPN-D] was in a res where the incident has smack. Followed by nurse then got a call from the aide. The a 2 a.m. rounds, I went 45-1 and woke up res process. I told [R47] should lay back down until coffee time. [R4 I'm waiting." NA-C sa NA-C went to pick up bed and [R47] swung fairly hard. I [NA-C] y said "why did you hit hit me you liar" then walkie the nurse"	ome Progress Notes dated indicated: "This nurse . room, 5 rooms away from appened, but heard a distinct a woman's out cry. This on the walkie [walkie-talkie] ide stated (in her words) On t to check resident in room sident in 45 -2 [R47] in the the time and said she n and try and get some sleep 47] said "No, I want to sit up aid "No lets lay down" and b [R47's] feet to bring them in g and hit me in the head, yelled out "ow" and NA-C me, R47 said "I didn't, you [NA-C] walked out and This nurse [LPN-D] asked he aide. Res. [R47] stated					
	on 1/28/15, indicated a nursing assistant o review of the related supervisory staff, it w R47's incident was d study revealed that F assistant, but resider nursing assistant stru	ubmitted to the state agency that R47 had a conflict with n 1/24/15. Following a progress notes, and vas originally determined ue to her dementia. Further R47 allegedly struck a nursing nt [R47] also alleged the uck her. The report indicated n needed to be completed.					
	the state agency on 2 the SW met with the 1/28/15 and 1/30/15 recall any incidents of	tive Report was submitted to 2/2/15. The report indicated resident R47 on the a.m. of and resident was unable to of concerns. The SW was NA-C until 2/2/15 (7 days					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE	•	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 27	21990			
	to her work schedule SW spoke with NA-C 10:45 p.m. NA-C ack happened as describ stated she had not st had tried to lift R47's The investigative report NA-C. This report als been implicated in a p During interview 7/23 stated the resident was incident had happened dementia. The SW suspended during he could "not be proved" R47 continued to be of SW said NA-C was of cares for R47, and was NA-C on how to keep Review of the facility' Schedule indicated N pending the investigat 1/28/15 and NA-C was and 1/29/15, while the progress. The investigation of the interviewing of the NA on 1/24/15 but was n 1/27/15. The investigation the R47 was actually suspend NA-C or tak during the investigation	said NA-C was not r investigation because it ' that NA-C abused R47, and on the work schedule. The ounseled on how to provide as asked for ideas from o R47 safe. s MLHS-LTC NA/R IA-C was not suspended tion of the incident dated as scheduled to work 1/28/15				

STATEMEN	ta Department of Healt T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
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	Referral Form (SSIRI R47 was involved in a a.m., of possible abu The SSIRF indicated (electronic progress r verbal statements an resident [R47]; possil maltreatment but jus resident's dementia." indicated the incident Investigative Team of reported submitted to 3/3/2015 at 12:30 p.m NA-C was a person v the situation. An initial Incident Rep state agency on 3/3/ of R47 on 3/2/15. Th progress notes from a.m. of 3/2 that sugge concerns/dementia s at work or possible m staff." The report ind whether this was mal to go ahead and sub- agency]" A nursing progress note a.m., written by LPN- "kicking at staff" and going to report 'her' to indicated R47 told sta everyone I heard" O second progress note wipe dry blood off [R47 The note continued, for	ble indication of t a likely symptoms of The SSIRF further it was discussed with n 3/3/15 at 8:30 a.m., and					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
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	Facility documentation was taken to protect during this investigat Documentation of the did not include detern bloody lip, and there with the nursing assis R47. The SSRIF als immediate reporting agency or administra A final, Investigative state agency on 3/00 The report indicated interviewed by RN C this SW. Resident de happening this past v or the nighttime that denied that anyone h her or that she has h also indicated "SW c about progress notes shift, "indicating the N the EZ lift (mechanic bathroom per resider noticed resident's lip apparently cracked ff winter air. [NA-C] tol the dried blood off, the causing NA's glasses The report indicated and assisted [R47] w same night, the NA w attempted to lift R47" resident kicked at NA	on did not indicate any action R47 and other residents ion of potential abuse. e investigation of this incident mination the cause of R47's was no evidence of interview stant who provided cares for o indicated there was no of this incident to the state tor. Report was submitted to the 6/15 regarding the incident. on 3/2/15 the "resident was are Coordinator (RN- A) and enied remembering anything weekend during the daytime upset her in any wayShe its her or has been mean to it anyone else." The report communicated with [LPN-B] is from 3/2/15 during night NAR was situating resident in al lift) to help her to the nt's request and the NAR had been bleeding rom being chapped with dry, d [R47] she was going wipe but R47 struck out at NA, is to dismount from her face." NA-C re-approached later rithout incident. Later the vas doing rounds and is feet back in bed, and				
	was slapped. The reperpetrator in this inc R47's care plan was	port did not confirm a sident. The report indicated reviewed, and suggestions o approach R47 during				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
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	coached by the SW a progress note chartin have been reminded reports. The report ir not resting well with t maltreatment of resid particular incident, SV	o indicated LPN-B was and DON on more thorough g, and further, that staff to submit timely incident acluded: "Something is just his, and although there is no ents 'substantiated' in this V will continue to keep eyes tterns and/or trends in					
	2015, indicated NA-0	's MLHS-LTC NA/R ary 23, 2015 to March 8, C was assigned to work e alleged incident) and also					
	stated, in review of th "concerns with NA-C" she had really done a felt they could not sul against NA-C, and th "suspension or discip investigation. There w	' but again could not prove nything wrong. The facility ostantiate the allegations erefore did not warrant a					
	was moderately cogn extensive assist with grooming. R12's care	dated 4/27/15 indicated she itively intact and needed dressing, bathing and e plan dated 1/31/15, tential for abuse from others npairment and limited					
	agency on 2/18/15, ir	port submitted to the state idicated that on 2/18/15, R12 d, on her cheek, by a staff mpting to administer					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED	
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21990	Continued From page	e 31	21990				
	medicine. The AP on the Incident Report was listed as unknown.						
	state agency on 2/23 The report indicated allegations, but the o "tracked," was the or [R12] during the adm Magnesia (MOM) that indicated the SW and more information abd administered the MO schedule, LPN-B and duty. At 10:45 p.m. o SW met with NA-C, given MOM to R12 u NA-C said "[R12] did took the cup and thre [NA-C] tried to clean resident's clothing an The report indicated any way, but acknow with the wet ones. T possible this was per The SW asked NA-C see if resident could/ her as the lady who s agreed to do so. [R1 however, so decided indicated "[NA-C's] w leads SW to believe about not slapping re indicated the DON sp 2/23/15 at 3:20 p.m.	at morning. Firstly, the report d DON proceeded to seek but who would have M that morning. Per d NA-C were the persons on on 2/19/15, the DON and who freely admitted having under direction of LPN-B. In't want the MOM, and [R12] ew the MOM all over." it up off the bedding, nd her face, using wet wipes." NA-C denied slapping R12 in vledged wiping R12's face off the report indicated, "It is received by [R12] as a slap." C to go to resident's room to would or would not identify slapped her, and NA-C [2] was sleeping soundly, not awaken her. The report <i>v</i> illingness to go, however, she [NA-C] is being truthful esident." The report then poke to LPN-B by phone on LPN-C admitted asking to R12 due to LPN being					

STATE FORM

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	//23/2015
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		07	123/2013
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21990	and NA-C was instruct without a colleague p During interview on 7 stated she did not sus could not prove NA-C acknowledged NA-C multiple incidents, an [NA-C], but did not fe suspend" or provide of during this investigati The investigation of th not determine if R12 follow up to have R12 nursing assistant who NA-C was instructed without a colleague p offered no indication for other residents who during this investigati regardless of its outco R22's admission MDS she had depression a accident (CVA), was impaired and needed and extensive assist plan dated 5/3/15, ind with toileting and tran depression and sadm care plan further indic abuse from others ref weakness, aches and	ng cares with this resident cted not to enter room resent. 7/23/15, at 5:20 p.m. the SW spend NA-C since they Sapped R12. The SW had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on. his incident by the facility did was slapped, nor was there 2 positively identify the p provided cares. Although not to enter R12's room resent, the documentation protections were put in place to were assisted by NA-C on of this incident, ome. S dated 4/24/15, indicated and a cerebral vascular moderately cognitively limited assist with transfers with toileting. R22's care dicated she needed assist isfers, had history of ess/isolating self. R22's cated she had potential for	21990	DEHCIEN		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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21990	Continued From page	e 33	21990			
	right shin measuring (centimeters) x 2 cm	d displayed a bruise on her approximately 8 cm R22's bruise was black, in color, with no apparent				
	that she had been tre and there is a staff m shift that is rough wit this staff member had transferring" which ca	15, at 5:54 p.m. R22 stated eated "roughly by the staff" ember who works the night h her. R22 went on to state d "grabbed her arm when aused a large bruise and also hit her leg into the metal of her bed.				
	state agency on 6/27 alleged mistreatment The report also ident right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm report was submitted the initial reporter, N/ perpetrator in this incon nursing assistant (N/ she had toileted R22 told [NA-C] she was that "some girl hurt h she [R22] stated she	an Incident Report to the 715, regarding an incident of and physical abuse of R22. ified a bruise on R22's top g 5.5 cm x 5 cm, circular in bruise on R22's lower right , circular in shape. The by RN-D, and indicated that A-A, was also the alleged cident. The report indicated, A)-C reported at 5:15 a.m., , After being toileted, R22 not coming back tonight, and er." NA-C asked who, and doesn't know who. The that registered nurse				
	(RN)-A, followed up y asked her to tell her y reported she is not st is not going to be trea explained that staff w night for getting up to times, and that a "gir	with R22 in the morning and what happened: "Resident taying here again tonight and ated like this anymore." R22 vas mad at her during the o use the bathroom so many I grabbed me and threw me ed out her hand hurt, and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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21990	Continued From page	e 34	21990			
	(centimeters) x 5 cm reported when she the leg on something me outer lower shin mea circular in shape. R2 girl was, nor her nam around 0400. The re- was the nursing assist during the night, and charge. No other inj reassured she will re- removed from working An additional Incident the state agency on a injury of unknown so 8 x 5 cm, reddish pur shape. The date of in	hand measures 5.5 cm circular is shape. R22 also prew me into bed, "I hit my tal;" a bruise noted on right sures 2.5 cm x 2.5 cm 22 could not recall who the ne. R22 thought it was eport further indicated NA-C stant working on that wing LPN-A was the nurse in furies noted, resident was main safe here, NA-C will be ng with resident at this time. At Report was submitted to 7/1/15, which identified an purce on R22's right forearm rple in color, and oval in neident occurrence was t indicated R22 said, "It is ago."				
	state agency on 07/0 two submitted incident indicated the DON and tried to investigate the been unable to subst perpetrator [AP] is for conclusion there is re- may have occurred in hence submitting a re- enforcement, in accor Act." Further, "The d investigation to the life submitted to OHFC [Complaints] the state Report further indicate SW met with the AP,	rdance with Elder Justice				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
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	(6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re [regarding] her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble." The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."					
	member who had hur for her and received r disciplinary action wa suspended pending t was no indication tha	scribed NA-C as the staff t her and NA-C was caring multiple large bruises, no s taken, NA-C was not he investigation. Also, there t a thorough investigation e facility to include other nd residents.				
	DON stated she has be doing the accusati certain. The DON sa during the night shift, that do that." The DO	/23/15, at 4:50 p.m. the concerns that NA-C might ons, but stated she was not id, "Staff monitor [NA-C] " and "we have nurses on DN stated the nurses were to nything and have concerns.				
		3/15, at 5:03 p.m. the SW with other residents or staff				

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	regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."						
	administrator said, "W working on nights, we	on 7/23/15 at 5:10 p.m., the We have three young people e can't suspend; there is not dministrator further stated, " I V did the right thing."					
	the DON stated NA-0 facility policy followin R22 . She stated, "If	on 07/23/15, at 5:14 p.m. C was not suspended per the g the allegation made by I had suspended one, I uspend all three staff, then of the residents?"					
	stated, " I don't work am mandated, but I c stated, "I have heard	on 07/24/15, 5:14 a.m., NA-E a lot of overnights unless I do hear a few things." NA-E about people being super I that some of the girls are a					

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21990	Continued From page	e 37	21990			
	stated one of the residue in the staff member as the staff member as the resident and stated the threw me into the charabathroom again." NAthe nurse a lot on night the nurse a lot on night buring interview on 7 stated she works part LPN-H stated she had NA-C is rough with the witnessed it directly. aware that she was the night shift when standicated she had here. NA-C had slapped here works on the North with the was because of the cost take care of any certast stated the aides on the stated she had here.	t tell you who." She further dents mentioned about a girl ing bruises. NA-E described they were described by the ne resident said " the girl air because I had to go to the A-E stated she does not see hts. 7/24/15, at 5:25 a.m. LPN-H t time on the night shift. s heard from other NAs that he residents but had not LPN-H stated she was not o monitor any staff during the works. She further ard R12 had reported that er and that NA-C no longer ring and thought the reason sat; not because she can not ain residents. She then he night shift don't work o work on each unit alone.				
	INJURIES OF UNKN	OWN ORIGIN				
	was moderately cogn plan, dated 3/30/15, i extensive assist with	lated 3/9/15, indicated she hitively impaired. Her care ndicated she required all activities of daily living, tand for transfers, and was red to dementia.				
	dated 10/7/14, indica purple bruise on the r buttock and that R39 bruising occurred. Th	vice Incident Report Form, ted R39 had a large, dark right upper portion of her was unaware of how the le report indicated R39 had r by staff a few days prior to				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			123/2013
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 38	21990			
	the injury. The incide anticoagulant medica clotting), other injurie unspecified times frau "minor." The injury wa During an interview o DON)stated, when R floor it would be hard during that event but due to use of anticoa therefore the injury w reportable. Although R39 was mu unable to recall how f was no evidence that investigation was cor	me, and listed the injury as as not reported to OHFC. In 7/24/15, at 12:54 p.m., the 39 had been lowered to the to know if injury occurred stated, R39 bruised easily gulant medication so as not considered oderately impaired and the bruise occurred, there is a more in-depth npleted to determine the s R39's injury of unknown				
	she was moderately of plan, dated 6/3/15, in extensive to total ass living, was cognitively abuse related to depr	ist for all activities of daily / impaired, and at risk for ression.				
	Report Forms indicat unknown origin. An ir indicated R39 had a l hand that was dark p 8 cm x 8 cm. The rep was unable to state h blood thinners and de	rate Social Services Incident ed R11 had injuries of incident form dated 10/21/15, bruise to the top of her right urple in color and measured ort further indicated R11 iow the injury occurred, used escribed the injury as ial Services Report Form,				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00374	DDRESS, CITY, STATE		07	/23/2015
				, 211 00DL		
IILLE LA	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21990	Continued From page	e 39	21990			
	dated 11/4/14, indicator to her left temple and was unable to state to third incident report of had a bruise of unknown knee, dark purple in of (unit of measurement report further indicate the cause of the injur medications, and the "minor." None of the to OHFC. During an interview of SW stated, R11 "had have ever known." So hand may have been of [R11's] nails." Reg R11's temple and for nursing felt the bruisi R11's nebulizer mask R11 who reported that way back from supper not ambulate, used at there were no record the bruising was likel nebulizer mask. During an interview of DON stated R11 cou	ted R11 had bruising noted a above her left eyebrow, and he cause of the injury. A lated 12/18/14, indicated R11 own origin to her left inner color, measuring 1 x 1 3/4. t was not indicated). The ed R11 was unable to report y, use of anticoagulant e injury was considered to be three bruises were reported on 7/24/15, at 12:54 p.m., more bruising than anyone I he stated the bruise on R11's o caused by "recent trimming arding the bruise noted to ehead, SW stated that ng was due to placement of k, however, SW interviewed at she slipped and fell on her er. SW further stated R11 did a Hoyer lift for transfer and s of any falls and indicated y due to placement of R 11's				
	she felt the injury was Although R11 was id cognitively impaired,	entified to be moderately and had multiple bruises at				
	what happened, there investigation complete causes of R11's bruis	nd were unable to determine e was no indepth ted to determine the actual ses. The facility administrator e of these incidents were				

