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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KLRI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00374

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245127**

2.STATE VENDOR OR MEDICAID NO.
(L2) **190247401**

3. NAME AND ADDRESS OF FACILITY
(L3) **MILLE LACS HEALTH SYSTEM**
(L4) **200 NORTH ELM STREET**
(L5) **ONAMIA, MN** (L6) **56359**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/16/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Sarah Kacena, HFE NE II — 11/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/30/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/20/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/30/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/18/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245127
November 18, 2016

Ms. Kim Kucera, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, MN 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 November 4, 2016 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.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 18, 2016

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

RE: Project Number S5127026

Dear Ms. Kucera:

On October 28, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 6, 2016. (42 CFR 488.422)

On October 28, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 25, 2016. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of November 17, 2016, 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 November 25, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on August 25, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 26, 2016. The most serious deficiencies at the time of the revisit were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 16, 2016, the Minnesota Department of Health completed a PCR to verify that your

facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on October 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 4, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 16, 2016, as of November 4, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 4, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 28, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 25, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 25, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 25, 2016, is to be rescinded.

In our letter of , we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 25, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 4, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 25, 2016 be rescinded effective November 4, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245127	A. Building B. Wing	11/16/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 11/04/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 11/16/2016	SIGNATURE OF SURVEYOR 36869	DATE 11/16/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KLRI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00374

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245127**

2.STATE VENDOR OR MEDICAID NO.
(L2) **190247401**

3. NAME AND ADDRESS OF FACILITY
(L3) **MILLE LACS HEALTH SYSTEM**
(L4) **200 NORTH ELM STREET**
(L5) **ONAMIA, MN** (L6) **56359**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/26/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Sarah Kacena, HFE NE II — 11/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/22/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/20/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/22/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/18/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 28, 2016

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

RE: Project Number S5127027

Dear Ms. Kucera:

On September 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on August 25, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 26, 2016, the Minnesota Department of Health and on September 22, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on August 25, 2016. The deficiency(ies) not corrected is/are as follows:

F0431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective November 6, 2016. (42 CFR 488.422)

However, as we notified you in our letter of September 12, 2016, 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 November 25, 2016.

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 25, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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,

- Include electronic acknowledgement signature of provider and date.

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 remedy be imposed:

• 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 ePoC, 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 allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 28, 2016

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

RE: Project Number F5127024

Dear Ms. Kucera:

On September 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 25, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 22, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on August 25, 2016.

However, compliance with the health deficiencies issued pursuant to the August 25, 2016 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 25, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 25, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 25, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Mille Lacs Health System is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 25, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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.

APPEAL RIGHTS

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

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	R 10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 10/25/2016 through 10/26/2016. The certification tags that were corrected can be found on the CMS2567B. Tag/s that were not corrected at the time of the onsite revisit are documented on a CMS 2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	{F 431}		

LABORATORY DIRECTOR'S OR PROVIDER/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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	R 10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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{F 431}	Continued From page 1	{F 431}		

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure insulin was labeled accurately for 2 of 7 residents (R44, R67) reviewed for insulin administration. In addition the facility failed to ensure nursing staff properly disposed of used fentanyl patches per facility policy for 2 of 2 residents (R15, R30) who receive fentanyl, and failed to reconcile and destroy liquid morphine for 1 residents (R46) who received liquid morphine to reduce the risk of potential drug diversion.

Findings include:

LABELING

R44's quarterly Minimum Data Set (MDS), dated 8/22/16, identified a diagnosis of diabetes mellitus.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	R 10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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{F 431}	Continued From page 2 R44's current signed physician orders, dated 9/22/16, had an order for Lantus Insulin (long acting insulin) 42 units. During observation on 10/25/16, at 6:58 p.m., the north medication cart contained R44's lantus insulin pen with a label reading "Inject 34 units" in the morning. R67's signed physician orders, dated 10/19/16, identified a diagnosis of diabetes with a physician order for Insulin Degludec (long acting insulin) 14 units once daily. During observation on 10/25/16, at 6:58 p.m., the north medication cart contained R67's Degludec Insulin pen with a label which instructed to give "10 units once daily." When interviewed on 10/25/16, at 6:58 p.m., registered nurse (RN)-A was unaware of the discrepancy between R44's signed physician order and the label. If the label and signed physician orders do not match, a note dosage sticker is placed over the label. On 10/26/16, at 9:43 a.m., the pharmacist stated the facility was responsible for notifying the pharmacy of new or changed orders. He reported the pharmacy was responsible for changing the label when dispensing a new insulin pen for the first time; however, it was the facility's responsibility to obtain a new label for current residents. The pharmacist stated he had not received any updated orders for R44 or R67's insulin pens.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	R 10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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{F 431}	Continued From page 3	{F 431}		

During interview on 10/26/16, at 10:24 a.m., RN-B stated R44 was on 34 units of long acting insulin prior to a hospitalization; however, the order was changed to 42 units when he was re-admitted. She further stated nursing staff should have been checking the label against the signed physician order when a discrepancy is identified. RN-B reported there was a higher potential for medication errors with the discrepancies.

On 10/26/16, at 10:32 a.m., RN-C stated R67 was admitted with orders for 14 units of long acting insulin. RN-C stated the label on the current insulin pen was incorrect. The nursing staff should be checking the label against the signed physician order to make sure it is correct before administering.

During an interview on 10/26/16, at 10:40 a.m., the director of nursing (DON) stated R44 and R67's medication changes should have been addressed sooner. She further stated it was ultimately the nursing staff's responsibility to check label accuracy. The facility has provided staff education about how to correct labeling of insulin.

A facility policy entitled, LTC- Pharmaceutical Services, last revised 6/16, directed nursing staff to "use a label alert sticker and place it over the previous directions indicating to check for a change until a new label is received from pharmacy" when medication orders changed.

NARCOTIC PATCH DESTRUCTION

R15's current physician orders, signed 9/27/16, had an order for fentanyl patch (narcotic pain

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	245127	A. BUILDING _____ B. WING _____	R 10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 4	{F 431}		

medication) 75 mcg (micrograms) topical change every three days. R15's MAR, dated 10/16, identified she received scheduled fentanyl patch every three days.

On 10/25/16, at 6:33 p.m.,RN-D stated, if she was unable to find someone to waste a used patch, she would store R15's used patch in a disposable glove in a plastic cup in the top drawer of the medication cart.

On 10/26/16, at 7:19 a.m., LPN-B stated she would store R15's used fentanyl patch in a plastic cup in the narcotic drawer of the medication cart.

R30's significant change MDS, dated 9/12/16, indicated she was on a scheduled pain medication regimen. R30's current physician orders, signed 10/24/16, had an order for fentanyl patch 50 mcg topical every three days.

R30's MAR, dated 10/16, identified her as receiving the scheduled fentanyl patch every 3 days.

On 10/25/16, at 6:58 p.m., RN-A stated, if she was unable to find someone to waste a used patch, she would store R30's used patch in a Kleenex unlabeled in the narcotic drawer of the medication cart.

On 10/26/16, at 7:44 a.m., LPN-A stated she would store R30's used patch in a disposable glove in a plastic cup in the medication room.

During an interview on 10/26/16, at 9:59 a.m., the DON stated facility policy is to store the used patch in a labeled clear plastic baggie in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	R 10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 5	{F 431}		

double locked narcotic drawer of the medication cart. She stated this policy had been reviewed with nursing staff. In addition, the DON was monitoring staff with weekly auditing and had discrepancies with fentanyl patch destruction each week. No additional education was provided to staff regarding the fentanyl destruction policy.

A facility policy entitled, "Medication Removal/ Destruction of Duragesic Transdermal Patch, dated 9/16, directed staff "used patch will be placed in a clean plastic baggie, labeled with resident's name." It further directed, patch "secured in the medication cart in the double locked narcotic box."

NARCOTIC RECONCILIATION/DESTRUCTION

R46's quarterly MDS, dated 8/10/16, identified she hospice care while in the facility, and discharge MDS identified she died on 10/11/16.

During an observation of the memory care medication cart on 10/25/16, at 6:49 p.m., an opened 30mL (milliliter) vial of oral liquid morphine (narcotic pain medication) was found in the double locked drawer in the medication cart. The trained medication aide (TMA)-A stated she was unaware any narcotics were in the cart. In a follow up interview on 10/25/16, at 7:51 p.m., TMA-A stated after finding the morphine in the medication cart, she alerted the nurses.

Review of the facility's bound Narcotic Record book identified R46 was administered 0.25mL of liquid morphine on 10/10/16, at 7:30 p.m., leaving 29.75 ml morphine remaining in the bottle. There was no indication in the facility Narcotic Record

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{F 431}	Continued From page 6	{F 431}		

book that the morphine medication was monitored by staff nurses between 10/10/16 and 10/25/16, to prevent potential diversion.

On 10/26/16, at 9:43 a.m., the pharmacist stated the facility should have a process to routinely count narcotics. Controlled substances should be destroyed within a day of the residents either discharging or dying by a nurse and pharmacist, which was not done. The pharmacist confirmed the liquid morphine was removed from the medication cart, and had been destroyed.

During an interview on 10/26/16, at 9:59 a.m., the DON stated she was unaware why the morphine was missed. The facility policy was for two nursing staff to count and sign the narcotics record book every shift to prevent potential diversion.

A facility policy entitled, "LTC- Pharmaceutical Services," last revised 6/16, directed "There is a count of each drug at the end of each shift. This should be signed by two nurses."

A facility policy entitled, "Medication: Destruction of Medications," last revised 6/16, directed that at the time of discharge or death, prescribed medications remaining were to be destroyed. In addition, the policy specifically directed "Controlled substances will be destroyed at the facility by a nurse and pharmacy."

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245127 Y1	A. Building B. Wing Y2	10/24/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0250	Correction	ID Prefix F0272	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.15(g)(1)	Completed	Reg. # 483.20(b)(1)	Completed
LSC	10/26/2016	LSC	10/26/2016	LSC	10/26/2016
ID Prefix F0279	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	10/26/2016	LSC	10/26/2016	LSC	10/26/2016
ID Prefix F0311	Correction	ID Prefix F0312	Correction	ID Prefix F0465	Correction
Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.70(h)	Completed
LSC	10/26/2016	LSC	10/26/2016	LSC	10/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	10/28/2016	18617	10/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/25/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245127	A. Building 01 - MAIN BUILDING 01 B. Wing	9/22/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 09/16/2016	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 08/25/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 10/28/2016	SIGNATURE OF SURVEYOR 27200	DATE 09/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/24/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245127	A. Building 01 - MAIN BUILDING 01 B. Wing	9/22/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	BF/mm	10/28/2016	27200	09/22/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/24/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KLRI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00374

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245127**

2.STATE VENDOR OR MEDICAID NO.
(L2) **190247401**

3. NAME AND ADDRESS OF FACILITY
(L3) **MILLE LACS HEALTH SYSTEM**
(L4) **200 NORTH ELM STREET**
(L5) **ONAMIA, MN** (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**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/25/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
James Anderson, HFE NE II — 09/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/06/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/20/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/18/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 12, 2016

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

RE: Project Number S5127026

Dear Ms. Kucera:

On August 25, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 4, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 4, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility 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.

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 November 25, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/22/16 to 8/25/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Mille Lacs Health System was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow bathing preference for 1 of 1 residents (R46) requesting a bath.	F 242	F242 R-46 with the Potential to affect all residents when their choice related to bathing is not followed. • Direct care staff, caring for resident	9/30/16

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

Electronically Signed | 09/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	08/25/2016

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F 242	Continued From page 1 Findings include: R46's quarterly Minimum Data Set (MDS), dated 8/11/16, indicated R46 had severe cognitive impairment, and required extensive physical assistance of one to complete bathing. R46's annual MDS dated 5/11/16, indicated it was somewhat important for R46 to be able to choose between a tub bath, shower, bed bath, or sponge bath. During interview with R46's family member on 8/25/16, at 1:53 p.m., R46's family member stated R46 enjoyed taking whirlpool baths because it helped to ease her arthritic pain. Further, R46's family member stated she felt it would cause less anxiety if R46 received a bath because of her (R46) fear of getting hurt during personal cares. During observation on 8/23/16, at 8:10 p.m. R46 was heard screaming and hollering from outside a room labeled, "Bathing Room" next to the entry doors to the locked memory care unit. The door to the shower room was opened by nursing assistant (NA)-G. R46 was visible inside a second shower room seated in a shower chair with her hands over her ears, water dripping from R46 and the chair. R46 continued to scream nonsensical speech which could be heard from the hallway. After R46 was brought to her room, she continued to yell and cry stating things such as "Someone help me" and "Help me, Help me" and, "Mother". At 8:29 p.m. R46 was no longer crying or screaming, and was watching television quietly in her room. An undated copy of the bathing schedule	F 242	R46, was verbally educated on 8/25/16 by the DON regarding this resident's preference for a bath instead of a shower as listed on the NAR worksheet. R46 has been receiving a bath on her bath day since 8/26/16. • All residents (or their family or representatives) will be asked about their bathing preference and the NAR worksheets will be revised where needed. This will be completed on 9/30/16. • The 2 NAR worksheets were combined to have only one worksheet for the NAR's to follow. • Nursing Assistants were provided education on 9/15/16 by the DON regarding the one worksheet which lists the resident's choices in their care, including their bathing choice. Licensed nurses will be educated on 9/20/2016 by the DON regarding the new worksheet for the NAR's which lists the resident's choices in their care, including their bathing choice. • Nursing Assistants were re-educated on 9/15/16 by the DON regarding the routine use of their 'worksheets', in order to accurately be following the plan of care for all residents. NAR's were instructed that they must carry the worksheet while on duty. • The Care Coordinators will re-assess bathing preferences during care conferences or by request of the resident/family. Preference changes will be communicated on the NAR worksheets. • Audits will be completed to determine that resident bathing choices as listed on	

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F 242	Continued From page 2 indicated R46 was scheduled for bathing on Monday evenings. The schedule specified R46 preferred baths. R46's care plan, dated 8/24/16, indicated R46 required extensive assistance with bathing and preferred a bath instead of a shower. During interview on 8/23/16, at 8:14 p.m. nursing assistant (NA)-G stated she had always given R46 showers and was unaware R46 preferred baths. Further, NA-G stated R46 always screamed and cried during showers and this was her (R46) "normal behavior" during personal cares. Further, NA-G stated she had always given R46 a shower, and had mentioned to the charge nurse a bath may be better. NA-G was unaware of what bath preferences R46 preferred, and as unsure of what interventions worked to help decrease her behaviors. When interviewed on 08/25/16, at 8:54 a.m., licensed social worker (LSW)-A stated R46 preferred to take baths and felt her (R46) increased anxiety was related to receiving showers. A facility policy on choices was requested, but none was provided.	F 242	the worksheet are honored will be completed weekly x4, and then monthly x3 by the DON or designee starting on 10/3/16. • The findings of these audits will be reported at the quality assurance meetings. Responsible Parties: DON, Care Coordinators or designee.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		9/26/16

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F 250	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medically related social service needs were identified and provided for 1 of 1 residents (R46) reviewed for behavior management. Findings include: R46 was admitted to the facility from a geriatric psychology unit on 5/3/16. She was discharged following treatment for advanced dementia, paranoia and refusal of cares. R46's annual Minimum Data Set (MDS) dated 5/11/16, indicated severe cognitive impairment. Further, the MDS indicated R46 had dementia with behavioral disturbance, and a mood disorder. Although Cognitive Loss/Dementia and Mood State Care Area Assessments (CAAs) were completed at this time, there was no analysis/assessment of R46's behavioral disturbances to assist with developing appropriate interventions. R46's care plan dated 5/23/16, identified R46 had "potential for alteration in mood which is manifested by crying, tearfulness, physically and verbally abusive behavior during baths. Behaviors can occur unprovoked." R46's care-planned interventions included: target behavior monitoring every shift; monitor for side effects from medications; attempting diversion with game shows; give small doll named Pete and offer snacks. During observation on 8/23/16, at 8:10 p.m. R46	F 250	F250 Provision of Medically related Social Service: R-46 with the Potential to affect all residents with Psychosocial Needs • A new Behavior Monitor Worksheet (Attachment A) was developed and started for resident R46 on 8/25/16. The form was updated to capture additional behavior information to be used for care planning. • A meeting with direct care staff was held on 8/31/16 to complete a chart review and develop additional interventions for R46's behavioral issues. An IDT (Interdisciplinary Team) meeting was held on 9/7/16 to further review resident R46's behavior monitoring worksheet, review interventions and the plan of care. The care plan was updated to reflect the findings and further interventions. The physician was contacted and updated with the findings and interventions. Input was obtained from the physician. • The Social Worker received MDS training on 6/29/16. In addition, she has received CAA and Care Planning training from a Pathway Health Services Consultant on 9/15/16. • The IDT Behavior Meeting Guidelines (Attachment B) has been reviewed and updated. • Education was provided to the NARs on 9/15/16 by the DON and to licensed nursing staff on 9/20/16 regarding the new behavior monitoring worksheets.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 250	Continued From page 4 was heard screaming and hollering from outside a room labeled, "Bathing Room" next to the entry doors to the locked memory care unit. At 8:15 p.m. R46 was brought out of the shower room by Trained Medication Assistant (TMA)-A. R46 had her hands over her ears and was crying while stating, "Someone help me." R46's face was red in color and flushed, and she had visible tears in her eyes and on her cheeks. After brought to her room, TMA-A turned R46's television on and left the room. R46 remained seated in her chair with her face in her hands crying, rocking back and forth stating, "Help me, Help me," and, "Mother" several times aloud. At 8:21 p.m. R46 remained in her chair in her room crying and screaming and, at times, could be heard at the nursing station. At 8:29 p.m. R46 was no longer crying or screaming, and was watching television quietly in her room. On 8/23/16, at 8:14 p.m. nursing assistant (NA)-G stated R46 typically screamed/hit at staff during personal cares and considered it her "normal" behavior. NA-G stated she had witnessed R46 scream and cry "for up to an hour" after receiving personal cares. On 8/23/16, at 8:23 p.m. TMA-A stated it was typical for R46 to "scream and cry" with personal cares. TMA-A stated R46 was supposed to get her shower within an hour of receiving her 3:00 p.m. Neurontin (a medication used for anxiety), but R46's shower was not given until 8:00 p.m. that evening. As a result, TMA-A felt R46 had increased anxiety and stress throughout the shower and stated, "we missed the mark on that." Further, TMA-A stated he felt R46 was "having a hard time" with her shower as she was observed screaming, crying and hitting out at staff.	F 250	• The new Behavior Monitoring Worksheets were initiated facility-wide on 9/20/16 and include care planning interventions for each resident, with an area to document if the interventions were effective and if additional, non-pharmalogical or non-care planned interventions were attempted and successful. • The IDT (Interdisciplinary Team) at daily meetings has identified three additional residents for Behavior Monitoring review and development of a behavior monitoring care plan. These residents are reviewed at weekly Behavior Monitoring meetings and their behavior monitoring care plans updated when indicated. The LSW is reviewing daily progress notes to identify future residents with behavior concerns. Those identified are discussed at daily IDT meetings and referred to the weekly Behavior Meetings when applicable. • An audit of residents identified for Behavior Monitoring will be conducted to determine that behavior monitoring worksheets are completed accurately and include documentation that interventions were effective or if not, additional interventions determined. The audit will be completed weekly x4, and monthly x3 beginning 9/26/16. The findings of these audits will be discussed at the weekly IDT meeting and reported at the quality assurance meetings. • An audit to determine that residents' psychosocial CAAs are completed accurately will be completed weekly x4, and if in compliance, will continue monthly	