STATE FORM

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374				
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	//23/2015
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page submitted to the state		21990			
	was moderately cogn dated 2/9/15, indicate assist of two staff with transfers, at risk for d related to depression During review of a So Referral Form, dated noted indicated R66 M from her hands to he indicated R66 was un the injury and that the "minor." The injury w During an interview of SW stated, the bruise was reviewing a prog with nursing and dete assessed to be a min reportable to to OHFO	bcial Service Incident 2/3/15, a facility progress had bruising along both arms r shoulders. The form further hable to state the cause of e injury was assessed to be vas not reported to OHFC. In 7/24/15, at 12:54 p.m., es were noted while the DON press note and she spoke ermined the bruising was nor injury and therefore not C.				
	DON stated, R66 use lift) and did not alway occasionally "flailing stated, R66 was conf "hard to say if R66 w	on 7/24/15, at 12:54 p.m., the ed a Hoyer lift (mechanical rs cooperate in lift, her arms." She further fused and that it would be ould have been able to to uising occurred after any				
	hands to her shoulde unwitnessed and the identify what happen	resident was unable to ed. The facility had not the incident to the state				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING			122/2045
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	//23/2015
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 41	21990			
	completed to determi arms" while using the	ne if R66 was "flailing her e mechanical lift.				
	was severely cognitive dated 7/10/15, indicated assist with activities of for abuse related to se impaired decision material Review of Social Serred ated 6/15/15, indicated 6/15/15, indicated	lated 6/9/15, indicated she vely impaired. Care plan, ted R44 required extensive of daily living, and was at risk short term memory loss and aking skills. vice Incident Referral Form, ted R44 had a purple bruise arm measuring 6.3 cm x 7				
	form indicated R66 d injury and that the inj	uring her bath. The incident id not state the cause of ury was determined to be as not reported to OHFC.				
	SW stated, on 8/18/1 bruise measuring 8.5 thumb and forefinger to her wrist. She state the initial evaluation a resulted from R8 wrin wringing of her hands She further stated the due to staff witness of Social Services Incid	on 7/24/15, at 12:54 p.m., 4, staff reported R8 had a cm in length between her from the base of the thumb ed the reporting nurse did and determined the bruising nging her hands, and the s was witnessed by staff. e injury was not reportable of the potential cause. A ent Referral form was ury but was not received.				
	SW stated when mak whether or not to rep refers to statutes, and also stated that she l	on 7/24/15, at 12:54 p.m., king a determination of ort an injury to OHFC, she d uses a decision tree. SW ooks at whether a resident is jury or if someone else saw				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00274	00374 B. WING			07/22/2015	
NAME OF PI	ROVIDER OR SUPPLIER		B. WING 07/23/2015 EET ADDRESS, CITY, STATE, ZIP CODE				
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
21990			21990				
nurse was r follow there would comp Even cogni origin indica inves injury	nurses judgement wh was minor or major a followed up on the inj there was no charting would show evidence completed.	nen determining if an injury nd that the RN in charge juries. However, she stated g in the clinical record that e that follow up had been					
	cognitively impaired, origin, on the posterio indication the facility investigation to deter	s assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her nt was not reported to the					
	her to be severely co requiring assist of two living. CP dated 5/15 extensive assist for a	um data set (MDS) identified gnitively impaired and o staff for activities of daily /15 indicated R8 required ctivities of daily living and related to diagnosis of					
uposoto Dar	had a bruise measuri	ated 8/18/14, indicated R8 ng 8.5 cm in length between nger from the base of her					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00274		B. WING		07/00/0045	
	ROVIDER OR SUPPLIER	00374	ADDRESS, CITY, STATE		07	//23/2015	
			RTH ELM STREET				
IILLE LA	CS HEALTH SYSTEM	ONAMIA	A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21990	Continued From pag	e 43	21990				
	initial evaluation and resulted from R8 with wringing of her hand During an interview of SW stated, the injury staff witness of the p investigation of the in facility administrator a report was not mad Social Services Incid requested for this inj Although R8 had sev and had a bruise 8.5 forefinger from the b There was no indicat thorough investigation	he reporting nurse did the determined the bruising nging her hands, and the s was witnessed by staff. on 7/24/15, at 12:54 p.m., was not reportable due to otential cause. No further njury was completed. The was notified of the injury but de to the state agency. A lent Referral form was ury but was not received. were cognitive impairment, cm between her thumb and ase of her thumb to her wrist. tion the facility completed an on to determine the source of acident was not reported to					
	revised 7/15, indicate (Mille Lacs Health Sy are vulnerable to abu physical, mental psy sexual abuse)" Th "protection will include individual abuse prev reporting of all cases neglect, or financial of reporting to the Com substantiated incider	Vulnerable Adult Policy, ed: "It is the policy of MLHS ystem) to protect adults who use (including verbal, chosocial/emotional, and e policy further indicated: de abuse prevention plans, vention plans, internal of suspected abuse, exploitation, and external mon Entry Point (CEP) of hts of maltreatment." In on of a reportable incident,					

STATE FORM

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1	
MILLE LA	CS HEALTH SYSTEM					
	SUMMARY ST		A, MN 56359	PROVIDER'S PLAN OF		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 44	21990			
	thoroughly investigate further potential abus progress." Under the Patient" section, the alleged perpetrator (<i>I</i> situation. If the AP is suspended until the in and further, "Disciplir up to and including d employee/employees defined Injury of Unk the injury was not ob suspicious." The pol definition top include to screening of poten	as appropriate." The Policy nown Origin as "source of served and injury as icy did not expound on this CMS definitions. In regard tial employees, the policy attempt to obtain information				
	The Administrator an and inservice the faci investigation of allega to the State rules and					
	TIME PERIOD FOR (14) days.	CORRECTION: Fourteen				
22000	MN St. Statute 626.5 Reporting - Maltreatn	557 Subd. 14 (a)-(c) nent of Vulnerable Adults	22000			
	facility, except home personal care attenda establish and enforce	ant services providers, shall e an ongoing written abuse e plan shall contain an				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, Z	ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
22000	and a statement of sp to minimize the risk of comply with any rules promulgated by the li (b) Each facility, in agency and personal providers, shall devel prevention plan for ea residing there or rece The plan shall contain assessment of: (1) th abuse by other indivity vulnerable adults; (2) other vulnerable adults; (2) other vulnerable; (3) other vulnerable; (3) other vulnerable; (3	population identifying courage or permit abuse, becific measures to be taken if abuse. The plan shall is governing the plan censing agency. cluding a home health care care attendant services op an individual abuse ach vulnerable adult tiving services from them. In an individualized the person's susceptibility to duals, including other the person's risk of abusing ts; and (3) statements of the be taken to minimize the berson and other vulnerable bases of this paragraph, the is self-abuse. Except home health agencies tendant services providers, rable adult has committed a ct of physical aggression dividual abuse prevention measures to be taken to the vulnerable adult might ted to pose to visitors to the utside the facility, if r this section, a facility knows is history of criminal cal aggression if it receives in a law enforcement a medical record prepared by the r health care provider, or				

winnesot	a Department of Healtl	h				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00374	B. WING		07/23/2015	
					07	20/2010
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
22000	Continued From page	e 46	22000			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their Vulnerable Adult Policy to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown origin were immediately reported to the administrator and state agency, were thoroughly investigated, and residents were protected during the investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. In addition, the facility failed to conduct reference checks according to their					
	NA-B, DA-A and RN- effect all 50 residents	/ hired employees (NA-A, -B). This had the potential to who resided in the facility, andard quality of care under d facility practices.				
	indicated: "It is the po Health System) to pro vulnerable to abuse (mental psychosocial/	e Adult Policy, revised 7/15, blicy of MLHS (Mille Lacs otect adults who are including verbal, physical, emotional, and sexual further indicated: "protection				
	will include abuse pre- abuse prevention plat cases of suspected a exploitation, and exte Common Entry Point incidents of maltreatm investigation of a repo	evention plans, individual ns, internal reporting of all buse, neglect, or financial rnal reporting to the (CEP) of substantiated				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00374				10010045
NAME OF PI	ROVIDER OR SUPPLIER	00374 STREET A	DDRESS, CITY, STATE,		07	/23/2015
	CS HEALTH SYSTEM		TH ELM STREET			
	CS REALTH STSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 47	22000			
	potential abuse while progress." Under the Patient" section, the p perpetrator (AP) will b situation. If the AP is suspended until the ir and further, "Disciplin up to and including di employee/employees INVESTIGATION ANI During interview 7/23, worker (SW) stated th has been implicated i reports from February alleged abuse, and no	an employee, they will be nvestigation is completed," ary action will be carried out smissal of as appropriate." D PROTECTION /15, at 5:09 p.m. with social nat nursing assistant (NA)-C n at least four incident / 2015 to July 2015 of eglect. dent and Investigation 5 to 7/20/2015 for NA-C				
	2/17/15, indicated she intact and needed ext R47's care plan dated dementia and needs a grooming and bathing indicated she had slig related to dementia a to be oriented to pers A facility Social Servic (SSIRF) indicated lice (LPN)-D verbally repo (SW) on 1/27/2014, a	 The care plan further The care plan further Int alteration in cognition Ind that resident will continue Int alteration in cognition Int alteration 				
	SSIRF, dated 1/27/15 altercation/conflict be	ight shift on 1/24/2015. The 5, indicated: "Alleged tween res [resident] & aides lapping aide and stating 'l				

ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		B. WING			
	00374			07	7/23/2015
AME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIF CODE		
IILLE LACS HEALTH SYSTEM	ONAMIA	, MN 56359			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000 Continued From page	48	22000			
didn't hit you, you hit m also indicated, "LPN s assisted res to bed, es inquire what happened indicated the incident investigation and/or re agency, and this was s 1/28/15. A review of Mille Lacs Notes, dated 1/28/15, "This nurse was in a re from where the inciden distinct smack. Follow This nurse then got a [walkie-talkie] from the NA)." The [NA] stated rounds, I went to check (room 45, bed 1) and w [R47] in the process. said she should lay ba some sleep until coffer want to sit up I'm waiti down" and NA went to bring them in bed and the head, fairly hard. NA said "why did you you hit me you liar' the walkie the nurse" Th the res. why she hit th that the aide hit her." identify the nursing as A facility email, written 1/28/2015, indicated tt informed by LPN-D of a nursing assistant. T	ne you liar." The SSIRF separated aide & resident, scorted aide to hallway to d." The SSIRF also required "further porting" to the state signed by the SW on Nursing Home Progress written by LPN-D indicated: es. room, 5 rooms away in happened, but heard a ved by a woman's out cry. call on the walkie e aide (nursing assistant, (in her words) "On 2 a.m. k resident in room 45-1 woke up resident in 45-2 l told [R47] the time and tek down and try and get e time." [R47] said "No, I ng." NA said "No lets lay pick up [R47's] feet to [R47] swung and hit me in I [NA] yelled out "ow" and hit me, [R47] said, 'I didn't, en [NA] walked out and nis nurse [LPN-D] asked e aide. Res. [R47] stated The nursing note did not sistant by name.				

STATE FORM

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	0374 B. WING		07/23/2015	
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	1 0.	
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
	CO NEALIN STOTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 49	22000			
	because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency.					
	on 1/28/15, indicated reported to this SW in 1/27/15" and furthe past weekend" with a Following a review of by the "Stand Up Tea Management Team", incident was due to [I symptoms" The re progress note which "claimed at the time to thus requiring a report	r that R47 had a conflict "this a nursing assistant. i the related progress notes am" and "Behavior it was originally determined R47's] "dementia port referred to a nursing indicated that [R47] that the NAR struck her," rt to the state agency, and tion done accordingly as per				
	initial report submitter indicated an incident the night shift/early m The report also indicate reported, and made a afternoon of 1/27/201 incident) and reporter 1/28/2015 (three day occurred). There wa was reported immediate and state agency. Ac of this incident: lacket	occurred sometime during horning hours of 1/25/14. ated the incident was first known to the SW on late 14, (two days after the d to the state agency on s after the incident allegedly s no indication this incident ately to the administrator dditionally, the investigation ed timely interviewing of				
nnesota Dep	affected residents; di was thoroughly inves	lved staff, and potentially d not provide evidence R47 tigated for injuries; and ction to protect residents				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	12312013
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
	oo neaenn or or en	ONAMIA	, MN 56359			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLET DATE
22000	Continued From page	e 50	22000			
	during the investigation.					
	state agency on 2/2/1 SW met with R47 "on 1/30/15," and "Reside incidents of concern w weekend." The SW w NA-C, (identified as th involved) until 2/2/15 learned of the inciden schedule not coincidin with NA-C by phone of NA-C "acknowledged described" by LPN-D" saying she had not st had merely tried to lift back down" The re apparent evidence of investigative report in perpetrator was NA-C	(7 days after the SW it) "in part due to her work ing with the SW." SW spoke on 2/2/15, at 10:45 p.m. The incident happened as 's note, and further, "[NA-C] ruck resident in any way, but t [R47's] legs to help her lay port indicated "There is no NAR striking resident." The				
	stated in the investiga recall if the incident h had dementia. The S suspended during her could not be proven the NA-C continued to be SW said NA-C was co	/23/15, at 5:10 p.m., the SW ation, R47 was unable to ad happened, and that R47 SW said NA-C was not r investigation because it hat NA-C abused R47, and on the work schedule. The pounseled on how to provide as asked for ideas from PR47 safe.				
	2015, indicated NA-C	s MLHS-LTC NA/R ry 26, 2014 to February 8, worked on the night shift on while the investigation of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED			
		00374	B. WING		07	/23/2015			
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE					
AILLE LA	CS HEALTH SYSTEM		A, MN 56359						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				SUMMARY STATEMENT OF DEFICIENCIES ID K (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLE DATE
22000	Continued From pag	e 51	22000						
	this incident was in progress.								
	Referral Form (SSIR R47 was involved in a.m., of possible abu The SSIRF indicated (electronic progress verbal statements ar resident [R47]; possi maltreatment but jus resident's dementia.' indicated the incider Investigative Team o reported submitted to 3/3/2015 at 12:30 p.1 NA-C was a person of the situation.	st a likely symptoms of ' The SSIRF further Int was discussed with In 3/3/15 at 8:30 a.m., and to the state agency on m. The report also indicated with credible knowledge of							
	state agency on 3/3/ maltreatment of R47 referenced "two prog shift early that a.m. o some behavioral con by resident [R47] at maltreatment of resid indicated uncertainty maltreatment, and "S	port was submitted to the 15 regarding possible on 3/2/15. The report gress notes from NOC (night) of 3/2 that suggests either accerns/dementia symptoms work or possible dent by staff." The report by staff on whether this was SW decided to go ahead and to [state agency]"							
	a.m., written by LPN "kicking at staff" and going to report 'her' t indicated R47 told st everyone I heard" second progress not	ote, dated 3/2/215 at 4:03 -B, indicated [R47] was [R47] told staff "she was to the nurse" The note also aff "you go around hitting On 3/2/15 at 6:03 a.m., a ed indicated staff went to 47's] lip, and [R47] hit staff.							

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			B. WING			
		00374			07	/23/2015
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
22000	Continued From pag	e 52	22000			
		that after R47 hit staff, R47 report you for hitting me."				
	was taken to protect during this investigat Documentation of the did not include detern bloody lip, and there with the nursing assis R47. The SSRIF als	on did not indicate any action R47 and other residents ion of potential abuse. e investigation of this incident mination the cause of R47's was no evidence of interview stant who provided cares for o indicated there was no of this incident to the state tor.				
	state agency on 3/00 The report indicated interviewed by RN C this SW. Resident d happening this past or the nighttime that denied that anyone h	Report was submitted to the 6/15 regarding the incident. on 3/2/15 the "resident was are Coordinator (RN- A) and enied remembering anything weekend during the daytime upset her in any wayShe its her or has been mean to				
	also indicated "SW of about progress notes shift, "indicating the I the EZ lift (mechanic bathroom per resider noticed resident's lip apparently cracked fit	rom being chapped with dry,				
	the dried blood off, the causing NA's glasses. The report indicated and assisted [R47] w same night, the NA w	d [R47] she was going wipe but R47 struck out at NA, s to dismount from her face." NA-C re-approached later vithout incident. Later the vas doing rounds and s feet back in bed, and				
nesota Der	referenced the allega	ations made by R47, that she				

STATE FORM

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STATEMEN	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
22000	R47's care plan was were made on how to cares. The report als coached by the SW a progress note chartin have been reminded reports. The report in not resting well with t maltreatment of resid particular incident, SV and ears open for pa conduct, etc." Review of the facility Schedule from Febru 2015, indicated NA-G 3/2/15 (the night of th worked on 3/3/15. During interview 7/23 stated, in review of th "concerns with NA-C she had really done a felt they could not sul against NA-C, and th "suspension or discip investigation. There we thorough investigation R12's quarterly MDS was moderately, cog extensive assist with grooming. R12's carr indicated she had po	ident. The report indicated reviewed, and suggestions o approach R47 during so indicated LPN-B was and DON on more thorough ig, and further, that staff to submit timely incident included: "Something is just his, and although there is no lents 'substantiated' in this <i>N</i> will continue to keep eyes tterns and/or trends in 's MLHS-LTC NA/R ary 23, 2015 to March 8, C was assigned to work he alleged incident) and also w/15, at 5:30 p.m. the SW his incident, she had " but again could not prove anything wrong. The facility bstantiate the allegations erefore did not warrant a				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	. ZIP CODE	07	12312015
			TH ELM STREET			
	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 54	22000			
	2000 Continued From page 54 A facility Social Service Incident Referral Form (SSIRF), signed by the SW 2/18/15 at 4:15 p.m., indicated there was an incident on "2/18/2015 early A.M.", which alleged "Abuse." The incident was described as: "[NA)-I] asked SW to meet w/ Res re some issues. 9:30 a.m. Res told SW 'I want to go home, they're mean to me here.' 'The lady with the ponytail hurt me when she clean me up yesterday', and 'The other lady slapped me when she tried to make me drink white stuff.' At 4p.m. resident [R12] was still claiming similar concerns." The SSIRF also indicated the following: an internal email report was completed on 2/18/15; that the report of alleged abuse was received by the SW in person, no date or time listed; the incident was discussed with "Investigative Team" on 2/18/15 at 0833; and that the state agency initial report was submitted on 2/18/15 (no time indicated).					
	agency on 2/18/15, in was "slapped on her this morning while sta her to take some med R12 had no apparent consistent with this of The report also indica investigation is warra					
	State Agency indicate occurred in the early possibly earlier, no ac or staff until it was dis on 2/18/15. There was	F, and the initial report to the ed, that although this incident morning of 2/18/15, and ction was taken by the facility scussed later that morning as no indication the incident orted to state agency and er, the investigation				

ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED	
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	00374	B. WING	7/2 0025	07	//23/2015	
AME OF PROVIDER OR SUPPLIEF		ADDRESS, CITY, STATE, RTH ELM STREET	ZIP CODE			
ILLE LACS HEALTH SYSTE	M	A, MN 56359				
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22000 Continued From	page 55	22000				
R12 was slapped have R12 positiv (possibly NA-C) v Although NA-C w room without a co documentation of were put in place assisted by NA-C	f this incident did not indicate if d; and there was no follow up to ely identify the nursing assistant, who provided her cares that day. vas instructed not to enter R12's colleague present, the ffered no indication protections of or other residents who were during the investigation of this ess of its outcome.					
state agency of 2 indicated the "Init agency]at 4 p. was made to loca indicated R12 ha but the only alleg the one about so administration of morning (the whit SW and DON pro- information about the MOM that mo- according to the si- the persons on d indicated, "DON a freely admitted ha direction of [LPN- "[NA-C] said resid resident took the over." and "[NA-C] bedding, resident wet wipes." The slapping resident	ve Report was submitted to the 2/23/15. The final report tial Reports submitted to [state .m.," on 2/18/15, and also a call al law enforcement. The report d made numerous allegations, ation that could be "tracked, was meone slapping her during the Milk of Magnesia (MOM) that te stuff)." The report indicated occeeded to seek more t who would have administered orning. The report identified, schedule, LPN-B and NA-C were uty. Further, the report and SW met with [NA-C], who aving given MOM upon the -B]." The report continued, dent didn't want the MOM, and cup and threw the MOM all C] tried to clean it up off the t's clothing and her face, using report indicated "[NA-C] denied t in any way, but acknowledged ue off with the wet ones." The					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
				A. BUILDING:			
		00374	B. WING		07	7/23/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
22000	Continued From page	9 56	22000				
	lady who slapped her "[R12] was sleeping s decided not awaken h "NA-C's willingness to believe she [NA-C] is slapping resident." T spoke to LPN-B by pl LPN-C admitted askin R12 due to LPN-C be LPN-C also acknowle (R12's) claim of being The report then indica to having "two persor this resident and NA- room without a collea During interview on 7 stated she did not sus could not prove [NA-C acknowledged NA-C multiple incidents, an [NA-C], but did not fe suspend" or provide of during this investigati Review of the facility' Schedule from Febru 2015, indicated NA-C	her." The report indicated b go, however, leads SW to being truthful about not he report indicated the DON hone on 2/23/15 at 3:20 p.m. ng NA-C to give MOM to eing occupied elsewhere edged that NA-C did report g slapped by a "blonde lady." ated staff have been alerted hs present" during cares with C was instructed not to enter gue present. /23/15, at 5:20 p.m. the SW spend NA-C since "they C] slapped [R12.]" The SW had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on.					
	There was no indicati was completed for R ²						
	she had depression a accident (CVA), and	S dated 4/24/15, indicated and a cerebral vascular was moderately cognitively limited assist with transfers					

	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
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22000	Continued From page	e 57	22000			
	plan dated 5/3/15, ind with toileting and tran depression and sadn care plan further india abuse from others re weakness, aches and indicated "resident w needs met in a safe of During observation o lifted her pant leg and right shin measuring (centimeters) x 2 cm. be black, fading to da apparent swelling. In p.m. R22 stated that "roughly by the staff" who works the night s R22 went on to state "grabbed her arm wh caused a large bruise	ess/isolating self. R22's cated she had potential for lated to her general d pains. The care plan goal ill remain safe and have environment." n 7/20/15 at 5:54 p.m., R22 d displayed a bruise on her				
	state agency on 6/27 alleged mistreatment The report also identi right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm report was submitted the initial reporter, NA perpetrator in this inc nursing assistant (NA she had toileted R22 told [NA-C] she was n	an Incident Report to the /15 regarding an incident of and physical abuse of R22. ified a bruise on R22 top g 5.5 cm x 5 cm, circular in bruise on R22's lower right , circular in shape. The by RN-D, and indicated that A-C, was also the alleged cident. The report indicated, A)-C reported at 5:15 a.m., , after being toileted, R22 not coming back tonight,and er." NA-C asked who, and				

TATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00374	B. WING		07	/23/2015
AME OF PROVIDER (R SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
IILLE LACS HEAL	TH SYSTEM		RTH ELM STREET , MN 56359			
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22000 Continu	ied From pag	e 58	22000			
report t (RN)-A asked I reporte is not g explain night fo times, a into be said "th bruise o (centim reporte leg on s outer lo circular girl was around was the during charge reassur remove An add the stat injury o "8 x 5 o shape." unknow happer	hen indicated , followed up her to tell her d she is not s oing to be tre ed that staff v r getting up to and that a "gir d." R22 point is where sh on top of right eters) x 5 cm d when she th something me wer shin mea in shape. R2 s, nor her nam 0400. The r e nursing assi the night, and No other in red she will re- d from workir itional Incider e agency on f unknown so m, reddish pu The date of <i>n</i> . The repor- ied a few day estigative Rep gency on 07/0 ed incident re- The report ir (DON) and s	that registered nurse with R22 in the morning and what happened: "Resident taying her again tonight and ated like this anymore." R22 vas mad at her during the o use the bathroom so many 1 grabbed me and threw me ed out her hand hurt, and he grabbed me," noted a thand measures 5.5 cm circular is shape. R22 also hrew me into bed, "I hit my etal" a bruise noted on right asures 2.5 cm x 2.5 cm 22 could not recall who the he. R22 thought it was report further indicated NA-C stant working on that wing I LPN-A was the nurse in juries noted, resident was emain safe here, NA-C will be ng with resident at this time. At Report was submitted to 7/1/15, which identified an furce on R22's right forearm urple in color and oval in incident occurrence was t indicated R22 said "It				

22000 Continued From page 59 conclusion there is reasona may have occurred in the fe hence submitting a report a enforcement, in accordance Act." Further the report ind our internal investigation to are being submitted to OHF agency." The Investigative indicated on 7/1/15, the DC	200 NOF ONAMIA	A. BUILDING: B. WING ADDRESS, CITY, STATE RTH ELM STREET A, MN 56359 ID PREFIX TAG 22000		CORRECTION ON SHOULD BE HE APPROPRIATE	/23/2015 (X5) COMPLET DATE
XILLE LACS HEALTH SYSTEM (X4) ID PREFIX TAG SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDE 22000 Continued From page 59 conclusion there is reasona may have occurred in the fe hence submitting a report a enforcement, in accordance Act." Further the report ind our internal investigation to are being submitted to OHF agency." The Investigative indicated on 7/1/15, the DC	STREET A 200 NOF ONAMIA NT OF DEFICIENCIES I BE PRECEDED BY FULL ENTIFYING INFORMATION) able suspicion a crime form of assault, and are also to law e with Elder Justice dicated, "The details of the limits of our ability FC and the state a Report further DN and SW met with	ADDRESS, CITY, STATE RTH ELM STREET A, MN 56359	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	CORRECTION ON SHOULD BE HE APPROPRIATE	(X5) COMPLET
XILLE LACS HEALTH SYSTEM (X4) ID PREFIX TAG SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDE 22000 Continued From page 59 conclusion there is reasona may have occurred in the fit hence submitting a report a enforcement, in accordance Act." Further the report ind our internal investigation to are being submitted to OHF agency." The Investigative indicated on 7/1/15, the DC	200 NOF ONAMIA	A, MN 56359	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	COMPLET
(X4) ID PREFIX TAG SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDE 22000 Continued From page 59 conclusion there is reasona may have occurred in the finhence submitting a report a enforcement, in accordance Act." Further the report indo our internal investigation to are being submitted to OHF agency." The Investigative indicated on 7/1/15, the DC	ONAMIA NT OF DEFICIENCIES I BE PRECEDED BY FULL ENTIFYING INFORMATION) able suspicion a crime form of assault, and are also to law e with Elder Justice dicated, "The details of the limits of our ability FC and the state a Report further DN and SW met with	A, MN 56359	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	COMPLET
(CACH DEFICIENCY MUST REGULATORY OR LSC IDE 22000 Continued From page 59 conclusion there is reasona may have occurred in the fe hence submitting a report a enforcement, in accordance Act." Further the report ind our internal investigation to are being submitted to OHF agency." The Investigative indicated on 7/1/15, the DC	able suspicion a crime form of assault, and are also to law e with Elder Justice dicated, "The details of the limits of our ability FC and the state e Report further DN and SW met with	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	COMPLET
conclusion there is reasonal may have occurred in the for hence submitting a report a enforcement, in accordance Act." Further the report ind our internal investigation to are being submitted to OHF agency." The Investigative indicated on 7/1/15, the DC	orm of assault, and are also to law e with Elder Justice dicated, "The details of the limits of our ability FC and the state Report further DN and SW met with	22000			
may have occurred in the fe hence submitting a report a enforcement, in accordance Act." Further the report ind our internal investigation to are being submitted to OHF agency." The Investigative indicated on 7/1/15, the DC	orm of assault, and are also to law e with Elder Justice dicated, "The details of the limits of our ability FC and the state Report further DN and SW met with				
the AP, (NA-C) who stated use the toilet 6-8 times that report then indicated [SW a with the AP the number of p involving this NAR, which c her credibility, and she bec defensive, face reddening a saying 'it's because I report don't, so I end up getting in further listed, that during ar DON and SW meet with NA "reported having heard fror 6/30, that [R22] is afraid of hair and bangs, that she is The blond hair with the bar NA-C. The report further in been "implicated in previou 78740, and 79433 with pos with residents, as she tries received coaching in these also involved in report 7986 specifically named as AP." Although R22 had describe member who had hurt her a for her and received multip incident documentation ind to protect residents during incidents. Also, there was r	and DON] "discussed previous incidences can raise red flags re same somewhat and voice tightening, t things and others a trouble.' " The report in interview 7/2/15 the A-D, who stated she m resident (R22) on the girl with the blonde not very nice, etc. ngs fits description of ncluded that NA-C had is reports 75814, ssible "power struggles" to perform cares; incidents. NA-C was 66 but was not ed NA-C as the staff and NA-C was caring le large bruises, the licated no action taken investigation of these				

Minnesota Department STATE FORM

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STATEMEN	a Department of Healt T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00374	B. WING		07	07/23/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
MILLE LA	CS HEALTH SYSTEM		A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
22000	Continued From page	e 60	22000				
	DON stated she "has be doing the accusat not certain." The DO during the night shift, on that do that." The were to report to her have concerns. In an interview on 7/2 stated she "did not ta staff regarding abuse DON stated, "I don't witch hunt." The DON name keeps coming guilty." The DON als around "data privacy further stated, when allegations come up on duty initiates the O said the nurse would address any immedia NA-C, the SW stated several residents she but that does change the allegation is not s further stated, in rega allegation of abuse, " The SW also said the "not intensive, and th plan initiated and no or mentoring done."	7/23/15, at 4:50 p.m. the concerns that NA-C might ions," but stated she "was N said, "staff monitor [NA-C] " and also "we have nurses DON stated the nurses if they notice anything and 23/15, at 5:03 p.m., the SW lk with other residents or e allegations by [R22]." The generally do that, it's not a N said, "Just because their up does not make them o said there were issues and confidentiality." SW something regarding abuse over the weekend, the nurse DHFC reporting. The SW talk to the resident, and ate concerns. Regarding d, "At times there have been e is not allowed to care for, if, during the investigation substantiated." The SW and to NA-C, after the first a lot of coaching was done." e coaching for NA-C was ere was no improvement documentation of education					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00374	B. WING		07	//23/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From page	e 61	22000				
	the DON stated NA-C facility policy followin R22 . She stated, "If would have had to su who would take care During an interview of stated, "I don't work am mandated, but I of stated, "I have heard wet and I have heard little rough, but I can' stated, one of the re being rough and leav the staff member as a resident and stated to threw me into the char	on 07/24/15 5:14 a.m., NA-E a lot of overnights unless I do hear a few things." NA-E about people being super I that some of the girls are a t tell you who." She further sident mentioned about a girl ring bruises. NA-E described they were described by the ne resident said " the girl air because I had to go to the -E stated she does not see					
	During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she is not aware that she is to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and also that NA-C no longer works on the North wing and thought the reason was because of the cat not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone.						
		OWN ORIGIN e Adult Policy, revised 7/15, nown Origin as "source of					

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00374	B. WING		07/23/2015	
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	123/2013
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	
22000	Continued From page 62 the injury was not observed and injury as suspicious." The policy did not expound on this definition to include criteria from the CMS interpretive guidance. R39's annual MDS, dated 3/9/15, indicated she was moderately, cognitively impaired. The CP, dated 3/30/15, indicated R39 required extensive assist with all activities of daily living (ADLs), used a mechanical stand for transfers, and was identified at risk for abuse, because of dementia.		22000			
	had a large, dark pur portion of her buttock injury, and R39 was " bruising occurred. Th "a few days ago had not standing when tra Hoyer (a mechanical SSRIF further indicat that could explain bru chart contained "falls	ated 10/7/14, indicated R39 ple bruise on the right upper a, and it was an "unknown" unaware" of how the le SSIRF also indicated R39 been lowered to floor due to ansferring & then lifted with lift) Possible cause." The ed R39 used a medication using, and also that R39's or other recent incidents produced the injury." The				
	SSIRF indicated R39 reported to the state investigation was con though there was no	's injury was "minor" and not				
	DON stated, when R floor "it would be hard during that event." T	on 7/24/15, at 12:54 p.m., the 39 had been lowered to the d to know if injury occurred he DON said R39 bruised anticoagulant medication, so ras "not considered				
	-	oderately impaired and				

STATEMEN	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00374	B. WING			07/00/0045	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	07/23/2015	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH DEFICIENCY DEFICIENCY DEFICIENCY		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
22000	Continued From page 63 unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency. R11's quarterly MDS, dated 4/15/15, indicated she was moderately, cognitively impaired. The CP, dated 6/3/15, indicated R11 required extensive to total assist for all ADLs, and was at risk for abuse related to depression.		22000				
	had a bruise to the to purple in color, and n SSIRF indicated R11 injury occurred, but F medication, and R11	ated 10/21/15, indicated R39 op of her right hand, dark neasured 8 cm x 8 cm. The was unable to state how the R11 used anticoagulant 's bruise was described as idministrator was notified but to the state agency.					
	had bruising noted to her left eyebrow. The unable to state the ca	ed 11/4/14, indicated R11 her left temple and above e SSIRF indicated R11 was ause of the injury. The was notified, but the injury he state agency.					
	a bruise of unknown dark purple in color, a inches. The SSIRF ir "unknown", that R11 cause of the injury, u indicated the injury w The facility administra	12/18/14, indicated R11 had origin to her left inner knee, and measuring 1 x 1 3/4 ndicated the injury was was unable to report the sed anticoagulants; and also ras considered to be "minor." ator was notified, but the ed to the state agency.					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	B. WING		0-	07/23/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	07	123/2013	
	CS HEALTH SYSTEM	200 NOF	TH ELM STREET				
		ONAMIA	, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	ACTION SHOULD BE CON TO THE APPROPRIATE		
22000	Continued From page	e 64	22000				
	unknown origin on 7/2 stated, R11 "had mor have ever known." Th R11's hand "may hav trimming of [R11's] na the bruise herself. Re R11's temple and fore nursing felt the bruisin [R11's] nebulizer mass stated, she interviewe she slipped and fell o SW further stated R1 Hoyer lift [a mechanic there were no records bruising was "likely do nebulizer mask." No f completed for this inju During an interview o DON stated R11 "cou reporting nurse asked abuse, therefore, the	bout the three injuries of 24/15, at 12:54 p.m., the SW e bruising than anyone I ne SW said the bruise on e been caused by recent ails," indicating R11 caused garding the bruise noted to ehead, the SW stated that ng "was due to placement of sk," however, the SW ed R11 who reported that n her way back from supper. 1 did not ambulate, used a cal lift] for transferring, and s of any falls. SW added the ue to placement of [R11's] further investigation was ury. n 7/24/15, at 12:54 p.m., the lift reliably answer" when the d if bruising was related to DON felt the injury was not					
	cognitively impaired, different locations, the investigation complet causes of R11's bruis was notified of the inj incidents were submi R66's quarterly MDS, was moderately, cogn dated 2/9/15, indicated	entified to be moderately and had multiple bruises at ere was no indepth ed to determine the actual ses. The facility administrator uries but none of these tted to the state agency. dated 1/7/15, indicated she nitively impaired. The CP, ed R66 required extensive th use of a mechanical lift,					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07/23/2015	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		123/2013
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
			, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page 65		22000			
	risk for delirium and p depression.	otential abuse, related to				
	a review of R66's nur 1/26/2015, there was bruises" on [R66] bott identified as bruising The SSIRF also indic sleeve/arm protectors was an "unknown inju state the cause, and to be "minor." The in facility administrator, the state agency. During an interview o SW stated, the bruise was reviewing R66's said she "spoke with bruising was assessed	"from hands to shoulder."				
	DON said R66 used a and R66 did not alwa occasionally "flailing I stated R66 was confu "hard to say if R66 was	n 7/24/15, at 12:54 p.m., the a Hoyer lift (mechanical lift), ys cooperate in lift, ner arms." The DON further used, and that it would be buld have been able to to uising occurred after any				
	hands to her shoulde unwitnessed and the identify what happene immediately reported agency nor was a tho	resident was unable to ed. The facility had not the incident to the state brough investigation ne if R66 was "flailing her				