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F 250	Continued From page 5 On 8/24/16, at 7:55 a.m. licensed practical nurse (LPN)- B entered R46's room and began providing personal cares. As LPN-B placed Ted stockings and pants, R46 started to cry and stated,"Please don't hurt me." NA-E then entered R46's room. As LPN-B and NA-E continued to assist with personal cares, R46 said, "I am sad" and began to cry with tears visible on her cheeks. When LPN-B and NA-E started perineal care R46 began to scream, "Help me!" and "You are hurting me!" R46 continued to cry when transferred into her wheelchair at 8:07 a.m. NA-E then wheeled R46 into the dining room, where R46 continued to intermittently cry until 8:29 a.m., nearly 20 minutes after personal cares were completed. During interview on 8/24/16, at 11:18 a.m. NA-E stated R46 always "screamed and cried" during personal cares or showers. NA-E stated she was not aware of nursing staff trying different interventions with R46 and stated it was a "very frustrating" situation. Further, NA-E stated it typically took "ten to fifteen" minutes for R46 to calm down after personal cares. During interview on 8/24/16, at 11:33 a.m. LPN-B stated R46 would normally become "upset" with any type of personal cares. LPN-B stated R46 had been like this "since admission" and other than adjusting R46's medications "nothing has seemed to help much." A physician progress note dated 8/23/16, identified -"I think staff could be more proactive in predicting when she is going to be upset and give an extra 1 ml. of gabapentin prior to her family leaving during visitation, as an example."	F 250	x3 beginning 9/26/16. The findings of these audits will be reported at quality assurance meetings. Responsible Parties: DON, Care Coordinators or designee, and LSW	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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F 250	Continued From page 6 R46's Target Behavior Monitoring from 6/1/16, through 8/24/16, identified: 64 episodes of crying/tearfulness; 19 episodes of physically abusive behavior; and 31 episodes of becoming anxious. The target behavior monitoring sheet did not identify any specific non-pharmalogical interventions staff could use to help reduce or prevent R46's target behaviors of anxiety, crying and physically/verbally abusive behavior. Review of nursing notes from 5/3/16, through 8/25/16, identified consistent behaviors including paranoia, hallucinating, verbal/physical abuse, restlessness and crying. The notes also indicated the non-pharmacological interventions identified in the plan of care were not helpful in reducing the behaviors. There was no evidence in the notes of other non-pharmacological interventions being implemented. In addition, there was no evidence the physician's suggestion of proactive approaches, including the utilization of as needed medications, being assessed and implemented. On 8/25/16, at 8:54 a.m. licensed social worker (LSW)-A stated approximately one week after being admitted to the facility R46 was anxious with cares, and physical/verbally abusive toward staff. LSW-A stated the facility was completing daily target behavior monitoring, but no analysis of trends or new care plan interventions had been attempted since her admission. Further, LSW-A stated R46 was not "as secure and comfortable" as she should have been at the facility and acknowledged her role was to work with staff to address R46's behaviors. On 8/25/16, at 10:13 a.m. the Director of Nursing (DON) stated there should have been more coordination of care for R46 between the social	F 250		

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F 250	Continued From page 7 worker and interdisciplinary team related to R46's ongoing behaviors. Further, the DON stated it was the responsibility of the care coordinator to monitor R46's ongoing behaviors and modify the interventions/care plan accordingly. The DON stated it had not occurred in this situation. The DON stated the social worker/care coordinator should have been monitoring personal cares to get a "better idea" of R46's behaviors with cares. Review of the undated job description titled, Long term Care Social Worker Job Description and Performance Evaluation, identified it was the social workers responsibility to effectively facilitate the psychosocial functioning of residents. The document further stated, it was the responsibility of the social worker to complete care planning and coordinate with the behavioral management team for non-pharmalogical interventions for resident behaviors.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272		9/30/16

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F 272	Continued From page 8 Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete care area assessments for 1 of 1 residents (R46) within 14 days of admission. Findings include: R46's admission record dated 5/6/16, identified multiple diagnosis including; dementia with behavioral disturbance and mood disorder. Review of nursing notes from 5/3/16, through 8/25/16, identified consistent behaviors including paranoia, hallucinating, verbal/physical abuse, restlessness and crying.	F 272	F272 Comprehensive Assessment of functional capacity for R-46 with the potential to affect all residents with Psychosocial Needs • A CAA policy (Attachment C) has been developed and shared with the IDT. • The new Social Worker (hired on April 18, 2016) following her initial orientation, received additional MDS training on 6/29/16. And on 9/15/16 she received specific CAA and Care Planning training from a Pathway Health Services consultant. • A review of residents' CAA	

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F 272	Continued From page 9 R46's annual Minimum Data Set (MDS) was completed on 5/11/16. The corresponding Care Area Assessments (CAA)'s were reviewed and the following was noted: The Cognitive Loss/ Dementia CAA indicated R46 had Alzheimer's disease, was receiving end of life care and noted R46 had a decreased ability to make self understood. Further, the CAA indicated R46 needed frequent reorientation to her environment. There was no assessment of R46's cognitive loss and subsequent behaviors to assist with developing appropriate interventions. The Mood State CAA indicated R46 had communication problems and dementia. Further, the CAA indicated R46 was receiving antipsychotics and identified a goal of minimizing risks and managing mood symptoms. There was no assessment of R46's mood and subsequent behaviors to assist with developing appropriate interventions. During interview on 8/25/2016, 8:54 a.m. licensed social worker (SW)-A stated R46 had incomplete CAA's from admission because she was unaware they needed to be completed. Further, SW-A stated R46's CAA's should have been completed prior to day 14 and were not. SW-A stated completing the CAA's was important because the "CAA's drive the care plan." A facility policy was requested for Care Area Assessments, but was not provided.	F 272	documentation (for current residents admitted since January, 2016) was completed on 9/29/16 to ensure those residents have CAAs completed. The review identified 5 residents (including R46) with 7 CAAs that needed additional information for completeness. These included (4) Cognitive, (2) Psychosocial, and (1) Mood. These will be completed by 9/30/16. • Starting 10/3/16 CAAs will be verified for completion by the Care Coordinators prior to submission of the MDS. • An audit by the DON or designee to determine that new residents' CAAs are comprehensive and timely. The audit will be completed on all new residents x3 months starting October, 2016. • The findings of these audits will be reported at the quality assurance meetings. Responsible Parties: DON, Care Coordinators or designee, and LSW	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		9/20/16

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F 279	Continued From page 10 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan to address oral hygiene for 1 of 2 residents (R8) reviewed for activities of daily living and whom was dependant on staff for care. Findings include: R8 had a swallowing screen completed on 9/11/15, by speech therapy (ST) because it was reported R8 was pocketing food in her mouth. ST confirmed R8 pocketed and held food in her left check when eating. ST recommended staff prompt R8 to swallow and chew by offering her	F 279	F279 R-8 Development of Comprehensive Care Plan that has the potential to affect all residents " Resident R8□s plan of care and Nursing Assistant work sheets were updated to reflect that she had a history of pocketing food in her mouth during meals and that oral hygiene is to be completed after meals. " All residents who have potential for pocketing food have had their care plans and Nursing Assistant worksheets updated to reflect therapy recommendations and that oral cares are required after meals.	

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F 279	Continued From page 11 more bites or sips of liquid with meals. R8's quarterly Minimum Data Set (MDS) dated 8/2/16, identified R8 had dementia with severe cognitive impairment. Further, the MDS identified R8 required extensive assistance from staff with eating and personal cares. The MDS did not indicate R8 had any difficulty with pocketing/swallowing foods as identified in the nutritional assessment. R8's care plan (CP) dated 8/13/16, identified R8 had, "potential for altered nutrition due to dementia, hypertension, poor cardiac output, edema, weakness and weight loss." The CP did not identify R8 had a history of pocketing food in her mouth during meals nor did it address providing oral hygiene after meals. On 8/22/16, at 10:45 a.m., approximately two hours after breakfast was served, R8 was seated in her wheelchair in the dayroom. R8 was chewing on a white substance which appeared to be chewed up food. During subsequent observation on 8/24/16, at 11:13 a.m. approximately thee hours after breakfast, R8 had a white grainy substance in her mouth which appeared to be chewed up food. On 8/24/16, at 11:13 a.m. nursing assistant (NA)-E stated R8 required supervision to extensive assistance with meals. Further, NA-E stated R8's mouth should be swapped with a toothette after every meal because she pocketed food in her mouth. After NA-E examined R8's mouth, she stated R8 had food in her mouth and stated "it was not cleaned" after breakfast because she had not "had time."	F 279	" Licensed Nurses will be educated on 9/20/16 to ensure the care plan and Nursing Assistant worksheets are updated to reflect therapy recommendations. " Nursing Assistants were re-educated on 9/15/16 regarding the routine use of their □worksheets□, in order to accurately be following the plan of care for all residents. " An audit of residents□ who pocket food at meals will be conducted to ensure that oral cares are completed after meals. Audits will be completed weekly x4, then monthly x3 starting 9/26/16. " The findings of these audits will be reported at the quality assurance meetings. Responsible Parties: DON or designee Completion Date: 9/20/16	

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F 279	Continued From page 12 On 8/24/16, at 11:32 a.m. licensed practical nurse (LPN)-B stated R8 required total assistance with all ADL's including meals. After LPN-B observed R8's mouth she stated R8 had some type of food in her mouth from breakfast and thought maybe it was oatmeal. LPN-B stated R8 often pocketed food in her mouth during meals and R8 should have her mouth cleaned at least twice a day. A facility Admission of Resident Procedure, revised 5/14, indicated; "Assess/evaluate need for hygiene and grooming the resident as they wish to be groomed (e.g., hair combed and styled, beards shaved/trimmed, nails clean and clipped). Hygiene and grooming needs will be care planned appropriately and reassessed quarterly and prn (as needed)."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete grooming as directed by the care plan for 2 of 3 residents (R5, R8) reviewed for activities of daily living. Findings include: R5's quarterly Minimum Data Set (MDS) dated 6/16/16, identified R5 had moderate cognitive	F 282	F282 R-5 and R-8 Services by Qualified Persons/Per Care Plan (POC) that has the potential to affect all residents " Resident R5 has had facial hair shaved weekly on the bath day since 8/25/16. Resident R8 had nail care completed on 8/26/16 and continues to have nail care completed on the weekly bath day.	9/15/16

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F 282	Continued From page 13 impairment and required extensive assistance from staff for personal cares (including grooming). R5's care plan dated 6/28/16, identified R5 required assistance with grooming, and identified R5's goal was, "Clean, odor free and well groomed daily." The care plan identified a staff intervention to, "Shave facial hair weekly on first bath day of the week." During observation on 8/22/16, at 4:06 p.m. R5 had several long visible white and gray facial hairs on her lower chin and upper neck. R5 stated, "The hair on my chin is too long," adding, "I wish the staff would shave these long hairs on my chin." During subsequent observation on 8/23/16, at 5:14 p.m. R5 continued to have several long white and gray hairs on her lower chin and upper neck. R5 stated staff didn't usually shave her on her bath days. R5 further stated the staff gave her a shower last night about 9:00 p.m. but did not offer to shave her. When interviewed on 8/23/16, at 6:37 p.m. NA-C stated she gave R5 her shower last night, but had, "Never done any facial hair trimming on [R5] on her shower days." NA-C observed R5 and stated R5 had facial hair. NA-C also stated she was unaware R5 should be shaved weekly as directed by her group assignment sheet. During interview on 8/23/16, at 6:44 p.m. registered nurse (RN)-B observed R5 and stated R5 should have been shaved on her first bath of the week as her care plan directed.	F 282	" All residents were physically observed to ensure shaving of facial hair and nail care had been completed on 8/26/16. Any resident found to be in need of shaving hygiene, were shaved. Any resident who was in need of nail care, had nail care provided. " Staff education by the DON regarding how to provide facial shaving and nail care for residents was given on 9/15/16. " Nursing Assistants were re-educated on 9/15/16 regarding the routine use of their □worksheets□, in order to accurately be following the plan of care for all residents. " Random audits to determine that residents□ facial hair is shaved and nail care is completed per their POC will be completed weekly x4, and monthly x3 starting on 9/26/16. " The findings of these audits will be reported at the quality assurance meetings. Responsible Parties: DON or designee Completion Date: 9/15/16	

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F 282	Continued From page 14	F 282		

When interviewed on 8/25/16, at 1:53 p.m. the director of nursing (DON) stated staff should have shaved R5 as directed by her care plan, "I would expect all nursing staff to follow the resident's plan of care."
R8's quarterly Minimum Data Set (MDS) dated 8/2/16, identified R8 had severe cognitive impairment and required extensive assistance from staff for personal cares (including grooming).

R8's care plan dated 8/13/16, identified R8 required extensive assistance with grooming/weekly baths and identified a goal for R8 to be, "clean and well groomed daily."

During observation on 8/22/16, at 10:45 a.m. R8 was seated in her wheelchair in the dayroom. R8 had long fingernails on both of her hands, with several nails having a dark colored substance underneath them.

During subsequent observation on 8/24/16, at 11:13 a.m. R8 continued to have long fingernails with a dark colored substance underneath them.

During interview on 8/24/16, at 11:13 a.m. with nursing assistant (NA)-E stated R8's nails were clipped/cleaned during her bath. After NA-E examined R8's nails she stated, "her nails are dirty and long" and need to be trimmed.

When interviewed on 8/24/16, at 11:32 a.m. licensed practical nurse (LPN)-B stated R8 required total assistance with all ADL's. After LPN-B observed R8's fingernails she stated her fingernails were" long and dirty."

A facility policy on the implementation of the care

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F 282	Continued From page 15 plan was requested, but was not provided.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess behavioral changes for 1 of 1 residents (R46) observed to become upset and anxious during activities of daily living (ADL)'s while staff were providing care. This resulted in actual psycho-social harm (mental health state which occurs because of a severely distressing event) for R46. Findings include: R46's annual Minimum Data Set (MDS) dated 5/11/16, indicated severe cognitive impairment with a diagnosis of dementia with behavioral disturbances, and a mood disorder. R46's annual MDS dated 5/11/16, did not identify any behavioral symptoms or mood assessments and were left blank. On R46's annual MDS dated 5/11/16, R46 had a PHQ-9 (tool used to identify depression levels) identified a score of 28 which indicated severe depression. Review of quarterly MDS dated 8/11/16, indicated R46's PHQ-9 score	F 309	F309 R-46 Provide Care/Services for Highest Wellbeing that has the potential to affect all residents with Psychosocial Needs. " A new Behavior Monitor Worksheet (Attachment A) was developed and started for resident R46 on 8/25/16. The form was updated to capture additional behavior information to be used for care planning. " A meeting with direct care was held on 8/31/16 to review the data from the new monitoring form and to complete a chart review for resident R46. An IDT (Interdisciplinary Team) meeting was held again on 9/7/16 to further review resident R46□s care plan. The care plan was updated to reflect the findings and further interventions. The physician was contacted and updated with the findings and interventions. Input was obtained from the physician. " The new Behavior Monitoring	9/20/16