STATE FORM

	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/23/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	1 1	
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	
22000	Continued From page	e 66	22000			
	was severely cognitiv 7/10/15, indicated R4 with ADLs, and was a short term memory lo decision-making skills A review of SSIRF da had a purple bruise of forearm, measuring 6 found during her bath was an "unknown" in the cause of injury. The minor". The facilit	•				
	SW stated, "The injur nursing staff to be 'm suspicious criteria. T a need to report" to th					
	DON stated, "[R44] w	24/15, at 12:54 p.m., the vould have been able to tell pened, she could make her				
	cognitively impaired, origin, on the posterio indication the facility investigation to deter	s assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her nt was not reported to the				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	00374 B. WING		07	07/23/2015	
IAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	07	123/2013	
AILLE LA	CS HEALTH SYSTEM		RTH ELM STREET				
	1		A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From page	e 67	22000				
	R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.						
	had a bruise measuri her thumb and forefin thumb to her wrist. Th initial evaluation and resulted from R8 wrin	ted 8/18/14, indicated R8 ng 8.5cm in length between ger from the base of her ne reporting nurse did the determined the bruising ging her hands, and the s was witnessed by staff.					
	SW stated, the injury staff witness of the po- investigation of the in- facility administrator v a report was not mad Social Services Incide	n 7/24/15, at 12:54 p.m., was not reportable due to otential cause. No further jury was completed. The was notified of the injury but e to the state agency. A ent Referral form was iry but was not received.					
	and had a bruise 8.5c forefinger from the ba There was no indicati thorough investigation	ere cognitive impairment, cm between her thumb and use of her thumb to her wrist. on the facility completed an in to determine the source of cident was not reported to					
	SW stated, when mal	n 7/24/15, at 12:54 p.m., king a determination of ort an injury to the state o statutes, and uses a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
				·			
		00374	B. WING		07	//23/2015	
NAME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
22000	Continued From page	e 68	22000				
	looks at whether a re- injury, or if someone a history of other reco SW further stated, "Iff injury or injury not su location, it does not r During an interview of DON said, minor inju state agency. She fur criteria or policy" the determine whether an "major." The DON all the nurses judgemen injury was minor or m charge "followed up of she stated there was	n 7/24/15, at 12:54 p.m., the ries are not reportable to the rther stated, there was "no facility has to identify and n injury was "minor" versus so stated she "would use t" when determining if an hajor, and that the RN in on the injuries." However, no charting on the clinical ow evidence that follow-up					
	7/15, indicated as its who are vulnerable to policy included: "To everything within its of occurrence of abuse attempt to obtain info employers and or/cur NA-A's personnel re hired on 7/13/15. The evidence reference of to employment at the NA-B's personnel rec	Prevention Policy, revised purpose "to protect adults o abuse" Further, the assure the facility was doing control to prevent the or neglectthe facility would armation from previous rrent employers." cord identified they were e personnel record lacked hecks were completed prior					
		hecks were completed prior					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING		07	//23/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		123/2013
/IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	9 69	22000			
	they were hired on 6/ lacked evidence refer completed prior to em Registered nurse (RN identified they were hipersonnel record lack checks were complet the facility. On 7/23/15, at 8:45 a staff stated four of the did not have document HR stated there was that reference checks facility used the applied	Al)-B's personnel record ired on 5/11/15. The sed evidence reference ed prior to employment at .m. human resources (HR) e five newly hired employees intation of reference checks. "not a process" to document is had been completed. They cation references "to inquire Id, date of hire, eligibility for				
	The Administrator and	OD OF CORRECTION: d/or designee could review staff to their policy in regard				
	TIME PERIOD FOR ((14) days.	CORRECTION: Fourteen				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING		07	/27/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
	CS HEALTH SYSTEM	200 NOR	TH ELM STREET			
	CO REALTH STOTEM	ONAMIA,	MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000	Initial Comments		2 000			
	*****ATTENTION******					
	NH LICENSING C	ORRECTION ORDER				
	144A.10, this correct pursuant to a survey, found that the deficie herein are not correc not corrected shall be with a schedule of fin the Minnesota Depar Determination of whe corrected requires co requirements of the r number and MN Rule When a rule contains comply with any of th lack of compliance. I re-inspection with any result in the assessm	ther a violation has been				
	that may result from a orders provided that	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.				
	receipt of State licens the Minnesota Depar Informational Bulletin	participate in the electronic sure orders consistent with tment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf licensing orders are				
BORATORY	partment of Health DIRECTOR'S OR PROVIDER/ cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATUR	Ξ	TITLE		(X6) DATE 08/21/15

If continuation sheet 1 of 70

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	74 B. WING			107/0045
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	7/27/2015
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
		ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 000	Continued From page	e 1	2 000			
	you electronically. All is necessary for State enter the word "corre text. You must then in State licensure proce completion date, the corrected prior to elec Minnesota Departme On July 20-24 and Ju this Department's sta and the following corr Please indicate in you correction that you ha and identify the date Minnesota Departme the State Licensing C federal software. Tag	Ily 27th, 2015 surveyors of ff, visited the above provider rection orders are issued. ur electronic plan of ave reviewed these orders, when they will be completed. Int of Health is documenting Correction Orders using				
	column entitled "ID F statute/rule out of cor "Summary Statement and replaces the "To correction order. This findings which are in after the statement, " evidence by." Followi are the Suggested M Time period for Correct PLEASE DISREGAR FOURTH COLUMN V "PROVIDER'S PLAN	D THE HEADING OF THE				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED 07/27/2015	
		00374	B. WING			
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		ATH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From page	2	2 000			
		IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.				
2 302	MN State Statute 144 or related disorder tra	.6503 Alzheimer's disease in	2 302			8/18/15
	ALZHEIMER'S DISEA DISORDER TRAININ MN St. Statute 144.65	G:				
	care staff					
	related disorders; (2) assistance with ac (3) problem solving w and (4) communication sk	Alzheimer's disease and ctivities of daily living; ith challenging behaviors; ills.				
	written or electronic for training program, the trained, the frequency topics covered.	rovide to consumers in orm a description of the categories of employees y of training, and the basic ocument compliance with				
	This MN Requiremen by:	t is not met as evidenced				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00374			07/27/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST		07	12112015
	CS HEALTH SYSTEM		TH ELM STREE	т		
			, MN 56359	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From page	e 3	2 302			
	facility failed to ensur information regarding dementia training, inc training program, the trained, the frequency topics covered in the	nd document review, the e consumers were provided Alzheimer's disease and cluding a description of the categories of employees y of training and the basic training in a written or had the potential to affect families.		Corrected 8/18/15		
	training program, the documentation that in (resident families) we Alzheimer's training p	e facility's Alzheimer's re was no information or ndicated the consumers ere provided a description of program, categories of equency of training and the				
	social worker stated, completed through eo sure how resident far information. The direc no family education w	n 7/21/15, at 4:07 p.m., the dementia training was ducare. She stated she not nilies received this ctor of nursing (DON) stated, was provided regarding and she was unaware that it				
	DON or designee coustaff training to the reconsumers were awa	OD OF CORRECTION: The uld add information regarding sident admission packet so ure of this information. The uld educate staff about this duct audits to ensure				
	TIME PERIOD FOR ((21) days. partment of Health	CORRECTION: Twenty-one				

HJY511

If continuation sheet 4 of 70

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00374	B. WING		07/27/2015
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TE, ZIP CODE	
IILLE LA	CS HEALTH SYSTEM		TH ELM STREE	т	
			, MN 56359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565		8/20/15
		prehensive plan of care ersonnel involved in the			
	by: Based on observatior review, the facility fail	· ·		corrected 8/20/15	
	Findings include:				
	(CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascula Minimum Data Set (M indicated R50 had se and was unable to wa R50 required extension activities of daily living	n bed mobility, transfers,			
	alteration in skin integ alteration in elimination staff to follow the mot R50 "to turn and repo	n/toileting. The CP directed bility plan of care, and assist sition every 2 hours and dditionally, the CP directed			

STATEMEN	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING		07/27/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		12112010
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
	CS HEALTH STSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 565	Continued From page	e 5	2 565			
	hours and PRN" [as I	hours and PRN" [as needed].				
	7:55 a.m. to 11:12 a.m. R50 was observed to upright in her wheel of seated in her wheel of from the north unit nu- news program on TV wheeled into the dinin breakfast, finishing at meal, and still seated moved from the table the activity area in the participated in the mo- the activity area until staff member wheele of the facility. R50 re- her wheel chair, until member pushed R50 joining other resident a.m., R50 was return aviary, and was appr (NA)-F, who after gree signs. More than 2 1 R50 was last toileted remained seated in h aviary until 11:12 a.m back to her room. In registered nurse (RN lift, assisted R50 into incontinent of urine, a care. RN-B assessed in color, free of any u there were no redder fully intact. RN-B als of urine. R50 was not	orning activity, and stayed in just after 10:00 a.m., when a d her into the main entryway emained there, still seated in 10:19 a.m., when a staff outside of the building, s to get fresh air. At 10:37 ed into the building near the oached by nursing assistant eting R50, took her vital /2 hours had elapsed since or repositioned. R50 er wheel chair near the h., when NA-F assisted her her room, NA-F and)-B, using the mechanical				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED	
		00374			07	//27/2015	
ME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, RTH ELM STREET	ZIP CODE			
	CS HEALTH SYSTEM		A, MN 56359				
X4) ID 'REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 565	Continued From page	9 6	2 565				
	nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and that R for "urinary incontiner definitely ready to be In an interview on 7/2 registered nurse (RN work group on the flo repositioning complet today, "I'll say was a be honest, [R50] shou During an interview o the director of nursing interventions were ca	3/2015 at 4:00 p.m.)-A said she "trusted the					
		ding the implementation of steed, but none provided.					
	The Director of Nursin review the importance	OD OF CORRECTION: ng and / or designee could e of implementing all es, to assure resident needs					
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one					
2 905	MN Rule 4658.0525 \$	Subp. 4 Rehab - Positioning	2 905			8/20/15	
		Residents must be dy alignment. The position change their own position					

HJY511

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	ROVIDER OR SUPPLIER	00374	DDRESS, CITY, ST		07	/27/2015
	ROVIDER OR SUFFLIER		RTH ELM STREE			
MILLE LA	CS HEALTH SYSTEM		, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 905	Continued From page	e 7	2 905			
	including periods of t been put to bed for th has documented that hours during this time	east every two hours, ime after the resident has ne night, unless the physician t repositioning every two e period is unnecessary or dered a different interval.				
	by: Based on observation review, the facility fai repositioning for 1 of	nt is not met as evidenced n, interview and document led to provide timely 2 residents (R50) reviewed ed at risk for development of		corrected 8/20/15		
	Findings include:					
	(CP), reviewed 6/6/2 affecting dominant sidue to cerebrovascul Minimum Data Set (Mindicated R50 had sea and was unable to wa R50 required extensi activities of daily livin two-person assist wit toileting, and persona Pressure Sore Risk A 5/26/2015, indicated for development of personal sea	h bed mobility, transfers, al hygiene. A Braden Assessment, dated R50 was at moderate risk				
	5/26/2015, identified total assist with ADLs walk, and was on a to every 2 hours. The c for pressure ulcers, c additional pressure u	R50 required extensive to s, that she was unable to urn-and-reposition schedule care area assessment (CAA) lated 2/25/2015, identified lcer risk factors for R50 incontinence, cognitive loss				

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING	B. WING		/27/2015
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
2 905	Continued From page 8 and functional limitation in range of motion.		2 905			
	skin integrity. The Cl mobility plan of care, reposition every 2 ho The nursing assistant	ne potential for alteration in P directed staff to follow the and assist R50 "to turn and urs and PRN" [as needed]. t care sheet "North" unit, R50: T & R q 2 hrs [turn 2 hours].				
	7:55 a.m. to 11:12 a.r R50 was observed to upright in her wheel of wrist fitted with a splin was supported and si 7:55 a.m., R50 was si the living area across station and watching 8:33 a.m., R50 was w and assisted with bre Following the meal, a chair, R50 was move	servation on 7/23/2015 from m. (3 hours and 7 minutes) be dressed and seated chair, with her right hand and nt device, and her right arm trapped into the arm rest. At eated in her wheel chair in from the north unit nursing a news program on TV. At wheeled into the dining room akfast, finishing at 9:36 a.m. nd still seated in the wheel d from the table where food civity area in the same room.				
	R50 participated in the stayed in the activity when a staff member entryway of the facilit seated in her wheel of a staff member pushe building, joining other	e morning activity, and area until just after 10 a.m., wheeled her into the main y. R50 remained there, still hair, until 10:19 a.m., when ed R50 outside of the residents to get fresh air.				
	near the aviary, and a assistant (NA)-F, who her vital signs. More elapsed since the init was not off loaded, o wheel chair. R50 rem	ial observation, and still R50 r repositioned out of her nained seated in her wheel until 11:12 a.m., when NA-F				

Minnesota Departme STATE FORM

Minnesota Department of Healt STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
	00374	B. WING		07	7/27/2015
IAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	1 0.	
AILLE LACS HEALTH SYSTEM	200 NOI	RTH ELM STREET			
MILLE LACS REALTH STSTEM	ONAMIA	A, MN 56359			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
2 905 Continued From page	e 9	2 905			
 mechanical lift, assist was incontinent of uncleansing cares for his urveyor, RN-B inspectskin. R50's skin was any unusual warmthineddened areas, and RN-B also said R50 whad not been repositi 11:12 a.m., a total of During an interview of nursing assistant (NA repositioned when shill about quarter to envise was on an "every two schedule," and R50, repositioned." A review of nursing a progress notes from indicated R50 did not develop and interview on 7/2 registered nurse (RN consider any resident was at risk for pressure sore would "look at everyt resident was at risk to RN stated R50 score measure for predicting that also R50 "had in other risk factors" and RN-A said she truster to get toileting and resident was at risk for some and the resident was at risk for some and resident was at risk factors. 	23/2015 at 4:00 p.m.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	B. WING		07	/27/2015	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
ILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 905	Continued From page	e 10	2 905				
	turned."						
	the director of nursing manager had already when a resident is on and checked for incot this instance, "[R50] s breakfast into other a The DON said reside planned, and the faci residents' needs for the A facility policy, Treat Breakdown and Ulcer "It is the policy to pro- residents whose clinic risk for impaired skin preventive measures directed, to "establish"	ment and Prevention of Skin rs, reviewed 3/14, indicated perly identify and assess cal conditions increase the integrity" and "implement " Further, the policy and record an and repositioning schedule					
	The Director of Nursin review with care staff repositioning for pres healing, and monitor	sure ulcer preventing and for compliance.					
	11ME PERIOD FOR ((14) days.	CORRECTION: Fourteen					
2 910	MN Rule 4658.0525 S Incontinence	Subp. 5 A.B Rehab -	2 910			8/20/15	
	have a continuous pr	e. A nursing home must ogram of bowel and bladder ce incontinence and the					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
					07/27/2015	
	ROVIDER OR SUPPLIER	00374	B. WING			
			RTH ELM STREE			
AILLE LA	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 910	Continued From page	e 11	2 910			
	comprehensive reside home must ensure the A. a resident who without an indwelling unless the resident's that catheterization w B. a resident who receives appropriate prevent urinary tract	o enters a nursing home catheter is not catheterized clinical condition indicates				
	by: Based on observation review, the facility fail assistance for 1 or 1 urinary incontinence.	t is not met as evidenced n, interview and document led to provide timely toileting residents (R50) who had		corrected 8/20/15		
	(CP), reviewed 6/6/20 affecting dominant sid due to cerebrovascul Minimum Data Set (M indicated R50 had se and was unable to wa R50 required extensi activities of daily livin two-person assist wit toileting, and persona bladder assessment, R50 was incontinent also was not safe to u to poor trunk control.	identified on the care plan D15, included hemiplegia de, dementia, and aphasia ar disease. The quarterly IDS), dated 5/27/2015, verely impaired cognition, alk. The MDS also identified ve, physical assistance for g (ADLs), including h bed mobility, transfers, al hygiene. A bowel and dated 2/25/2015, indicated of bowel and bladder, and use a commode or toilet due Further, the assessment				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00374	B. WING		07	/27/2015
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From page	e 12	2 910			
	 q 2hr [every 2 hours] and peri care given after each incontinence episode." The care area assessment (CAA) for urinary incontinence, dated 3/11/2015, indicated R50 had dementia, and past history of cardio-vascular accident (stroke), with right-sided hemiplegia. The CAA also indicated R50 was not a candidate for retraining. R50's CP identified alteration in elimination/toileting, that she was incontinent of bowel and bladder, and also that R50 was not using the bathroom due to safety. The CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, also directed for R50: Check and change q 2hrs and PRN [every 2 hours and as needed]. 					
	7:55 a.m. to 11:12 a.t R50 was observed to upright in her wheel of wrist fitted with a splin was supported and si 7:55 a.m., R50 was si the living area across station and watching 8:33 a.m., R50 was w and assisted with bre Following the meal, a chair, R50 was move was served to the act R50 participated in the stayed in the activity when a staff member entryway of the facilit	servation on 7/23/2015 from m. (3 hours and 7 minutes) be dressed and seated chair, with her right hand and nt device, and her right arm trapped into the arm rest. At eated in her wheel chair in from the north unit nursing a news program on TV. At wheeled into the dining room akfast, finishing at 9:36 a.m. and still seated in the wheel d from the table where food civity area in the same room. Wheeled her into the main y. R50 remained there, still thair, until 10:19 a.m., when				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374		7/0.0005	07	/27/2015	
AME OF PI	ROVIDER OR SUPPLIER		.DDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE			
IILLE LA	CS HEALTH SYSTEM		, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE	
2 910	Continued From page	e 13	2 910				
	near the aviary, and a assistant (NA)-F, who her vital signs. More elapsed since the init was not off loaded, or wheel chair. R50 rem chair near the aviary assisted her back to H NA-F and registered mechanical lift, assist was incontinent of uri cleansing cares for he surveyor, RN-B inspe skin, and also said R8 R50 was not assisted to 11:12 a.m., a total During an interview o nursing assistant (NA repositioned when sh "at about quarter to e was on an "every two schedule," and that R for "urinary incontiner In an interview on 7/2 registered nurse (RN consider resident "wh for pressure sores." If on the Braden" (a me pressure ulcer risk), b immobility, incontiner and was "at risk for put trusted the work grou	ial observation, and still R50 r repositioned out of her ained seated in her wheel until 11:12 a.m., when NA-F her room. In her room, nurse (RN)-B, using the ed R50 into her bed. R50 ne, and NA-F provided er. In the presence of the acted and assessed R50's 50 was incontinent of urine. I for toileting from 7:55 a.m. of 3 hours and 7 minutes. n 7/23/2015 at 11:16 a.m., .)-F stated R50 was last e was put in her wheel chair ight." NA-F then stated R50 hour repo [repositioning] 50 should also be checked nce."					
	•	n 7/27/2015 at 1:19 p.m., g (DON) said the nurse					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/27/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			12112010
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 910	manager had already when a resident is on and checked for inco this instance, "[R50] s breakfast into other a The DON said reside planned, and the faci residents' needs for t A facility policy, Bowe Policy, revised 3/14, f "Maintain resident's of continence and main indicated individual of to toilet based on indi checking for incontine SUGGESTED METH The Director of Nursi review with care staff assistance with toileti compliance.	A taken steps to avoid issues a a schedule to be turned intinence. The DON said in should not go right from ctivities, that is too long." int interventions were care lity takes "very seriously, imely assistance." A and bladder Program indicated as its purpose to optimal bowel and bladder tain skin integrity The policy are plan will address "Times ividual schedule and/or ence." OD OF CORRECTION: ing and / designee could residents requiring	2 910			
21565	(21) days. MN Rule 4658.1325 Medications Self Adm	Subp. 4 Administration of	21565			8/13/15
	self-administer medic resident assessment care as required in pa 4658.0405 indicate th	istration. A resident may cations if the comprehensive and comprehensive plan of arts 4658.0400 and his practice is safe and there in the attending physician.				
	This MN Requiremen	t is not met as evidenced				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00374	B. WING		07/07/0045			
NAME OF PI	ROVIDER OR SUPPLIER		B. WING 07/27/2015 ET ADDRESS, CITY, STATE, ZIP CODE 07/27/2015					
	CS HEALTH SYSTEM	200 NOR	TH ELM STREE	т				
	CO REALTH STOTEM	ONAMIA	, MN 56359					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLET DATE		
21565	Continued From page	e 15	21565					
	review, the facility fail self-administration of	medications (SAM) for 1 of served for self-administration		corrected 8/13/15				
	Findings include:							
	During observation on 7/20/15, at 7:28 p.m. R63 was observed alone in her room with a nebulizer (a drug delivery device used to administer medications in the form of a mist inhaled into the lungs) running, with a face mask. The trained medication aide (TMA)-A who had administered the medicaiton was on the opposite side of the dining room passing medications and assisting other residents in their rooms. R63 remove the mask off her nose and mouth and placed the mask on her chest with the elastic strap still around the back of her neck. The TMA-A walked past R63's room while R63 had the mask on her chest and into the room next to R63 twice. TMA-A made no attempted to check, or reapply the mask to R63's nose and mouth for installation of the medication. At 7:44 p.m. TMA-A entered R63's room turned off the nebulizer and removed the mask from R63's chest.							
	chronic obstructive pu and congestive heart plan dated 6/2/15, inc disorientated to time moderately impaired	es, depression, anxiety, ulmonary disease (COPD) failure. A cognition care dicated R63 was and place and had						
	Administration Record Duoneb to be administration	d (MAR) for 7/15, directed stered four times a day. A the MAR indicated R63 did						