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F 309	Continued From page 16 was a 0, identifying minimal depression. R46's Cognitive Loss/ Dementia Care Area Assessment (CAA) dated 5/11/16, indicated R46 had Alzheimer's disease, was receiving end of life care and had a decreased ability to make self understood. The CAA indicated R46 needed frequent re-orientation to her environment. Although Cognitive Loss/Dementia and Mood State Care Area Assessments (CAAs) were completed at this time, there was no analysis/assessment of R46's behavioral disturbances, or patterns to assist with developing appropriate interventions to help reduce or remove R46's behaviors. The Mood State CAA, dated 5/11/16, indicated R46 had communication problems and dementia. The CAA indicated R46 was receiving antipsychotics and identified a goal of minimizing risks and managing mood symptoms. R46's care plan, dated 5/23/16, identified, "potential for alteration in mood which is manifested by crying, tearfulness, physically and verbally abusive behavior during baths. Behaviors can occur unprovoked." R46's care-planned interventions included: target behavior monitoring every shift; monitor for side effects from medications; attempting diversion with game shows; give small doll named 'Pete'; offer snacks-likes. Additional care planned interventions were added during the survey on 8/24/16, that identified to offer candy to suck which was soothing and decreased behaviors; pre-treat with gabapentin (generic name for Neurontin to treat nerve pain, help with anxiety) before bath weekly, residents enjoys talking about pets, and when resident agitated she strikes out.	F 309	Worksheets have been initiated on 9/16/16 for residents requiring behavior monitoring. The new behavior monitoring worksheets include care planning interventions for each resident, with an area to document if the interventions were effective and if additional, non-pharmacological interventions were attempted and successful. This information will be reviewed at weekly IDT Behavior Meetings. " Education was provided to the NARs on 9/15/16 by the DON and will be provided to licenses nursing staff on 9/20/16 regarding the new behavior monitoring worksheets. " The IDT Behavior Meeting Guidelines (Attachment B) has been reviewed and updated (Attachment B). " IDT Behavior Meetings will be completed weekly instead of monthly. Residents with behavior issue will be reviewed to ensure interventions are effective and that new interventions are initiated. " An audit to determine that residents Behavior Monitoring Forms are completed accurately will be completed weekly x4, and monthly x3 beginning 9/26/16. The findings of these audits will be reported at the quality assurance meetings " The Social Worker received MDS training on 6/29/16. In addition, she has received CAA and Care Planning training from a Pathway Health Services Consultant on 9/15/16. " An audit to determine that residents psychosocial CAAs are completed accurately will be completed weekly x4,	

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F 309	Continued From page 17 Review of R46's undated Nursing Assistant Aid Care sheet, indicated R46 was to receive baths every Tuesday evening. There was no mention of R46 resisting her baths. During observation on 8/23/16, at 8:10 p.m. R46 was heard screaming and hollering from outside a room labeled, "Bathing Room" next to the entry doors to the locked memory care unit. The surveyor knocked on the door and it was opened by nursing assistant (NA)-G. R46 was visible inside a second shower room seated in a shower chair with her hands over her ears, visible water dripping from her and the chair as she continued to scream nonsensical speech which continued to be audible from the hallway. Trained Medication Aide (TMA)-A was standing in the shower room holding a towel, however, R46 was totally exposed seated on the shower chair facing the wall. At 8:15 p.m. R46 was brought out of the shower room by TMA-A. R46 had her hands over her ears and was crying while stating, "Mother help me." R46's face was red in color and flushed, and she had visible tears in her eyes and on her cheeks. R46 had furrowed eyebrows with a puckered lower lip as she was wheeled in her chair past the nursing station to her room on the opposite side of the unit. TMA-A turned R46's television on for her and left the room the assist another resident. R46 remained seated in her chair with her face in her hands crying and rocking back and forth stating, "Help me, Help me," and, "Mother" several times aloud. At 8:21 p.m. R46 remained in her chair in her room crying and screaming and at times, could be heard from the nursing station. At 8:29 p.m. R46 was no	F 309	and if in compliance, will continue monthly x3 beginning 9/26/16. The findings of these audits will be reported at the quality assurance meetings. " An audit to determine that residents psychosocial POC are completed accurately will be completed weekly x4, and monthly x3 starting 9/26/16. The findings of these audits will be reported at the quality assurance meetings. Responsible Parties: DON, Care Coordinators or designee, and LSW Completion Date: 9/20/16	

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longer crying or screaming, and was watching television quietly in her room.

During interview at the nursing station on 8/23/16, at 8:14 p.m. NA-G stated R46's screaming and crying during her showers was, "Just a behavior for her." R46 often cries out, screams and hits at staff during her shower, "Usually she will just scream and cry," and this had been occurring for the past several months. NA-G stated R46 will, "Usually cry for a little while" after her shower is completed adding she had observed R46 to continue to cry and scream, "For a good hour," after her shower. NA-G stated staff had never tried a different kind of bathing for R46 because she, "Heard the bath leaks," however, added the facility had multiple bathing rooms available to use. NA-G stated she sometimes will give R46 a piece of candy which, "Will help quite a bit," however, nobody had presented her any other interventions to attempt with R46 and her behaviors, "What else can I do?"

During an interview on 8/23/16, at 8:23 p.m. TMA-A stated it was typical for R46 to "scream and cry" with personal cares. TMA-A stated R46 received her scheduled 3:00 p.m. Neurontin (a medication used for anxiety) on time that evening, but R36's shower was delayed several hours later and was given at 8:00 p.m. that evening. As a result of the late shower, TMA-A stated R46 had increased anxiety/stress throughout personal cares. Further, TMA-A stated R46 was "having a hard time" with her shower as she was observed screaming, crying and hitting out at staff and NA-G should have notified him sooner of the situation.

During observation on 8/24/16, at 7:50 a.m. NA-E

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F 309	Continued From page 19 entered R46's room, turned on her bedroom light and left R46's room. Licensed practical nurse (LPN)-B entered R46's room and pulled back the covers on her (R46)'s bed while she (R46) appeared to be sleeping. As a result, R46 woke up and stated, "don't do that" as LPN-B started providing personal cares. LPN-B then placed (R46)'s Ted stockings on, R46 started to cry and stated, "Please don't hurt me" and "that hurts! ouch, ouch" as she (R46) attempted to hit LPN-B's hands. NA-E then entered R46's room to assist with R46's personal cares. As LPN-B placed R46's pants on R46 repeated, "please don't hurt me." LPN-B continued to provide cares and told R46 it would "be okay" several times throughout the process while providing personal cares. NA-E then began washing R46's face, she (R46) started to hit LPN-B's hands and stated, "no, no don't do that" and sobbed intermittently making convulsant gasps in between her cries. As LPN-B and NA-E attempted to place on her (R46)'s shirt she stated, "I am sad" and began to cry, with visible tears coming down her cheeks. When LPN-B turned R46 to her side, R46 gave a loud piercing cry and yelled, "Help me!" and "You are hurting me!" as she (R46) attempted to hit and pinch LPN-B. LPN-B and NA-E continued to provide personal cares and again told R46 it would, "be okay, " as they continued to dress R46. R46 continued to cry and stated, "don't do that, stop it" as LPN-B and NA-E transferred R46 into her wheelchair. At 8:07 a.m. NA-E wheeled R46 into the dining room and gave her a cup of coffee, where R46 continued to intermittently cry until 8:29 a.m.,nearly 20 minutes after morning cares were completed. No staff attempted to intervene and provide comfort to R46 as she was sitting in the dining room.	F 309		

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During interview on 8/24/16, at 11:18 a.m. NA-E stated R46 always "screamed and cried" during personal cares or showers. NA-E stated she was not aware of nursing staff trying different interventions with R46 and stated it was a "very frustrating" situation. Further, NA-E stated it typically took on average "ten to fifteen" minutes for R46 to calm down after receiving personal cares.

During interview on 8/24/16, at 11:33 a.m. LPN-B stated R46 would normally become "upset" with any type of personal cares. Further, LPN-B stated R46 had been like this "since admission" and other than adjusting her (R46)'s medications "nothing has seemed to help much."

During interview with R46's family member on 8/25/16, at 1:53 p.m., R46's family member stated R46 enjoyed taking whirlpool baths because it helped to ease her arthritic pain. Further, R46's family member stated she felt it would cause less anxiety if R46 received a bath because of her (R46) fear of getting hurt during personal cares.

Review of R46's physician progress notes from 5/03/16, through 8/24/16 indicated the following:

5/3/16- Discharge Physician Progress Note Geri-Psych- R46 has began having behavioral problems (screaming, crying, yelling and searching for husband) since moving away from her husband into a memory care unit in May 2015. R46 is often anxious, agitated and very difficult to redirect. She is very uncooperative with cares, and suspicious of staff. Lately she had become physically threatening and agitated.

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F 309	Continued From page 21 5/17/16- Resident is a new resident from geriatric psych who was admitted with hospice and advanced dementia with behavioral issues. R46 is currently restless/anxious and has already been physically/verbally abusive towards staff within the facility. They have seen increased irritability if she is pushed beyond her comfort zone. 8/23/16- The majority of R46's behaviors include crying, yelling, screaming related to cares and when her family leaves following visitation. During the worst times, R46 scratches, kicks and hits at staff. These episodes typically occur two to three times a shift in the mornings/evenings. R46 has also had three episodes of paranoia during July. In review of R46's behavior logs, it is obvious there are times where she is visibly distraught. R46's behaviors can persist for an hour up to an hour and a half at times after personal cares/shower are given. Nursing assistants at the facility explain they keep her nails clipped to decrease injury inflicted to staff by scratching. Review of R46's Target Behavior Monitoring in the month of June 2016, identified approximately 20 episodes of crying/tearfulness which interfered with R46's ADL's. There were no target behaviors identified for physically/verbally abusive behavior in June 2016 behavioral monitoring sheet and no non-pharmalogical interventions were identified to reduce R46's anxiety. In July 2016, R46 had 26 episodes of crying/tearfulness of which 11 of these episodes interfered with R46's ADL's and 5 of these episodes were identified as disturbing and difficult to ignore. In addition, R46 also had target behavior monitoring for physically/verbally	F 309		

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abusive behavior which identified R46 had approximately 20 episodes during the month. Of these incidences,17 of them were identified as interfering with R46 ADL's and 16 of these occupancies were considered disturbing and difficult to ignore. July's target behavior monitoring sheet did not identify any specific non-pharmalogical interventions staff could use to help reduce or prevent R46's target behaviors of anxiety, crying and physically/verbally abusive behavior.

From 7/26/16 through 8/17/16, a facility daily behavioral log was identified several disruptive behaviors of yelling, crying, physically and verbally abusive behaviors. There was no indication what specific non-pharmalogical interventions were completed or if they were effective in decreasing R46's physical/behavior symptoms during personal cares.

Review of R46's "24 Hour Assessment" dated 5/10/16, identified R46 was resistive to cares and required a behavioral management program. After review of R46's medical record, there was no indication a behavioral management program, besides what was identified on the care plan since her (R46)'s admission. There was no indication R46's care plan interventions (offer doll,, diversion and snacks) were implemented or if they decreased her anxiety during personal cares after review of R46's medical record.

Review of nursing notes from May 2016 identified at the end of the month R46 began becoming resistive towards personal cares and identified behaviors of increased anxiety and verbal/physical aggression towards facility staff which lasted anywhere from 30 to 60 minutes in

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duration. There was no indication of what intervention were implemented and if they were effective.

After review of June 2016 nursing notes, it was identified R46 began having increased anxiety and tearfulness after her (R46) family left after visits. R46 continued to express verbal and physical behaviors during personal cares. 1:1 monitoring, comforting R46 and distraction was found not be be beneficial interventions.

Review of July's 2016 nursing noted identified R46 began refusing prescribed medications. R46 continued to have verbal/physical abusive behaviors towards facility staff during personal cares and showers. No successful non-pharmalogical interventions were identified.

In August 2016, R46 began having an increase in paranoid behaviors towards facility staff (i.e. accusations of facility staff feeding her 'old food' and were talking negatively about her). Licensed social worker (SW) identified nursing needed to assess R46's target behaviors as she (R46) continued to be verbally/physically abusive towards facility staff.

During interview on 8/25/16, at 8:54 a.m. LSW-A stated approximately one week after being admitted to the facility R46 started becoming anxious with cares, and was physical/verbally abusive towards facility staff. These behaviors for R46 have continued since her admission to the facility. LSW-A stated the facility was completing daily target behavior monitoring, but no analysis of trends or new care plan interventions had been attempted since her (R46)'s admission.

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The Mood State CAA, dated 5/11/16, indicated R46 had communication problems and dementia. The CAA indicated R46 was receiving antipsychotics and identified a goal of minimizing risks and managing mood symptoms.

LSW-A stated the purpose of the Care Area Assessments (CAA)s is to, "drive the care plan." LSW-A stated a psychology consult should have been recommended with R46 to help address R46's increase in anxiety and verbal/physical symptoms with personal cares. Further, LSW-A stated R46 was not "as secure and comfortable" as she should have been at the facility and acknowledged her role was to work with staff to address R46's behaviors

When interviewed on 8/25/16, at 9:38 a.m. registered nurse (RN)- B stated she had not coordinated with the social worker in the past in regards to CAA assessments and the development of the resident's care plan. RN-B stated R46's behavior began in May 2016 and became worse near the end of July/beginning of August 2016. Further, RN-B stated she should have communicated more with floor staff about R46's behaviors during personal cares and her (R46)'s care plan should have been modified accordingly.

During interview on 8/25/16, at 10:13 a.m. director of nursing (DON) stated there should have been more coordination of care for R46 between the social worker and interdisciplinary team in regards to R46's ongoing anxiety with personal cares. Further, DON stated it was the responsibility of the care coordinator to monitor R46's ongoing behaviors and to modify the

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F 309	Continued From page 25 interventions/care plan accordingly which had not occurred in this situation. DON acknowledged R46 had very few interventions added to her care plan and stated the social worker/care coordinator should have been monitoring personal cares to get a "better idea" of R46's anxiety with cares. Although R46 was distraught with personal cares in which she screamed, cried and becomes inconsolable even after cares were completed for approximately 1 to 1.5 hours. The facility had not comprehensively reassessed R46's increased behaviors of physical aggression, crying, and screaming during personal cares. The facility had not changed or modified interventions to help decrease or removed R46's ongoing anxiety/behaviors which resulted in actual psychosocial harm for R46. Review of facility policy titled, "Target Behavior Monitoring," dated 03/2014, indicated it was the responsibility of the care coordinator for reviewing target behaviors, and providing a summary to the physician during rounds. Target behavior monitoring should examine a review of the residents diagnosis, psychotherapeutic medications, target behaviors, potential casual factor and interventions.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311		9/26/16

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F 311	Continued From page 26 by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to maximize independence with eating for 1 of 3 residents (R17) reviewed for activities of daily living (ADLs) who had a change in ability to feed themselves. Findings include: R17's admission Minimum Data Set (MDS) dated 3/17/16, identified R17 had moderate cognitive impairment, and required set up with supervision for eating. R17's progress note dated 4/8/16, identified R17 required, "Extensive assist with adl's, except supervision with eating." R17's most recent quarterly MDS dated 6/16/16, identified R17 had severe cognitive impairment, but now required extensive assistance from staff with eating. R17's care plan dated 7/1/16, identified R17 had an, "Alteration in EATING," and listed a goal for R17 to, "Cont [continue] to feed self as able." The care plan identified R17 required, "Extensive assist with eating." During observation of meal service on 8/24/16, at 12:27 p.m. R17 was assisted to a table and provided cut up meat, cubed vegetable medley, and 1/2 a baked potato. Activities assistant (AA)-A sat on R17's right side and began to feed R17. AA-A fed R17 for the duration of the meal. R17 received no encouragement or assistance to attempt to feed herself. R17 had no modified utensils or dishes for eating. R17 was removed from the table at 12:56 p.m.. On 8/24/16, at 12:52 p.m. nursing assistant	F 311	F311 R-17 Treatment/Services to improve/maintain ADLs (A resident is given the appropriate treatment and services to maintain or improve his or her abilities). This has the potential to affect all residents. • Resident R17 was seen by Speech Therapy on 9/9/16 and 9/14/16 to assess needs regarding feeding. Recommendations were given and her care plan was updated to reflect the changes. • An assessment (by observation in the resident dining room at a noon meal) comparing feeding assistance to the care plan was completed. Discrepancies were referred to the Care Coordinators to follow up to determine to asses and determine if a referral (physician, dietitian, or therapy) and a revision of the care plan might be needed. • The “Activities of Daily Living Identification of Changes” document (Attachment D) was developed and education regarding this was given to the NAR staff during staff meetings on 9/15/16 and to the Licensed Nursing staff on 9/20/16. • Audits (by observation) of those residents’ who require assistance at meals will be conducted and compared with the plan of care to ensure the plan of care is reflective of the actual residents’ assistance needed. Audits will be completed weekly x4, then monthly x3, beginning 9/26/16. • The findings of these audits will be reported at the quality assurance	

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F 311	Continued From page 27 (NA)-H stated R17, "Used to be able to eat" on her own, however was no longer feeding herself at meals. NA-H stated R17 will at times take bread or a roll food from her plate, take a bite then set it back down. NA-H added R17, "might" try to feed herself if given encouragement. NA-H stated the registered nurses were aware of the need for total assistance with meals. On 8/24/16, at 1:05 p.m. NA-A stated R17 was, "A total assist as far as feeding goes," however will at times pick up a glass or attempt to take a drink of fluids on her own. NA-A stated R17 struggled to hold glasses up to her mouth on her own. NA-A stated she was unaware if therapy had ever been consulted about R17's need for feeding assistance. On 8/24/16, at 3:40 p.m. registered nurse (RN)-A stated R17 required, "Pretty much extensive total assist" with eating. R17 had recently seemed to, "just drop" her ability to feed herself, "in a short amount of time." RN-A stated R17 still had, "maybe some" potential to feed herself, however had not been assessed to determine why there was a change, or what interventions may be helpful to improve her ability to feed herself. RN-A stated staff should contact occupational therapy (OT) if there was a change in eating ability. RN-A stated R17 had not been referred to OT. During interview on 8/25/16, at 11:03 a.m. the director of rehab (DOR) stated OT had several pieces of adaptive equipment available to potentially help R17 feed herself. The DOR added, OT should have been contacted when it was identified R17 had a change in ability. A facility policy on assessing a change in ability	F 311	meetings. Responsible Parties: DON, Care Coordinators or designee	