STATEMEN	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/27/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21565	not like the nebulizer in front of her face ar A Self Administration effective 7/21/15, ind cognitively able to pa During interview on 7 stated she did not kn with the nebulizer. Sh residents alone with the had been so hectic a On 7/23/15, at 11:20 (RN)-A stated R63 w alone to SAM the neb	mask and to hold the mask ad let her breathe in that way. of Medication Assessment icated R63 was not irticipate in a SAM. 7/20/15, at 7:50 p.m. TMA-A ow if R63 could be left alone he usually does not leave their nebulizer but because it nd busy she left R63 alone. a.m. registered nurse as assessed to not to be left pulizer. In the past she would ask but now will allow staff to	21565			
21685	The Director of Nursi review the facility's p residents for the abili medications, with the TIME PERIOD FOR (14) days. MN Rule 4658.1415 Housekeeping, Oper Subp. 2. Physical pla including walls, floors systems, and equipm continuous state of g with regard to the hea	IOD OF CORRECTION: ng and/or designee could olicy for assessment of ty for self administration of a facility staff responsible. CORRECTION: Fourteen Subp. 2 Plant ation, & Maintenance ant. The physical plant, s, ceilings, all furnishings, nent must be kept in a ood repair and operation alth, comfort, safety, and idents according to a written	21685			8/18/15

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00374			07/27/2015	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE	07	12112013
	CS HEALTH SYSTEM		RTH ELM STREE	т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21685	Continued From page	e 17	21685			
	routine maintenance	and repair program.				
	This MN Requiremen	it is not met as evidenced				
	review, the facility fail duct work, lights above kitchen were clean of	n, interview, and document led to ensure exhaust fan ve grill and screen in the f dust and debris. This had residents, staff and visitors from the kitchen.		corrected areas cited were cl 7/21/15	eaned on	
	Findings include:					
	registered dietician (F six metal caged lights food is cooked, were thick dust and debris addition there was a window screen above	of the facility kitchen with RD) on 7/20/15, at 1:15 p.m.; s above the grill where the covered with 1/4 inch visible from the light fixtures. In 12 inch long by 6 inch e the kitchen sink was n a black dust and debris.				
	7:30 a.m. the lights a	is completed on 7/21/15, at nd screen were still red with visible dust and				
	manager (DM) stated dust along with the so department was in ch DM stated the mainter	/15, at 8:15 a.m. dietary d the lights were covered in creen and the maintenance harge of cleaning those. The enance has a staff of 5 and 3 luty so things just are not				
	a contracted service	/15, at 8:30 a.m. the er (MM)-A stated they have that cleans the overhead a year. The maintenance				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	B. WING		-		
	ROVIDER OR SUPPLIER	00374 STREET A	B. WING 07/27/2015 TADDRESS, CITY, STATE, ZIP CODE 07/27/2015				
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET	,			
			A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
21685	Continued From page	e 18	21685				
	stated "That doesn't d	ne lights and the screen and cut it" and expressed it is still mplete needed tasks.					
	document form Fire F After Service Follow I indicated the kitchen cleaned but not to co inaccessible. The rec "replacing box-style f better access duct we again on 3/2/15 and t Equipment Co. After recommended "repla- fan with upblast fan te Replace damaged filt During interview 7/22	Service Follow Up Report cing box-style down blast o access fan and duct work. ters." 2/15, at 2:00 p.m. the MM-A					
	air up to create a vac The MM then stated t but that is how this st	down and then diverts the cuum up and out of the roof". the fans should be cleaned, cyle exhaust fan works and it we remodel the kitchen at					
	representative from the Equipment Co. stated inaccessible because down to the bare met	d the fan and ducts are e they were unable to see tal. The system was very old, manufactured in 1960's or					
	Procedure Equipmen indicated 1. the inside and outs cleaned once per mo	nal Services Cleaning It Hood policy undated side of the hood will be onth nd outside of the hood					

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STATEMEN	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00374	B. WING		07/27/2015	
	ROVIDER OR SUPPLIER CS HEALTH SYSTEM	200 NOF	ADDRESS, CITY, STAT RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21685	 4. use a brush or clot grease and/or dust 5. wash hood with so 7. the interior section the roof is cleansed s commercial hood-clean SUGGESTED METH The Administrator and the cleaning schedule 	res within the hood. ures and clean with soap h as needed to remove ap and water of the hood that extends to emi annually by a	21685			
21805	days. MN St. Statute 144.64 Residents of HC Fac. Subd. 5. Courteous residents have the rig courtesy and respect	Bill of Rights treatment. Patients and	21805			8/14/15
	by: Based on observatior review, the facility fail rising and morning ro (R50 and R12),who re	t is not met as evidenced n, interview and document led to provide a dignified utines for 2 of 8 residents equired extensive staff te activities of daily living		corrected 8/14/15		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00074		B. WING		107/0045
	ROVIDER OR SUPPLIER	00374	DDRESS, CITY, STATE		07	/27/2015
			RTH ELM STREET	, 0002		
	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLE DATE
21805	Continued From page	e 20	21805			
	(CP), reviewed 6/6/2 dementia, and aphas Data Set (MDS), date had severely impaire extensive, physical a	ssistance for ADL's, assist with bed mobility,				
	R50 was lying on her left hand positioned of blanket was at the for resident, exposing R see she already had R50 remained in bed NA-G assisted her w already dressed, with when NA-F removed for incontinence, NA- into her wheel chair w NA-F then brushed h in placing R50's hand wheel chair armrest a During an interview of NA-G said R50 was a morning, and we "just	st needed to get up, out of				
	dressing, and R50 w needs to staff. In an interview on 7/2 acknowledged R50 v when she assisted R NA-F did not know w "someone on nights	0 needed "total assistance" as not able to verbalize her 22/2015 at 9:18 a.m., NA-F vas dressed this morning 50 to get up for the day. ho worked with R50, but said [the night shift] got her as typical for R50's routine.				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/27/2015
NAME OF PI	ROVIDER OR SUPPLIER		.DDRESS, CITY, STATE	, ZIP CODE		12112013
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
		ONAMIA	A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
21805	Continued From page	e 21	21805			
	on Tuesdays, "because she gets a bath on that day."					
	NA-H stated she wor routinely got R50 "cle not removed from be that." NA-H stated sl on her scheduled bat residents whom she dressed, prior to the said "I just need to m and ready to go. I ge them back to bed; it H NA-H said if there wa want to get up, she w someone else up." N the residents she ass and there were some night anyway." During an interview of family member (FM)- were getting R50 dre bed. FM-A said that was often awake late restless, and they [st than stated, "I would	on 7/24/2015 at 6:00 a.m., ks on the overnight shift, and eaned up and dressed," but d, "the day shift would do he does not get R50 dressed th days. She has a list of helped get cleaned and end of the night shift. NA-H the sure they are dressed et them dressed and then put helps out the morning shift." as a resident that did not vas instructed "to get VA-H did add that some of sisted "liked to get up early," e who simply "were up all on 7/24/2015 at 1:06 p.m., A said he was unaware staff issed, then having her stay in depending on the night, R50 e, or was "up at 3:00 a.m. and aff] will get her up." FM-A think if [R50] got dressed, and up to breakfast for the				
	director of nursing (D "to help the day shift someone was trying and keep [the residen	24/2015 at 1:17 p.m., the DON) stated the night shift try staff." The DON said "If to get up, then get them up, nt] from getting out of bed				
	social worker (SW) s during the night was	the same interview, the aid getting a resident up "not just a decision for the k into this some more."				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	B. WING		07/07/004 5		
IAME OF PI	ROVIDER OR SUPPLIER		B. WING 07/27/2015 TADDRESS, CITY, STATE, ZIP CODE 07/27/2015				
	CS HEALTH SYSTEM		TH ELM STREET				
	1		, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
21805	Continued From page	22	21805				
	5/18/15, indicated she impaired and required transfers, dressing an (CP), dated 8/28/13, opportunities to make including clothing, be also indicated R12 ha related to insomnia, w hours of sleep at nigh	hum data set (MDS), dated e was severely, cognitively d extensive assist for nd grooming. The care plan directed staff to give R12 e daily preferences choices, d time and bathing. The CP ad an alteration in sleep, with a goal of at least six nt. The CP did not address a erence of when R12 wanted					
	was noted fully dress chair. R12 was positi television in the comr asleep in her wheelch jerking movements as in chair until 8:15 a.m approached, and awa R12 if if she wanted to breakfast. R12 replied	non area on the east wing, nair. R12 repeatedly made is she dozed. R12 remained i., (75 minutes) when staff akened her. The staff asked o go back to bed, or eat d "I don't care." n 7/24/15, at 5:59 a.m.,					
	residents up, washed the over night shift. N shower, there was an up in their place. NA- the residents up, was back to bed."	and dressed when working A-E stated if a resident had other one assigned to get E stated she will usually "get hed, dressed and put them					
	licensed practical nur the over night shift is she stated they are n	on 7/24/15 12:24 p.m., se (LPN)-C stated, " usually getting up the early risers, ot getting up anyone that in. LPN-C further stated,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				B. WING			
	ROVIDER OR SUPPLIER	00374	ADDRESS, CITY, STATE		07	//27/2015	
	CS HEALTH SYSTEM		RTH ELM STREET				
	CO REALTH STOTEM	ONAMIA	A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From page	e 23	21805				
	"Some of the Hoyers [residents who require use of a mechanical lift to transfer] get washed, dressed and put back in bed, I don't have any idea why they would do that."						
	director of nursing (D people getting up and bed on the night shift and care coordinators day shift. The DON fu this list are usually up like the night shift to h the day." She further the only nursing home that." The intent is to prevent falls. The DO if the rationale for wa	on 7/24/15, at 1:16 p.m., the ON) stated, there are many d dressed and put back to . She stated, The nurses s schedule them to help the urther stated, "the people on o or crawling out of bed," we help day shift "get a jump on s stated, "I'm sure we are not e in the world that does o help day shift out and DN stated she was not sure king a resident on night shift and dressed is on the care					
	registered nurse (RN residents for the nigh dressed. She stated, who are trying to get people who want to g who are a "Hoyer lift. dress them in bed. RI prefers to get up early further stated, there is East unit that is care to fall risk. RN-C state	on 7/24/15, at 2:07 p.m.,)-C stated, We schedule t shift to get up, washed and We usually look at people up but if there aren't enough get up, we will pick people " The aides will wash and N- C stated, "If someone y it is not care planned." She s no one currently on the planned to get up early due ed, The rationale for night s washed and dressed is n the morning.					
	sheet directed night s cares, oral cares, dre	s undated East night group shift to complete morning ssing, making bed and five residents on the unit,					

STATEMEN	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY IPLETED
		00374	B. WING		07/27/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	· · ·	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	including R12. A review of the facility Responsibilities of Pa 4/15, indicated the fa promote care for [res maintains and enhan full recognition of [a r SUGGESTED METH The Administrator an inservice facility staff care in a dignified ma	y policy, Rights and atients/Residents, dated cility "must, with courtesy, idents] in a manner that ces dignity and respect in resident's] individuality."	21805			
21990	(14) days. MN St. Statute 626.5 Maltreatment of Vuln Subd. 4. Reporting immediately make an entry point. Use of a for the deaf or other s considered an oral re point may not require extent possible, the r content to identify the caregiver, the nature maltreatment, any ev maltreatment, the na reporter, the time, da incident, and any oth reporter believes mig the suspected maltreatment	A mandated reporter shall n oral report to the common telecommunications device similar device shall be eport. The common entry written reports. To the report must be of sufficient vulnerable adult, the and extent of the suspected	21990			8/21/15

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00374	D374 B. WING		07/27/201		
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
MILLE LA	CS HEALTH SYSTEM		TH ELM STREE , MN 56359	т			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLE DATE	
21990	Continued From page	e 25	21990				
	in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision.						
	by: Based on observation review, the facility fai of abuse, neglect, mi unknown were imme adminstrator and stat investigated, and res their investigations for R12, R22, R39, R11, allegations reviewed, reference checks for employees (NA-A, NA Findings include: Investigation and Pro- During interview 7/23 worker (SW) stated th has been implicated January 2015 to July	The facility failed to conduct 4 of 5 newly hired A-B, DA-A and RN-B). Detection B/15, at 5:09 p.m. with social hat nursing assistant (NA)-C in four incident reports from 2015 as the potential		corrected8/21/15			
	R47's quarterly Minin 2/17/15, indicated sh intact and needed ex	ident and Investigation following: num Data Set (MDS) dated e was moderately cognitively ttensive assistance in ADLs.					
	dementia and needs grooming and bathin indicated she had slig	g. The care plan further ght alteration in cognition and that resident will continue					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING		07	//27/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 26	21990			
	1/24/15, at 3:49 a.m. [LPN-D] was in a res where the incident has smack. Followed by nurse then got a call from the aide. The a 2 a.m. rounds, I went 45-1 and woke up res process. I told [R47] should lay back down until coffee time. [R4 I'm waiting." NA-C sa NA-C went to pick up bed and [R47] swung fairly hard. I [NA-C] y said "why did you hit hit me you liar" then walkie the nurse"	ome Progress Notes dated indicated: "This nurse . room, 5 rooms away from appened, but heard a distinct a woman's out cry. This on the walkie [walkie-talkie] ide stated (in her words) On t to check resident in room sident in 45 -2 [R47] in the the time and said she n and try and get some sleep 47] said "No, I want to sit up aid "No lets lay down" and b [R47's] feet to bring them in g and hit me in the head, yelled out "ow" and NA-C me, R47 said "I didn't, you [NA-C] walked out and This nurse [LPN-D] asked he aide. Res. [R47] stated				
	on 1/28/15, indicated a nursing assistant o review of the related supervisory staff, it w R47's incident was d study revealed that F assistant, but resider nursing assistant stru	ubmitted to the state agency that R47 had a conflict with n 1/24/15. Following a progress notes, and vas originally determined ue to her dementia. Further R47 allegedly struck a nursing nt [R47] also alleged the uck her. The report indicated n needed to be completed.				
	the state agency on 2 the SW met with the 1/28/15 and 1/30/15 recall any incidents of	tive Report was submitted to 2/2/15. The report indicated resident R47 on the a.m. of and resident was unable to of concerns. The SW was NA-C until 2/2/15 (7 days				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	•	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 27	21990			
	to her work schedule SW spoke with NA-C 10:45 p.m. NA-C ack happened as describ stated she had not st had tried to lift R47's The investigative report NA-C. This report als been implicated in a p During interview 7/23 stated the resident was incident had happened dementia. The SW suspended during he could "not be proved" R47 continued to be of SW said NA-C was of cares for R47, and was NA-C on how to keep Review of the facility' Schedule indicated N pending the investigat 1/28/15 and NA-C was and 1/29/15, while the progress. The investigation of the interviewing of the NA on 1/24/15 but was n 1/27/15. The investigation the R47 was actually suspend NA-C or tak during the investigation	said NA-C was not r investigation because it ' that NA-C abused R47, and on the work schedule. The ounseled on how to provide as asked for ideas from o R47 safe. s MLHS-LTC NA/R IA-C was not suspended tion of the incident dated as scheduled to work 1/28/15				