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F 311	Continued From page 28 with ADL's was requested, but none was provided.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral hygiene, nail care, and facial hair removal was provided for 2 of 3 residents (R8, R5) reviewed for activities of daily living and whom were dependant on staff for care. Findings include: R8's quarterly Minimum Data Set (MDS) dated 8/2/16, identified R8 had severe cognitive impairment and required extensive assistance from staff for personal cares. R8's care plan dated 8/13/16, identified R8 required extensive assistance with grooming/weekly baths and identified a goal for R8 to be, "clean and well groomed daily". On 9/11/15, R8 had a swallowing screen completed by speech therapy (ST) because it was reported R8 was pocketing food in her mouth. After confirming the pocketing, ST recommended staff prompt R8 to swallow and	F 312	F312 R-8 and R-5 ADL Care Provided for Dependent Residents with the potential to affect 3 out of 3 residents • All residents who have potential for pocketing food have had their care plans and nursing assistant worksheets updated to reflect therapy recommendations and that oral cares are required after meals. • Licensed Nurses will be educated on 9/20/16 to ensure the care plan and nursing assistant worksheets are updated to reflect therapy recommendations. • Nursing Assistants were re-educated on 9/15/16 regarding the routine use of their 'worksheets', in order to accurately be following the plan of care for all residents. • Audits of residents' who pocket food for 3 of 3 residents at meals will be conducted to ensure that oral cares are completed. Audits will be completed weekly x4, then monthly x3 starting 9/26/16.	9/20/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 29 chew by offering her more bites or sips of liquid with meals. On 8/22/16, at 10:45 a.m. R8 was seated in her wheelchair in the dayroom. R8 had long fingernails on both hands,with several nails having a dark colored substance underneath. Further, R8 was chewing on a white substance (appeared to be chewed up food) in her mouth. On 8/24/16, at 11:13 a.m. R8 continued to have long, dirty fingernails and a white grainy substance in her mouth. On 8/24/16, at 11:13 a.m. with nursing assistant (NA)-E stated R8 required extensive assistance of one with all cares and her bath day was on Mondays. Further, NA-E stated R8's nails were clipped/cleaned on bath days. After NA-E examined R8's nails she stated, "her nails are dirty and long" and needed to be trimmed. NA-E also stated R8's mouth should be swabbed with a toothette after every meal because she had pocketed food in her mouth after meals. After NA-E examined R8's mouth, she stated R8 had food in her mouth and stated it was not cleaned after breakfast. When interviewed on 8/24/16, at 11:32 a.m. licensed practical nurse (LPN)-B stated R8 required total assistance with all ADL's. After LPN-B observed R8's fingernails she stated her fingernails were long and dirty. Further, after observing R8's mouth LPN-B stated R8 had some type of food in her mouth from breakfast and thought maybe it was oatmeal. LPN-B stated R8 should have her mouth cleaned at least twice a day. R5's quarterly Minimum Data Set (MDS) dated	F 312	• Resident R5 has had facial hair shaved weekly on the bath day since 8/25/16. Resident R8 had nail care completed on 8/26/16 and continues to have nail care completed on the weekly bath day. • All residents were physically observed to ensure shaving of facial hair and nail care had been completed on 8/26/16. Any resident found to be in need of shaving hygiene, were shaved. Any resident who was in need of nail care, had nail care provided. • Staff education by the DON regarding how to provide facial shaving and nail care for residents was given on 9/15/16. • Nursing Assistants were re-educated on 9/15/16 regarding the routine use of their 'worksheets', in order to accurately be following the plan of care for all residents. • Random audits to determine that residents' facial hair is shaved and nail care is completed per their POC will be completed weekly x4, and then monthly x3 starting on 9/26/16. • The findings of these audits will be reported at the quality assurance meetings. Responsible Parties: DON or designee	

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6/16/16, identified R5 had moderate cognitive impairment and required extensive assistance from staff for personal cares.

R5's care plan dated 6/28/16, identified R5 required assistance with grooming,with a goal of, "Clean, odor free and well groomed daily". The care plan directed staff to, "Shave facial hair weekly on first bath day of the week".

An undated care sheet (guide directing resident care for nursing assistants) indicated, "Shave facial hair w [with]/shower." The care sheet identified R5 received a shower every Monday and Friday evening.

On 8/22/16, at 4:06 p.m. R5 had several long visible white and gray facial hairs on her lower chin and upper neck. R5 stated, "The hair on my chin is too long," adding, "I wish the staff would shave these long hairs on my chin."

On 8/23/16, at 5:14 p.m. R5 continued to have several long white and gray hairs on her lower chin and upper neck. R5 stated she received two baths per week on Monday and Friday evenings, but the staff didn't usually shave her on the bath days. R5 further stated the staff gave her a shower last night about 9:00 p.m. but did not offer to shave her.

On 8/23/16, at 6:21 p.m. nursing assistant (NA)-B stated R5 received a shower on Monday and Friday evenings. Further, NA-B observed R5 and stated, "[R5] does have facial hair on her chin and it needs to be trimmed."

On 8/23/16, at 6:37 p.m. NA-C stated she gave R5 her shower last night, but had, "never done

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F 312	Continued From page 31 any facial hair trimming on [R5] on her shower days". NA-C observed R5 and stated, "[R5] does have facial hairs on her chin right now" adding, "She does need to be shaved." Further, NA-C stated she was unaware R5 should be shaved weekly as directed by the care sheet. On 8/23/16, at 6:44 p.m. registered nurse (RN)-B observed R5 and stated R5 should have been shaved on her first bath of the week. A facility Admission of Resident Procedure, revised 5/14, indicated, "Assess/evaluate need for hygiene and grooming the resident as they wish to be groomed (e.g., hair combed and styled, beards shaved/trimmed, nails clean and clipped). Hygiene and grooming needs will be care planned appropriately and reassessed quarterly and prn (as needed)."	F 312		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		9/20/16

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F 431	Continued From page 32 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Duragesic patches were destroyed in a timely manner to reduce the risk of potential diversion for 1 of 1 residents (R30) observed to have used patches left in the medication cart. This deficient practice had potential to affect 3 of 3 residents (R30, R15, R26) in the facility who had current orders for transdermal narcotic patches. In addition, the facility failed to ensure insulin was labeled accurately with current physician orders for administration for 1 of 2 residents (R48) reviewed for insulin administration. Findings include: NARCOTIC PATCH DESTRUCTION: A current facility Fentanyl Patch listing dated	F 431	F431 R=30, R-15, R-26 Drug Records, Label/Storage Drugs and Biologicals with the ability to affect all residents " The Duragesic patch for resident R30 was destroyed on 8/25/16 per policy guidelines. " The policy Duragesic Patch Disposal (Attachment E) was updated to reflect storage of medication patches if no other licensed staff members were immediately present to witness the destruction. Licensed nursing staff will be educated on this policy on 9/20/16. " A random audit to determine that residents Duragesic patches are stored appropriately until the nurse is able to find another nurse to destroy the patch with him/her, will be completed weekly x4, then	

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F 431	Continued From page 33 8/25/16, identified R30, R15, and R26 had current orders for Fentanyl patches (a narcotic pain patch). On 8/25/16, at 10:53 a.m. the north unit medication cart was reviewed with registered nurse (RN)-C. The top drawer of the cart was opened and a folded light brown patch which read, "Fentanyl 50 mcg/h [micrograms/hour]" was sitting inside a plastic container. RN-C stated it was, "a used one" she had removed from R30 approximately "an hour and a half" ago. RN-C stated she was waiting to find another nurse so it could be destroyed but there was "nobody around at the moment." RN-C stated setting it inside the medication cart under only a single lock was, "probably a bad place to put it," for "sanitary reasons," and because, "there's a potential for narcotics to be still in that [patch]." On 8/25/16, at 1:49 p.m. the director of nursing (DON) stated staff was expected to fold the used narcotic patches in half and flush them with a second person. Further, the DON stated having used patches sitting in the top of the medication cart was, "an infection control issue," but was not concerning for potential drug diversion because staff, "could take it anytime." A facility Medication Removal/Destruction of Duragesic Transdermal Patch policy dated 6/16, identified, "Duragesic patches still contain some medication when they are timed to be removed," and directed staff to fold the used patch in half and flush it down the toilet with two staff members witnessing the disposition. The policy did not provide direction on how to securely store/dispose of used patches if no other staff members were immediately present to witness	F 431	monthly x3 starting 9/26/16. " The findings of these audits will be reported at the quality assurance meetings. " A sticker, □Check Dosage Strength□ was place on the insulin label on 8/25/16 for resident R48. " The policy LTC □Pharmaceutical Services (Attachment F) will be reviewed with the Licensed Nurses on 9/20/16. The policy includes the use of the □Check Dosage Strength□ stickers that are to be placed over the dosage part of the medication label when a new order is obtained that changes the dosage. " A random audit to determine that residents□ medication labels match the MAR and physician orders will be completed weekly x4, then monthly x3 starting 9/26/16. " The findings of these audits will be reported at the quality assurance meetings. Responsible parties: DON or designee and Care Coordinators Completion Date: 9/20/16	