STATEMEN	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00374	B. WING			
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	//27/2015
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
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21990	Continued From page	e 28	21990			
	Referral Form (SSIRI R47 was involved in a a.m., of possible abus The SSIRF indicated (electronic progress r verbal statements an resident [R47]; possil maltreatment but jus resident's dementia." indicated the inciden Investigative Team or reported submitted to 3/3/2015 at 12:30 p.m NA-C was a person v the situation. An initial Incident Reg state agency on 3/3/1 of R47 on 3/2/15. Th progress notes from I a.m. of 3/2 that sugge concerns/dementia st at work or possible m staff." The report ind whether this was mal to go ahead and subr agency]" A nursing progress note a.m., written by LPN- "kicking at staff" and going to report 'her' to indicated R47 told sta everyone I heard" O second progress note wipe dry blood off [R47 The note continued, f	ble indication of t a likely symptoms of The SSIRF further t was discussed with n 3/3/15 at 8:30 a.m., and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
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IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21990	Continued From page	e 29	21990			
	Facility documentation was taken to protect during this investigat Documentation of the did not include detern bloody lip, and there with the nursing assis R47. The SSRIF als immediate reporting agency or administra A final, Investigative state agency on 3/00 The report indicated interviewed by RN C this SW. Resident de happening this past v or the nighttime that denied that anyone h her or that she has h also indicated "SW c about progress notes shift, "indicating the N the EZ lift (mechanic bathroom per resider noticed resident's lip apparently cracked ff winter air. [NA-C] tol the dried blood off, the causing NA's glasses The report indicated and assisted [R47] w same night, the NA w attempted to lift R47" resident kicked at NA	on did not indicate any action R47 and other residents ion of potential abuse. e investigation of this incident mination the cause of R47's was no evidence of interview stant who provided cares for o indicated there was no of this incident to the state tor. Report was submitted to the 6/15 regarding the incident. on 3/2/15 the "resident was are Coordinator (RN- A) and enied remembering anything weekend during the daytime upset her in any wayShe its her or has been mean to it anyone else." The report communicated with [LPN-B] is from 3/2/15 during night NAR was situating resident in al lift) to help her to the nt's request and the NAR had been bleeding rom being chapped with dry, d [R47] she was going wipe but R47 struck out at NA, is to dismount from her face." NA-C re-approached later rithout incident. Later the vas doing rounds and is feet back in bed, and A-C. The report then				
	was slapped. The reperpetrator in this inc R47's care plan was	ations made by R47, that she port did not confirm a cident. The report indicated reviewed, and suggestions o approach R47 during				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
	ROVIDER OR SUPPLIER	00374	DDRESS, CITY, STATE	07	//27/2015		
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MILLE LA	CS HEALTH SYSTEM		, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
21990	Continued From page	e 30	21990				
	coached by the SW a progress note chartin have been reminded reports. The report in not resting well with t maltreatment of resid particular incident, SV and ears open for pa conduct, etc."	so indicated LPN-B was and DON on more thorough ng, and further, that staff to submit timely incident included: "Something is just this, and although there is no lents 'substantiated' in this W will continue to keep eyes tterns and/or trends in					
	2015, indicated NA-0	r's MLHS-LTC NA/R lary 23, 2015 to March 8, C was assigned to work he alleged incident) and also					
	stated, in review of th "concerns with NA-C" she had really done a felt they could not sul against NA-C, and th "suspension or discip investigation. There w	" but again could not prove anything wrong. The facility bstantiate the allegations erefore did not warrant a					
	was moderately cogr extensive assist with grooming. R12's car indicated she had po	dated 4/27/15 indicated she nitively intact and needed dressing, bathing and e plan dated 1/31/15, tential for abuse from others npairment and limited					
	agency on 2/18/15, ir	port submitted to the state ndicated that on 2/18/15, R12 d, on her cheek, by a staff mpting to administer					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
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		00374	B. WING	······	07	/27/2015
AME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
IILLE LAG	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 2Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE
21990	Continued From page	e 31	21990			
	medicine. The AP on the Incident Report was listed as unknown.					
	state agency on 2/23 The report indicated allegations, but the o "tracked," was the or [R12] during the adm Magnesia (MOM) that indicated the SW and more information abd administered the MO schedule, LPN-B and duty. At 10:45 p.m. o SW met with NA-C, given MOM to R12 o NA-C said "[R12] did took the cup and thre [NA-C] tried to clean resident's clothing an The report indicated any way, but acknow with the wet ones. T possible this was per The SW asked NA-C see if resident could/ her as the lady who s agreed to do so. [R1 however, so decided indicated "[NA-C's] w leads SW to believe about not slapping re indicated the DON sp 2/23/15 at 3:20 p.m.	at morning. Firstly, the report d DON proceeded to seek but who would have M that morning. Per d NA-C were the persons on on 2/19/15, the DON and who freely admitted having under direction of LPN-B. In't want the MOM, and [R12] ew the MOM all over."				

STATE FORM

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00374			07	/27/2015	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE	
21990	persons present durin and NA-C was instruc- without a colleague p During interview on 7 stated she did not sus could not prove NA-C acknowledged NA-C multiple incidents, an [NA-C], but did not fe suspend" or provide of during this investigati The investigation of the not determine if R12 follow up to have R12 nursing assistant who NA-C was instructed without a colleague p offered no indication for other residents who during this investigati regardless of its outco R22's admission MDS she had depression a accident (CVA), was impaired and needed and extensive assist plan dated 5/3/15, ind with toileting and tran- depression and sadm care plan further indic abuse from others ref weakness, aches and	ng cares with this resident cted not to enter room resent. /23/15, at 5:20 p.m. the SW spend NA-C since they c slapped R12. The SW had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on. his incident by the facility did was slapped, nor was there 2 positively identify the p provided cares. Although not to enter R12's room resent, the documentation protections were put in place to were assisted by NA-C on of this incident, ome. S dated 4/24/15, indicated and a cerebral vascular moderately cognitively limited assist with transfers with toileting. R22's care dicated she needed assist sfers, had history of ess/isolating self. R22's cated she had potential for	21990	DEFICIEI			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
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		00374			07	/27/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE		
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21990	Continued From page	e 33	21990			
	right shin measuring (centimeters) x 2 cm	d displayed a bruise on her approximately 8 cm R22's bruise was black, in color, with no apparent				
	that she had been tre and there is a staff m shift that is rough wit this staff member had transferring" which ca	15, at 5:54 p.m. R22 stated eated "roughly by the staff" ember who works the night h her. R22 went on to state d "grabbed her arm when aused a large bruise and also hit her leg into the metal of her bed.				
	state agency on 6/27 alleged mistreatment The report also ident right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm report was submitted the initial reporter, Nu perpetrator in this incon nursing assistant (Nu she had toileted R22 told [NA-C] she was that "some girl hurt h she [R22] stated she	an Incident Report to the (15, regarding an incident of and physical abuse of R22. ified a bruise on R22's top g 5.5 cm x 5 cm, circular in bruise on R22's lower right , circular in shape. The by RN-D, and indicated that A-A, was also the alleged cident. The report indicated, A)-C reported at 5:15 a.m., , After being toileted, R22 not coming back tonight, and er." NA-C asked who, and doesn't know who. The that registered nurse				
	(RN)-A, followed up y asked her to tell her y reported she is not st is not going to be trea explained that staff w night for getting up to times, and that a "gir	that registered nurse with R22 in the morning and what happened: "Resident taying here again tonight and ated like this anymore." R22 vas mad at her during the o use the bathroom so many I grabbed me and threw me ed out her hand hurt, and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
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AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
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21990	Continued From page	e 34	21990			
	 Continued From page 34 bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal;" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time. An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm 8 x 5 cm, reddish purple in color, and oval in shape. The date of incident occurrence was unknown. The report indicated R22 said, "It happened a few days ago." 					
	state agency on 07/0 two submitted incident indicated the DON and tried to investigate the been unable to subst perpetrator [AP] is for conclusion there is re- may have occurred in hence submitting a re- enforcement, in accor Act." Further, "The de- investigation to the life submitted to OHFC [Complaints] the state Report further indicate SW met with the AP,	rdance with Elder Justice				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00074	B. WING			
	ROVIDER OR SUPPLIER	00374	DDRESS, CITY, STATE		07	//27/2015
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MILLE LA	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21990	Continued From page	e 35	21990			
	Continued From page 35 (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re [regarding] her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble." The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."					
	member who had hur for her and received r disciplinary action wa suspended pending t was no indication that	scribed NA-C as the staff t her and NA-C was caring multiple large bruises, no is taken, NA-C was not he investigation. Also, there t a thorough investigation e facility to include other and residents.				
	DON stated she has on be doing the accusation certain. The DON sa during the night shift, that do that." The DO	/23/15, at 4:50 p.m. the concerns that NA-C might ions, but stated she was not id, "Staff monitor [NA-C] " and "we have nurses on DN stated the nurses were to nything and have concerns.				
		23/15, at 5:03 p.m. the SW k with other residents or staff				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00074	5.1470.0				
NAME OF PI	ROVIDER OR SUPPLIER	00374 STREET A	DDRESS, CITY, STATE		07	7/27/2015	
	CS HEALTH SYSTEM		TH ELM STREET	,			
		ONAMIA	, MN 56359				
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21990	Continued From page	e 36	21990				
	Continued From page 36 regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."						
	administrator said, "W working on nights, we	on 7/23/15 at 5:10 p.m., the We have three young people e can't suspend; there is not dministrator further stated, " I V did the right thing."					
	the DON stated NA-0 facility policy followin R22 . She stated, "If	on 07/23/15, at 5:14 p.m. C was not suspended per the g the allegation made by I had suspended one, I uspend all three staff, then of the residents?"					
	stated, " I don't work am mandated, but I c stated, "I have heard	on 07/24/15, 5:14 a.m., NA-E a lot of overnights unless I do hear a few things." NA-E about people being super I that some of the girls are a					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY PLETED	
		00374	B. WING		07/	27/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page	e 37	21990				
	stated one of the rest being rough and leave the staff member as a resident and stated the threw me into the char bathroom again." NA the nurse a lot on nig During interview on 7 stated she works par LPN-H stated she har NA-C is rough with the witnessed it directly. aware that she was to the night shift when so indicated she had her NA-C had slapped her works on the North we was because of the of take care of any certar stated the aides on the	t tell you who." She further idents mentioned about a girl ing bruises. NA-E described they were described by the he resident said " the girl air because I had to go to the A-E stated she does not see ghts. 7/24/15, at 5:25 a.m. LPN-H t time on the night shift. Is heard from other NAs that he residents but had not LPN-H stated she was not o monitor any staff during she works. She further ard R12 had reported that er and that NA-C no longer ving and thought the reason cat; not because she can not ain residents. She then he night shift don't work to work on each unit alone.					
	INJURIES OF UNKN	IOWN ORIGIN					
	R39's annual MDS, dated 3/9/15, indicated she was moderately cognitively impaired. Her care plan, dated 3/30/15, indicated she required extensive assist with all activities of daily living, used a mechanical stand for transfers, and was at risk for abuse related to dementia.						
mesota De	dated 10/7/14, indica purple bruise on the buttock and that R39 bruising occurred. Th	vice Incident Report Form, ted R39 had a large, dark right upper portion of her was unaware of how the ne report indicated R39 had or by staff a few days prior to					

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	2.1410		07	07/27/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			12112013	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page	e 38	21990				
	the injury. The incide anticoagulant medica clotting), other injurie unspecified times frau "minor." The injury wa During an interview o DON)stated, when R floor it would be hard during that event but due to use of anticoa therefore the injury w reportable. Although R39 was mu unable to recall how the was no evidence that investigation was cor	me, and listed the injury as as not reported to OHFC. In 7/24/15, at 12:54 p.m., the 39 had been lowered to the to know if injury occurred stated, R39 bruised easily gulant medication so as not considered oderately impaired and the bruise occurred, there is a more in-depth npleted to determine the s R39's injury of unknown					
	she was moderately o plan, dated 6/3/15, in extensive to total ass	ist for all activities of daily / impaired, and at risk for					
	Report Forms indicat unknown origin. An ir indicated R39 had a l hand that was dark p 8 cm x 8 cm. The rep was unable to state h blood thinners and de	rate Social Services Incident ed R11 had injuries of ncident form dated 10/21/15, bruise to the top of her right urple in color and measured ort further indicated R11 how the injury occurred, used escribed the injury as ial Services Report Form,					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	/27/2015
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	07	12112015
	CS HEALTH SYSTEM		TH ELM STREET , MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
21990	to her left temple and was unable to state th third incident report d had a bruise of unknow knee, dark purple in or (unit of measurement report further indicate the cause of the injury medications, and the " minor." None of the to OHFC. During an interview o SW stated, R11 "had have ever known." SH hand may have been of [R11's] nails." Rega R11's temple and fore nursing felt the bruisin R11's nebulizer mask R11 who reported that way back from suppe not ambulate, used a there were no records the bruising was likely nebulizer mask. During an interview o DON stated R11 coul asked if bruising was she felt the injury was Although R11 was ide cognitively impaired, f	ted R11 had bruising noted above her left eyebrow, and he cause of the injury. A ated 12/18/14, indicated R11 own origin to her left inner color, measuring 1 x 1 3/4. was not indicated). The d R11 was unable to report y, use of anticoagulant injury was considered to be three bruises were reported n 7/24/15, at 12:54 p.m., more bruising than anyone I he stated the bruise on R11's caused by "recent trimming arding the bruise noted to ehead, SW stated that ng was due to placement of , however, SW interviewed t she slipped and fell on her r. SW further stated R11 did Hoyer lift for transfer and s of any falls and indicated y due to placement of R11's	21990	DEFICIEN	NU(Y)	
	different locations, an what happened, there investigation complet causes of R11's bruis	d were unable to determine				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374 B. WING			07	07/27/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	12112015	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page submitted to the state		21990				
	was moderately cogr dated 2/9/15, indicate assist of two staff wit transfers, at risk for or related to depression During review of a So Referral Form, dated noted indicated R66 from her hands to he indicated R66 was un the injury and that the "minor." The injury w During an interview of SW stated, the bruise was reviewing a prog with nursing and dete	bocial Service Incident 2/3/15, a facility progress had bruising along both arms in shoulders. The form further hable to state the cause of e injury was assessed to be was not reported to OHFC. on 7/24/15, at 12:54 p.m., es were noted while the DON gress note and she spoke ermined the bruising was nor injury and therefore not					
	DON stated, R66 use lift) and did not alway occasionally "flailing stated, R66 was cont "hard to say if R66 w	on 7/24/15, at 12:54 p.m., the ed a Hoyer lift (mechanical vs cooperate in lift, her arms." She further fused and that it would be ould have been able to to ruising occurred after any					
	hands to her shoulde unwitnessed and the identify what happen	resident was unable to ed. The facility had not I the incident to the state					

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	00374 B. WING		07	07/27/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	07	12112015	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page	e 41	21990				
	completed to determine if R66 was "flailing her arms" while using the mechanical lift.						
	was severely cognitive dated 7/10/15, indicated assist with activities of for abuse related to se impaired decision mathematic Review of Social Ser dated 6/15/15, indicated on her posterior foreated cm that was found du form indicated R66 d injury and that the inj	vice Incident Referral Form, ted R44 had a purple bruise arm measuring 6.3 cm x 7 uring her bath. The incident id not state the cause of ury was determined to be					
	During an interview of SW stated, on 8/18/1 bruise measuring 8.5 thumb and forefinger to her wrist. She state the initial evaluation a resulted from R8 wrir wringing of her hands She further stated the due to staff witness of Social Services Incid	as not reported to OHFC. on 7/24/15, at 12:54 p.m., 4, staff reported R8 had a 5 cm in length between her 6 from the base of the thumb ed the reporting nurse did and determined the bruising nging her hands, and the s was witnessed by staff. e injury was not reportable of the potential cause. A ent Referral form was ury but was not received.					
	SW stated when mak whether or not to rep refers to statutes, and also stated that she l	on 7/24/15, at 12:54 p.m., king a determination of ort an injury to OHFC, she d uses a decision tree. SW ooks at whether a resident is jury or if someone else saw					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING	07/27/2015		
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 42	21990			
	 it, and if there is a history of other recent falls and/or injuries. She further stated, if the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported. During an interview on 7/24/15, at 12:54 p.m., the DON stated, there was no criteria for determining whether an injury was minor vs major. She further stated, the nurse finding the injuries did initial evaluation to determine the above injuries to be minor. The DON stated she would use the nurses judgement when determining if an injury was minor or major and that the RN in charge followed up on the injuries. However, she stated there was no charting in the clinical record that would show evidence that follow up had been completed. 					
	cognitively impaired, origin, on the posterio indication the facility investigation to deter	s assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her ent was not reported to the				
	her to be severely co requiring assist of two living. CP dated 5/15 extensive assist for a	um data set (MDS) identified gnitively impaired and o staff for activities of daily /15 indicated R8 required activities of daily living and related to diagnosis of				
	had a bruise measuri	ated 8/18/14, indicated R8 ing 8.5 cm in length between nger from the base of her				

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00374		B. WING			
OVIDER OR SUPPLIER		ADDRESS, CITY, STATE		07/	27/2015
		RTH ELM STREET	, 211 CODE		
S HEALTH SYSTEM	ONAMIA	, MN 56359			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Continued From page	e 43	21990			
thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff.					
SW stated, the injury staff witness of the po- investigation of the in facility administrator a report was not mad Social Services Incid	was not reportable due to otential cause. No further jury was completed. The was notified of the injury but le to the state agency. A ent Referral form was				
and had a bruise 8.5 forefinger from the ba There was no indicat thorough investigatio	cm between her thumb and ase of her thumb to her wrist. ion the facility completed an n to determine the source of				
revised 7/15, indicate (Mille Lacs Health Sy are vulnerable to abu physical, mental psyc sexual abuse)" The "protection will includ individual abuse prev reporting of all cases neglect, or financial e reporting to the Com	ed: "It is the policy of MLHS rstem) to protect adults who use (including verbal, chosocial/emotional, and e policy further indicated: e abuse prevention plans, rention plans, internal of suspected abuse, exploitation, and external mon Entry Point (CEP) of				
	(EACH DEFICIENC REGULATORY OR Continued From page thumb to her wrist. TI initial evaluation and resulted from R8 wrir wringing of her hands During an interview of SW stated, the injury staff witness of the po- investigation of the in facility administrator of a report was not mad Social Services Incid requested for this inju Although R8 had sev and had a bruise 8.5 forefinger from the ba There was no indicat thorough investigatio her injury, also the in the state agency. Review of the facility revised 7/15, indicate (Mille Lacs Health Sy are vulnerable to abu physical, mental psyo sexual abuse)" The "protection will includ individual abuse prev reporting of all cases neglect, or financial e reporting to the Com-	SHEALTH SYSTEM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a bruise 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. Review of the facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)" The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident,	S HEALTH SYSTEM DNAMIA, MN 56359 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 43 21990 thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. 21990 During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a bruise 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. Review of the facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)" The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident,	SHEALTH SYSTEM ONAMIA, MN 56359 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENT/WIST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) D PREVIDENT TAG D PREVIDENT TAG PROVIDER'S PLAN OF -I (EACH CORRECTIVE AT CROSS-REFERENCED TO T DEFICIENC Continued From page 43 21990 CONTINUE (ACH CORRECTIVE AT CROSS-REFERENCED TO DEFICIENC During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a buries 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. 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In regard to	S HEALTH SYSTEM ONAMIA, MN 56359 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BERRECEDED BY FULL REDULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG ID PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SINCULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 43 21990 thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. 21990 During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was completed. The facility administrator was notified of the injury but a report was not made to use. No further investigation of the injury but was not received. Athough R8 had severe cognitive impairment, and had a bruise 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. Review of the facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)" The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, of financial exploitation, and external reporting of all cases of suspected abuse, neglect, of inancial exploitation, and external reporting of an areportable incident," In regard to investigation of a reportable incident," In

Minnesota Department of Health STATE FORM

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STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	//27/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
	CS HEALTH SYSTEM		TH ELM STREET			
(X4) ID PREFIX			, MN 56359 ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO 1 DEFICIENC		DATE
21990	Continued From page	e 44	21990			
	thoroughly investigate further potential abus progress." Under the Patient" section, the p alleged perpetrator (A situation. If the AP is suspended until the in and further, "Disciplin up to and including di employee/employees defined Injury of Unka the injury was not obs suspicious." The poli definition top include to screening of poten	as appropriate." The Policy nown Origin as "source of served and injury as icy did not expound on this CMS definitions. In regard tial employees, the policy attempt to obtain information				
	The Administrator and and inservice the faci investigation of allega to the State rules and	IOD OF CORRECTION: d/or designee could review ility staff responsible for the ations of abuse and neglect, d facility policy. CORRECTION: Fourteen				
	(14) days.					
22000	MN St. Statute 626.5 Reporting - Maltreatn	557 Subd. 14 (a)-(c) nent of Vulnerable Adults	22000			8/21/15
	facility, except home personal care attenda establish and enforce	ant services providers, shall e an ongoing written abuse e plan shall contain an				

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
		00374			07	//27/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE			
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECACH DEFICIENCY MUST BE PRECEDED BY FULL ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOP)		SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BEREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
22000	and a statement of sp to minimize the risk of comply with any rules promulgated by the li (b) Each facility, in agency and personal providers, shall devel prevention plan for ea residing there or rece The plan shall contain assessment of: (1) th abuse by other indivity vulnerable adults; (2) other vulnerable adults; (2) other vulnerable; (3) other vulnera	population identifying acourage or permit abuse, becific measures to be taken of abuse. The plan shall a governing the plan censing agency. cluding a home health care care attendant services lop an individual abuse ach vulnerable adult eving services from them. In an individualized the person's susceptibility to duals, including other the person's risk of abusing ts; and (3) statements of the be taken to minimize the bess of this paragraph, the s self-abuse. Accept home health agencies tendant services providers, rable adult has committed a ct of physical aggression dividual abuse prevention measures to be taken to t the vulnerable adult might ted to pose to visitors to the putside the facility, if r this section, a facility knows s history of criminal cal aggression if it receives in a law enforcement a medical record prepared by the r health care provider, or					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00374					
IAME OF PI	ROVIDER OR SUPPLIER	00374 STREET A	DDRESS, CITY, STA		07	//27/2015	
	CS HEALTH SYSTEM		TH ELM STREE				
	CS HEALTH STSTEM	ONAMIA	, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From page	€ 46	22000				
	by: Based on observation review, the facility fail Vulnerable Adult Polic abuse, neglect, mistre unknown origin were administrator and star investigated, and res during the investigatio (R47, R12, R22, R39 allegations reviewed. to conduct reference policy for 4 of 5 newly NA-B, DA-A and RN- effect all 50 residents	t is not met as evidenced h, interview and document led to implement their cy to ensure all allegations of eatment and injuries of immediately reported to the te agency, were thoroughly sidents were protected ons for 8 of 15 residents' , R11, R66, R44 and R8) In addition, the facility failed checks according to their / hired employees (NA-A, -B). This had the potential to who resided in the facility, andard quality of care under		corrected 8/21/15			
	resident behavior and Findings include:	facility practices.					
	indicated: "It is the po Health System) to pro vulnerable to abuse (mental psychosocial/ abuse)" The policy will include abuse pre	including verbal, physical, emotional, and sexual further indicated: "protection evention plans, individual					
	cases of suspected a exploitation, and exte Common Entry Point incidents of maltreatm investigation of a repo	(CEP) of substantiated					

Minnesota Depart

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00374	B. WING		07	/27/2015
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 47	22000			
	potential abuse while progress." Under the Patient" section, the p perpetrator (AP) will t situation. If the AP is suspended until the in and further, "Disciplin up to and including di employee/employees INVESTIGATION AN During interview 7/23 worker (SW) stated th has been implicated i reports from February alleged abuse, and n	an employee, they will be hyestigation is completed," lary action will be carried out ismissal of a as appropriate." D PROTECTION /15, at 5:09 p.m. with social hat nursing assistant (NA)-C n at least four incident y 2015 to July 2015 of eglect. dent and Investigation 5 to 7/20/2015 for NA-C				
	2/17/15, indicated she intact and needed ex R47's care plan dated dementia and needs grooming and bathing indicated she had slig related to dementia a to be oriented to pers A facility Social Servio (SSIRF) indicated lice (LPN)-D verbally repo	g. The care plan further ght alteration in cognition nd that resident will continue on, place and time. ce Incident Referral Form				
	occurred during the n SSIRF, dated 1/27/15 altercation/conflict be	ight shift on 1/24/2015. The				

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		B. WING			
	00374			07	//27/2015
ME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, RTH ELM STREET	, ZIF CODE		
LLE LACS HEALTH SYSTEM	ONAMIA	A, MN 56359			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
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also indicated, "LPN assisted res to bed, inquire what happen indicated the incider investigation and/or agency, and this wa 1/28/15. A review of Mille Lao Notes, dated 1/28/19 "This nurse was in a from where the incid distinct smack. Follo This nurse then got [walkie-talkie] from t NA)." The [NA] state rounds, I went to che (room 45, bed 1) and [R47] in the process said she should lay some sleep until cof want to sit up I'm wa down" and NA went bring them in bed ar the head, fairly hard NA said "why did yo you hit me you liar' t walkie the nurse" the res. why she hit that the aide hit her. identify the nursing a A facility email, writte 1/28/2015, indicated informed by LPN-D o a nursing assistant.	reporting" to the state s signed by the SW on cs Nursing Home Progress 5, written by LPN-D indicated: res. room, 5 rooms away ent happened, but heard a bwed by a woman's out cry. a call on the walkie he aide (nursing assistant, ed (in her words) "On 2 a.m. eck resident in room 45-1 d woke up resident in 45-2 . I told [R47] the time and back down and try and get fee time." [R47] said "No, I iting." NA said "No lets lay to pick up [R47's] feet to ad [R47] swung and hit me in . I [NA] yelled out "ow" and u hit me, [R47] said, 'I didn't, hen [NA] walked out and This nurse [LPN-D] asked the aide. Res. [R47] stated " The nursing note did not assistant by name.				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/27/2015
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	CS HEALTH SYSTEM	ONAMIA	A, MN 56359			
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	also that the resident NAR struck her, the in reported" to the state An Incident Report su on 1/28/15, indicated reported to this SW in 1/27/15" and furthe past weekend" with a Following a review of by the "Stand Up Tea Management Team", incident was due to [I symptoms" The rep progress note which "claimed at the time t	R [nursing assistant] and claimed at the time that the ncident DOES need to be agency. ubmitted to the state agency : "An incident was verbally in the late afternoon in that R47 had a conflict "this a nursing assistant. if the related progress notes am" and "Behavior it was originally determined R47's] "dementia port referred to a nursing				
	policy." The alleged unidentified.	F, the internal email, and the				
	indicated an incident the night shift/early m The report also indica reported, and made k afternoon of 1/27/201	occurred sometime during norning hours of 1/25/14. ated the incident was first known to the SW on late 14, (two days after the				
	1/28/2015 (three day occurred). There wa was reported immedi	d to the state agency on s after the incident allegedly s no indication this incident ately to the administrator dditionally, the investigation				
	of this incident: lacke NA-C, and other invo affected residents; di	ed timely interviewing of Ived staff, and potentially d not provide evidence R47 tigated for injuries; and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	/27/2015
IAME OF PI	ROVIDER OR SUPPLIER		.DDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE		
AILLE LA	CS HEALTH SYSTEM		, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
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	during the investigation	on.				
	state agency on 2/2/1 SW met with R47 "on 1/30/15," and "Reside incidents of concern weekend." The SW w NA-C, (identified as the involved) until 2/2/15 learned of the incider schedule not coincidi with NA-C by phone of NA-C "acknowledged described" by LPN-D saying she had not st had merely tried to lift back down" The re apparent evidence of investigative report in perpetrator was NA-C	6 (7 days after the SW ht) "in part due to her work ng with the SW." SW spoke on 2/2/15, at 10:45 p.m. I the incident happened as 's note, and further, "[NA-C] truck resident in any way, but t [R47's] legs to help her lay port indicated "There is no NAR striking resident." The				
	During an interview 7/23/15, at 5:10 p.m., the S stated in the investigation, R47 was unable to recall if the incident had happened, and that R4 had dementia. The SW said NA-C was not suspended during her investigation because it could not be proven that NA-C abused R47, an NA-C continued to be on the work schedule. T SW said NA-C was counseled on how to provid cares for R47, and was asked for ideas from NA-C on how to keep R47 safe.	ation, R47 was unable to ad happened, and that R47 W said NA-C was not r investigation because it hat NA-C abused R47, and on the work schedule. The ounseled on how to provide as asked for ideas from				
	2015, indicated NA-C	s MLHS-LTC NA/R ry 26, 2014 to February 8, worked on the night shift on while the investigation of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE RTH ELM STREET	, ZIP CODE		
AILLE LA	CS HEALTH SYSTEM		A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
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	this incident was in p	progress.				
	Referral Form (SSIR R47 was involved in a.m., of possible abu The SSIRF indicated (electronic progress verbal statements ar resident [R47]; possi maltreatment but jus resident's dementia.' indicated the incider Investigative Team o reported submitted to 3/3/2015 at 12:30 p.1 NA-C was a person o the situation.	st a likely symptoms of ' The SSIRF further Int was discussed with In 3/3/15 at 8:30 a.m., and to the state agency on m. The report also indicated with credible knowledge of				
	state agency on 3/3/ maltreatment of R47 referenced "two prog shift early that a.m. o some behavioral con by resident [R47] at maltreatment of resid indicated uncertainty maltreatment, and "S	port was submitted to the 15 regarding possible on 3/2/15. The report gress notes from NOC (night) of 3/2 that suggests either accerns/dementia symptoms work or possible dent by staff." The report by staff on whether this was SW decided to go ahead and to [state agency]"				
	a.m., written by LPN "kicking at staff" and going to report 'her' t indicated R47 told st everyone I heard" second progress not	ote, dated 3/2/215 at 4:03 -B, indicated [R47] was [R47] told staff "she was to the nurse" The note also aff "you go around hitting On 3/2/15 at 6:03 a.m., a ed indicated staff went to 47's] lip, and [R47] hit staff.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
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AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
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		that after R47 hit staff, R47 report you for hitting me."				
	was taken to protect during this investigat Documentation of the did not include detern bloody lip, and there with the nursing assis R47. The SSRIF als	on did not indicate any action R47 and other residents ion of potential abuse. e investigation of this incident mination the cause of R47's was no evidence of interview stant who provided cares for o indicated there was no of this incident to the state tor.				
	state agency on 3/00 The report indicated interviewed by RN C this SW. Resident d happening this past or the nighttime that denied that anyone h	Report was submitted to the 6/15 regarding the incident. on 3/2/15 the "resident was are Coordinator (RN- A) and enied remembering anything weekend during the daytime upset her in any wayShe its her or has been mean to				
	also indicated "SW of about progress notes shift, "indicating the I the EZ lift (mechanic bathroom per resider noticed resident's lip apparently cracked fit	rom being chapped with dry,				
	the dried blood off, the causing NA's glasses. The report indicated and assisted [R47] w same night, the NA w	d [R47] she was going wipe but R47 struck out at NA, s to dismount from her face." NA-C re-approached later vithout incident. Later the vas doing rounds and s feet back in bed, and				
nesota Der	referenced the allega	ations made by R47, that she				

STATE FORM

STATEMEN	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/27/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
22000	R47's care plan was were made on how to cares. The report als coached by the SW a progress note chartin have been reminded reports. The report in not resting well with t maltreatment of resid particular incident, SV and ears open for pa conduct, etc." Review of the facility Schedule from Febru 2015, indicated NA-G 3/2/15 (the night of th worked on 3/3/15. During interview 7/23 stated, in review of th "concerns with NA-C she had really done a felt they could not sul against NA-C, and th "suspension or discip investigation. There we thorough investigation R12's quarterly MDS was moderately, cog extensive assist with grooming. R12's carr indicated she had po	ident. The report indicated reviewed, and suggestions o approach R47 during so indicated LPN-B was and DON on more thorough ig, and further, that staff to submit timely incident included: "Something is just his, and although there is no lents 'substantiated' in this <i>N</i> will continue to keep eyes tterns and/or trends in 's MLHS-LTC NA/R ary 23, 2015 to March 8, C was assigned to work he alleged incident) and also is incident, she had " but again could not prove anything wrong. The facility bstantiate the allegations erefore did not warrant a				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		07	/2//2015
	CS HEALTH SYSTEM		TH ELM STREET			
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	(SSIRF), signed by the indicated there was a early A.M.", which alle was described as: "[I Res re some issues. want to go home, the lady with the ponytail up yesterday', and 'TI when she tried to mail 4p.m. resident [R12] concerns." The SSIR following: an internal on 2/18/15; that the re received by the SW in listed; the incident wa "Investigative Team"	email report was completed eport of alleged abuse was n person, no date or time is discussed with on 2/18/15 at 0833; and that al report was submitted on				
	agency on 2/18/15, in was "slapped on her this morning while sta her to take some med R12 had no apparent consistent with this cl The report also indica investigation is warra perpetrator" on the re "unknown."	nted." The "alleged port form was listed as				
	State Agency indicate occurred in the early possibly earlier, no ac or staff until it was dis on 2/18/15. There was	F, and the initial report to the ed, that although this incident morning of 2/18/15, and ction was taken by the facility accussed later that morning as no indication the incident orted to state agency and er, the investigation				

Minnesota Departme STATE FORM

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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AME OF PROVIDER OR SUPPLIER	00374	ADDRESS, CITY, STATE		07	//27/2015
ILLE LACS HEALTH SYSTEM		A, MN 56359			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
22000 Continued From page	ge 55	22000			
R12 was slapped; a have R12 positively (possibly NA-C) who Although NA-C was room without a colle documentation offer were put in place fo	ed no indication protections r other residents who were uring the investigation of this				
state agency on 2/2 indicated the "Initial agency]at 4 p.m. was made to local la indicated R12 had r but the only allegati the one about some administration of Mi morning (the white s SW and DON proce information about w the MOM that morn according to the sch the persons on duty indicated, "DON and freely admitted havi direction of [LPN-B] "[NA-C] said resider resident took the cu over." and "[NA-C] t bedding, resident's wet wipes." The rep slapping resident in wiping R12's face of	Report was submitted to the 3/15. The final report Reports submitted to [state ," on 2/18/15, and also a call aw enforcement. The report nade numerous allegations, on that could be "tracked, was cone slapping her during the lk of Magnesia (MOM) that stuff)." The report indicated weded to seek more ho would have administered ing. The report identified, nedule, LPN-B and NA-C were c. Further, the report d SW met with [NA-C], who ng given MOM upon the ." The report continued, nt didn't want the MOM, and p and threw the MOM all ried to clean it up off the clothing and her face, using port indicated "[NA-C] denied any way, but acknowledged off with the wet ones." The s possible this was perceived				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
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IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AILLE LA	CS HEALTH SYSTEM		ATH ELM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
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	lady who slapped her "[R12] was sleeping s decided not awaken h "NA-C's willingness to believe she [NA-C] is slapping resident." T spoke to LPN-B by pl LPN-C admitted askin R12 due to LPN-C be LPN-C also acknowle (R12's) claim of being The report then indica to having "two persor this resident and NA- room without a collea During interview on 7 stated she did not sus could not prove [NA-C acknowledged NA-C multiple incidents, an [NA-C], but did not fe suspend" or provide of during this investigati Review of the facility' Schedule from Febru 2015, indicated NA-C 2/22/2015, that is on incident, and during t	her." The report indicated b go, however, leads SW to being truthful about not he report indicated the DON hone on 2/23/15 at 3:20 p.m. ng NA-C to give MOM to eing occupied elsewhere edged that NA-C did report g slapped by a "blonde lady." ated staff have been alerted hs present" during cares with C was instructed not to enter gue present. //23/15, at 5:20 p.m. the SW spend NA-C since "they C] slapped [R12.]" The SW had been involved in d had "suspicions" with el "there was a reason to disciplinary action to her on. s MLHS-LTC NA/R ary 9, 2015 to February 22, c worked on 2/17/15 through the date of the alleged he subsequent investigation. ion a thorough investigation				
	she had depression a accident (CVA), and	S dated 4/24/15, indicated and a cerebral vascular was moderately cognitively limited assist with transfers				

	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/27/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
MILIFIA	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET			
		ONAMIA	A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
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	plan dated 5/3/15, ind with toileting and tran depression and sadn care plan further india abuse from others re weakness, aches and indicated "resident w needs met in a safe of During observation o lifted her pant leg and right shin measuring (centimeters) x 2 cm. be black, fading to da apparent swelling. In p.m. R22 stated that "roughly by the staff" who works the night s R22 went on to state "grabbed her arm wh caused a large bruise	ess/isolating self. R22's cated she had potential for lated to her general d pains. The care plan goal ill remain safe and have environment." n 7/20/15 at 5:54 p.m., R22 d displayed a bruise on her				
	state agency on 6/27 alleged mistreatment The report also identi right hand, measuring shape; and a second shin 2.5 cm x 2.5 cm report was submitted the initial reporter, NA perpetrator in this inc nursing assistant (NA she had toileted R22 told [NA-C] she was n	I an Incident Report to the /15 regarding an incident of and physical abuse of R22. ified a bruise on R22 top g 5.5 cm x 5 cm, circular in bruise on R22's lower right , circular in shape. The by RN-D, and indicated that A-C, was also the alleged ident. The report indicated, A)-C reported at 5:15 a.m., , after being toileted, R22 not coming back tonight, and er." NA-C asked who, and				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
	00374	B. WING		07	/27/2015
AME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
IILLE LACS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
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report then indicated (RN)-A, followed up a asked her to tell her reported she is not s is not going to be tre explained that staff w night for getting up to times, and that a "gir into bed." R22 point said "this is where sh bruise on top of right (centimeters) x 5 cm reported when she th leg on something me outer lower shin mea circular in shape. R2 girl was, nor her nam around 0400. The r was the nursing assi during the night, and charge. No other in reassured she will re removed from workin An additional Inciden the state agency on injury of unknown so "8 x 5 cm, reddish pu shape." The date of i unknown. The report happened a few days An Investigative Rep state agency on 07/0 submitted incident re 7/1/15. The report in nursing (DON) and s	that registered nurse with R22 in the morning and what happened: "Resident taying her again tonight and ated like this anymore." R22 vas mad at her during the o use the bathroom so many 1 grabbed me and threw me ed out her hand hurt, and he grabbed me," noted a hand measures 5.5 cm circular is shape. R22 also herew me into bed, "I hit my etal" a bruise noted on right sources 2.5 cm x 2.5 cm 22 could not recall who the he. R22 thought it was eport further indicated NA-C stant working on that wing LPN-A was the nurse in juries noted, resident was main safe here, NA-C will be ng with resident at this time. At Report was submitted to 7/1/15, which identified an urce on R22's right forearm urple in color and oval in incident occurrence was t indicated R22 said "It				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00374	B. WING		07	/27/2015	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
IILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLE DATE	
22000	Continued From pag	e 59	22000				
	may have occurred in hence submitting a re enforcement, in acco Act." Further the rep our internal investiga are being submitted agency." The Invest indicated on 7/1/15, it the AP, (NA-C) who use the toilet 6-8 time report then indicated with the AP the numb involving this NAR, w her credibility, and sh defensive, face redde saying 'it's because I don't, so I end up get further listed, that du DON and SW meet w "reported having hea 6/30, that [R22] is aff hair and bangs, that The blond hair with th NA-C. The report fur been "implicated in p 78740, and 79433 w with residents, as sho received coaching in also involved in repo specifically named as	ordance with Elder Justice bort indicated, "The details of tition to the limits of our ability to OHFC and the state igative Report further the DON and SW met with stated R22 had requested to es that night (6/27/15). The [SW and DON] "discussed ber of previous incidences which can raise red flags re he became somewhat ening and voice tightening, report things and others tting in trouble.' " The report ring an interview 7/2/15 the with NA-D, who stated she and from resident (R22) on raid of the girl with the blonde she is not very nice, etc. he bangs fits description of rther included that NA-C had previous reports 75814, ith possible "power struggles" e tries to perform cares; these incidents. NA-C was rt 79866 but was not s AP." escribed NA-C as the staff rt her and NA-C was caring multiple large bruises, the on indicated no action taken during investigation of these e was no indication that a					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	//27/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
22000	Continued From page	e 60	22000			
	DON stated she "has be doing the accusat not certain." The DO during the night shift, on that do that." The were to report to her have concerns. In an interview on 7/2 stated she "did not ta staff regarding abuse DON stated, "I don't witch hunt." The DON name keeps coming guilty." The DON als around "data privacy further stated, when a allegations come up on duty initiates the O said the nurse would address any immedia NA-C, the SW stated several residents she but that does change the allegation is not s further stated, in rega	7/23/15, at 4:50 p.m. the concerns that NA-C might ions," but stated she "was 'N said, "staff monitor [NA-C] " and also "we have nurses DON stated the nurses if they notice anything and 23/15, at 5:03 p.m., the SW Ik with other residents or allegations by [R22]." The generally do that, it's not a N said, "Just because their up does not make them o said there were issues and confidentiality." SW something regarding abuse over the weekend, the nurse DHFC reporting. The SW talk to the resident, and ate concerns. Regarding d, "At times there have been e is not allowed to care for, if, during the investigation substantiated." The SW and to NA-C, after the first a lot of coaching was done."				
	The SW also said the "not intensive, and th plan initiated and no or mentoring done."	e coaching for NA-C was ere was no improvement documentation of education on 7/23/15 at 5:10 p.m., the				
	administrator said, "W working on nights, we	Ve have three young people e can't suspend; there is not Iministrator further stated, " I				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING		07	//27/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 61	22000			
	the DON stated NA-C facility policy followin R22 . She stated, "If would have had to su who would take care During an interview of stated, "I don't work am mandated, but I of stated, "I have heard wet and I have heard little rough, but I can't stated, one of the resi being rough and leav the staff member as the resident and stated the threw me into the chart	on 07/24/15 5:14 a.m., NA-E a lot of overnights unless I do hear a few things." NA-E about people being super I that some of the girls are a t tell you who." She further sident mentioned about a girl ring bruises. NA-E described they were described by the ne resident said " the girl air because I had to go to the -E stated she does not see				
	stated she works par LPN-H stated she ha NA-C is rough with th witnessed it directly. aware that she is to r night shift when she she had heard R12 h slapped her and also on the North wing an because of the cat no care of any certain re aides on the night sh prefer to work on eac					
		OWN ORIGIN e Adult Policy, revised 7/15, nown Origin as "source of				

IND PLAN OF CORRECTION IDENTIFICATION NUMBE		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00374	B. WING		07	/27/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE		07	/2//2015
	CS HEALTH SYSTEM		RTH ELM STREET			
			A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 62	22000			
	the injury was not obs suspicious." The poli definition to include c interpretive guidance	cy did not expound on this riteria from the CMS				
	was moderately, cogr dated 3/30/15, indicat assist with all activitie a mechanical stand for	ated 3/9/15, indicated she nitively impaired. The CP, ted R39 required extensive as of daily living (ADLs), used or transfers, and was buse, because of dementia.				
	had a large, dark purp portion of her buttock injury, and R39 was " bruising occurred. Th "a few days ago had not standing when tra Hoyer (a mechanical SSRIF further indicate that could explain bru chart contained "falls that could likely have SSIRF indicated R39 reported to the state a investigation was con though there was no	e SSIRF also indicated R39 been lowered to floor due to ansferring & then lifted with lift) Possible cause." The ed R39 used a medication using, and also that R39's or other recent incidents produced the injury." The 's injury was "minor" and not				
	ground. During an interview o DON stated, when R3 floor "it would be hard during that event." Th	n 7/24/15, at 12:54 p.m., the 39 had been lowered to the 3 to know if injury occurred he DON said R39 bruised nticoagulant medication, so				

STATEMEN	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00074	B. WING			10710045
NAME OF P	ROVIDER OR SUPPLIER	00374 STREET A	ADDRESS, CITY, STATE	. ZIP CODE	07	//27/2015
	CS HEALTH SYSTEM	200 NOF	RTH ELM STREET	,		
			A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 63	22000			
	unable to recall how was no evidence that investigation was cor	the bruise occurred, there t a more in-depth npleted to determine the s R39's injury of unknown				
	she was moderately, CP, dated 6/3/15, inc	ist for all ADLs, and was at				
	had a bruise to the to purple in color, and n SSIRF indicated R11 injury occurred, but F medication, and R11	ated 10/21/15, indicated R39 op of her right hand, dark neasured 8 cm x 8 cm. The was unable to state how the R11 used anticoagulant 's bruise was described as administrator was notified but to the state agency.				
	had bruising noted to her left eyebrow. The unable to state the ca	ted 11/4/14, indicated R11 o her left temple and above e SSIRF indicated R11 was ause of the injury. The was notified, but the injury he state agency.				
	a bruise of unknown dark purple in color, a inches. The SSIRF ir "unknown", that R11 cause of the injury, u indicated the injury w	12/18/14, indicated R11 had origin to her left inner knee, and measuring $1 \times 1 3/4$ ndicated the injury was was unable to report the sed anticoagulants; and also vas considered to be "minor." ator was notified, but the				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00374		B. WING		//27/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	07	/2//2015
	CS HEALTH SYSTEM	200 NOF	TH ELM STREET			
		ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 64	22000			
	unknown origin on 7/2 stated, R11 "had mor have ever known." Th R11's hand "may hav trimming of [R11's] na the bruise herself. Re R11's temple and fore nursing felt the bruisii [R11's] nebulizer mas stated, she interviewe she slipped and fell o SW further stated R1 Hoyer lift [a mechanic there were no records bruising was "likely du nebulizer mask." No completed for this inju During an interview o DON stated R11 "cou reporting nurse asked	bout the three injuries of 24/15, at 12:54 p.m., the SW re bruising than anyone I ne SW said the bruise on re been caused by recent ails," indicating R11 caused egarding the bruise noted to ehead, the SW stated that ng "was due to placement of sk," however, the SW ed R11 who reported that on her way back from supper. 1 did not ambulate, used a cal lift] for transferring, and s of any falls. SW added the ue to placement of [R11's] further investigation was ury.				
	cognitively impaired, different locations, the investigation complet causes of R11's bruis was notified of the inj incidents were submi R66's quarterly MDS, was moderately, cogn dated 2/9/15, indicate	entified to be moderately and had multiple bruises at ere was no indepth red to determine the actual ses. The facility administrator uries but none of these tted to the state agency.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00374	B. WING		07	//27/2015
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE		07	12112015
	CS HEALTH SYSTEM		RTH ELM STREET			
			A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 65	22000			
	risk for delirium and p depression.	potential abuse, related to				
	a review of R66's nur 1/26/2015, there was bruises" on [R66] bot identified as bruising The SSIRF also indic sleeve/arm protectors was an "unknown inju state the cause, and to be "minor." The in facility administrator, the state agency. During an interview of SW stated, the bruise was reviewing R66's said she "spoke with bruising was assessed	"from hands to shoulder."				
	DON said R66 used a and R66 did not alwa occasionally "flailing I stated R66 was confu "hard to say if R66 was	on 7/24/15, at 12:54 p.m., the a Hoyer lift (mechanical lift), nys cooperate in lift, her arms." The DON further used, and that it would be ould have been able to to uising occurred after any				
	hands to her shoulde unwitnessed and the identify what happend immediately reported agency nor was a tho	resident was unable to ed. The facility had not the incident to the state prough investigation ine if R66 was "flailing her				

STATE FORM

	OF DEFICIENCIES	h (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	7/27/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	1 1	
MILLE LA	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 66	22000			
	was severely cognitiv 7/10/15, indicated R4 with ADLs, and was a short term memory lo decision-making skill A review of SSIRF da had a purple bruise of forearm, measuring 6 found during her bath was an "unknown" in the cause of injury. The se "minor". The facili					
	SW stated, "The injur nursing staff to be 'm suspicious criteria. T a need to report" to th	on 7/24/15, at 12:54 p.m., the ry was determined by inor' and did not meet any The SW said she "did not see the state agency. 24/15, at 12:54 p.m., the				
	DON stated, "[R44] v	vould have been able to tell pened, she could make her				
	cognitively impaired, origin, on the posterior indication the facility investigation to deter	s assessed to be severely had an injury of "unknown" or of her arm. There was no completed an thorough mine the source of her ent was not reported to the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00074	B. WING			10710045
	ROVIDER OR SUPPLIER	00374	ADDRESS, CITY, STATE		07	//27/2015
			RTH ELM STREET	,211 0002		
IILLE LA	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	9 67	22000			
	her to be severely correquiring assist of two living. CP dated 5/15, extensive assist for a	um data set (MDS) identified gnitively impaired and o staff for activities of daily (15 indicated R8 required ctivities of daily living and related to diagnosis of				
	had a bruise measuri her thumb and forefin thumb to her wrist. Th initial evaluation and resulted from R8 wrin	ated 8/18/14, indicated R8 ng 8.5cm in length between ager from the base of her ne reporting nurse did the determined the bruising aging her hands, and the s was witnessed by staff.				
	SW stated, the injury staff witness of the po- investigation of the in facility administrator v a report was not mad Social Services Incide	n 7/24/15, at 12:54 p.m., was not reportable due to otential cause. No further jury was completed. The was notified of the injury but e to the state agency. A ent Referral form was iny but was not received.				
	and had a bruise 8.5c forefinger from the ba There was no indicati thorough investigation	ere cognitive impairment, cm between her thumb and ase of her thumb to her wrist. fon the facility completed an in to determine the source of cident was not reported to				
	SW stated, when mal whether or not to repo	n 7/24/15, at 12:54 p.m., king a determination of ort an injury to the state o statutes, and uses a				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00374	B. WING		07	/27/2015
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
	CS HEALTH SYSTEM		RTH ELM STREET A, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
22000	Continued From page	e 68	22000			
	looks at whether a re injury, or if someone a history of other reco SW further stated, "If injury or injury not su location, it does not r During an interview of DON said, minor inju state agency. She fur criteria or policy" the determine whether an "major." The DON al the nurses judgemen injury was minor or m charge "followed up of she stated there was	n 7/24/15, at 12:54 p.m., the ries are not reportable to the rther stated, there was "no facility has to identify and n injury was "minor" versus so stated she "would use t" when determining if an hajor, and that the RN in on the injuries." However, no charting on the clinical ow evidence that follow-up				
	7/15, indicated as its who are vulnerable to policy included: "To a everything within its o occurrence of abuse attempt to obtain info employers and or/cur NA-A's personnel re- hired on 7/13/15. The	Prevention Policy, revised purpose "to protect adults o abuse" Further, the assure the facility was doing control to prevent the or neglectthe facility would armation from previous rrent employers." cord identified they were e personnel record lacked hecks were completed prior				
	NA-B's personnel rec hired on 6/30/15. The	cord identified they were e personnel record lacked hecks were completed prior				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
	ROVIDER OR SUPPLIER	00374	DDRESS, CITY, STATE		07	7/27/2015
			RTH ELM STREET	, ZIF CODE		
AILLE LA	CS HEALTH SYSTEM	ONAMIA	, MN 56359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 69	22000			
	they were hired on 6/ lacked evidence refer completed prior to en Registered nurse (RN identified they were h personnel record lack checks were complet the facility. On 7/23/15, at 8:45 a staff stated four of the did not have docume HR stated there was that reference checks facility used the appli about the position he rehire and any feedba SUGGESTED METH The Administrator and	A)-B's personnel record hired on 5/11/15. The ked evidence reference hed prior to employment at h.m. human resources (HR) e five newly hired employees ntation of reference checks. "not a process" to document is had been completed. They cation references "to inquire ld, date of hire, eligibility for ack."				
	TIME PERIOD FOR ((14) days.	CORRECTION: Fourteen				