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F 431	Continued From page 34 the destruction. INACCURATE LABELING: On 8/23/16, at 6:06 p.m. registered nurse (RN)-D removed a Lantus (insulin) Solostar pen from the medication cart and prepared to administer it to R48. RN-D provided the insulin pen to the surveyor for review. The pen was labeled with directions of, "Inject 18 units SQ [subcutaneously] at bedtime". RN-D applied a needle to the pen and turned the dial on top of the pen to a dose of 22 units stating, "That's what it states her in the MAR [medication administration record]." RN-D then administered 22 units of insulin to R48. On 8/23/16, at 6:25 p.m. RN-D stated R48 only had one Lantus insulin pen in the medication cart for use adding she had, "noticed her label said 18 [units]." RN-D stated R48's insulin order was changed on 7/22/16 (31 days prior) and the label had not been changed to identify the new orders. RN-D stated medication labels should match the physician orders, "to avoid an error," because they, "could end up giving the 18 units instead of the 22 units." Further, RN-D stated, "[I'm] not sure if I have seen a [medication] label modified." During interview on 8/25/16, at 1:49 p.m. the director of nursing (DON) stated staff should have placed a sticker on the incorrect label which would alert them to consult with the most recent physician orders. Further, the DON stated labels should match the most current physician orders, "to prevent medication errors." A facility Pharmaceutical Services policy dated 6/16, directed staff, "When a medication dosage changes, via practitioner orders, a sticker with	F 431		

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F 431	Continued From page 35 'change of orders' will be placed over the previous medication order until a new label is obtained."	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oxygen equipment was kept in a clean and sanitary manner for 1 of 2 residents (R17) observed to use oxygen. In addition, the facility failed to ensure resident living spaces were kept in good repair for 5 of 5 resident rooms (RM) including (RM-21, RM-50, RM-24, RM-19, RM-14) observed to have damaged walls. Findings include: UNCLEAN OXYGEN EQUIPMENT: R17's quarterly Minimum Data Set (MDS) dated 6/16/16, identified R17 had severe cognitive impairment and received oxygen therapy. R17's signed physician orders dated 7/7/16, identified an order for, "O2 [oxygen] at 2L [2 liters] per n/c [nasal cannula] to keep sats [amount of oxygen in the blood] 90% or greater". On 8/22/16, at 2:44 p.m. R17 was in bed with her	F 465	F465 R-17, (Rooms 21, 50, 24, 19, and 14) Safe/Functional/Sanitary/Comfortable Environment with the potential to affect all residents • Resident R17's oxygen concentrator, including the filter was cleaned on 8/26/16. • All oxygen concentrators were checked on 8/26/16, and those requiring cleaning, including the intake filter, were cleaned at that time. • Staff education regarding 'Routine Oxygen Use Guidelines' was provided to the professional nursing staff on 9/20/16. The routine cleaning of the oxygen concentrator, including the weekly cleaning of the intake filters is included in the guidelines. • The 'Routine Oxygen Use Guidelines' (Attachment G) is included on the TAR for nurses to sign off when the cleaning is completed. • An audit to determine that Oxygen	9/26/16

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F 465	Continued From page 36 eyes closed. R17 had a nasal cannula in place which was connected to a AirSep NewLife oxygen concentrator placed behind her recliner chair. The oxygen concentrator had a filter on the back of the machine which had a dull white color. The filter was removed and inspected. The filter was nearly occluded with copious amounts of thick, clumping dust and debris. During subsequent observation on 8/24/16, at 10:14 a.m. R17 was again in bed with her eyes closed with a nasal cannula in place providing oxygen from the AirSep oxygen concentrator. The filter on the back of the machine remained a dull white color and nearly occluded with copious amounts of thick, clumping dust and debris. When interviewed on 8/24/16, at 11:56 a.m. nursing assistant (NA)-A stated R17 used the oxygen concentrator when she is in bed, and the floor nurses were responsible to clean the equipment, "The nurses do that." R17's Treatment Administration Record (TAR) dated 8/2016, directed staff to, "Changes 02 tubing, clean off concentrator with damp cloth and clean filter q [every] week." The last time this task was initialed as being completed was 8/20/16 (two days prior). During interview on 8/24/16, at 12:00 p.m. licensed practical nurse (LPN)-A stated the oxygen equipment, including the filters, were supposed to be cleaned on a weekly basis and recorded in the treatment administration record (TAR). LPN-A observed R17's oxygen concentrator filter with the surveyor at 12:01 p.m. and stated, "It didn't get cleaned." Further, LPN-A stated R17's oxygen concentrator filter	F 465	concentrators/intake filters are clean will be conducted weekly x4, then monthly x3 starting 9/26/16 and will be reported to the Quality Assurance Committee quarterly. • All areas of damaged walls noted on the plan of correction were repaired by 9/16/16. • All other resident rooms were inspected on 9/13/16 and a list of additional repairs has been made. A repair schedule has been developed for these areas for completion as soon as possible, and least disruption to the residents. • A procedure (Attachment H) regarding Resident Room Inspections was developed on 9/13/16. The procedure includes a check list of resident room issues that will be inspected starting the third quarter to ensure resident rooms are in good repair. • The Housekeeping, Facilities, and Nursing Staff members were educated (by memo) on the requirement of observing and reporting wall damage or other repairs needed for either resident rooms or public areas. The staff was instructed to use the “Facility Dude” system for reporting needed repairs. This memo was distributed on 9/19/16. • The completed quarterly (3rd Quarter) room inspection check list will be given to the DON for review of repair completion or other follow up starting 9/26/16. • The findings of these audits will be reported at the quality assurance meetings. Responsible Parties: DON or designee	

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F 465	Continued From page 37 should of been cleaned, "So it doesn't overheat and runs properly." When interviewed on 8/24/16, at 4:36 p.m. registered nurse (RN)-A stated oxygen concentrator filters should be cleaned on a weekly basis, "So they run properly." A NewLife Elite Patient Manual dated 03/02, identified the oxygen concentrator filter should be cleaned, "On a weekly basis," and, "Cleaned and positioned correctly" before operating the machine. When interviewed on 8/25/16, at 9:04 a.m. the AirSep Field Service Engineer (FSE) stated the oxygen concentrator filter should be, "cleaned weekly and switched out," and allowing dust and debris to collect on the filter, "could potentially have a fire risk." Further, the FSE stated if the filter was left occluded, the machine could switch off and the patient would not have any oxygen flow, "it may keep running, it may not." An undated facility Routine Oxygen Use Guidelines policy directed staff to, "Clean external intake filters on concentrator weekly and wipe off cabinet with damp cloth and water weekly." DAMAGED WALLS: On 8/22/16, at 3:07 p.m. RM 21 was observed to have several dents in the plaster on the interior wall located behind the resident's bed and behind the resident's recliner. When interviewed on 8/24/16, at 7:09 a.m. nursing assistant (NA)-D stated there were dents in the wall behind the resident's bed and behind	F 465	and Facilities Manager or designee	

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the resident's recliner in RM 21. The dents were from the resident's recliner going back too far and hitting the wall. NA-D further stated these dents definitely "need to be repaired" and "are an eyesore."

During interview on 8/24/16, at 8:21 a.m. the facility maintenance (FM) stated there were dents on the wall in RM 21. The FM stated the dents measured 27" (inches) x (by) 9" behind the resident's bed and 13" x 56" behind the recliner and may have been caused by the brass buttons on the back of the resident's recliner. The FM added, these areas had to be patched, painted, cosmetically, did not look very nice, and needed to be repaired.

On 8/22/16, at 10:34 a.m. RM 50 was observed to have several scuff marks on the wall next to the head of the bed. The wall was tan in color with white sheetrock exposed in several areas.

When interviewed on 8/24/16, at 7:23 a.m. NA-D observed wall in RM 50 and stated there were several scrapes on the wall next to the bed. NA-D stated these "need to be repaired" and the scrapes "are an eyesore."

During interview on 8/24/16, at 8:46 a.m. the FM stated there were scrapings on the wall in RM 50 behind the resident's bed that measured 4" x 22" and they needed to be patched and painted.

On 8/22/16, at 11:47 a.m. RM 24 was observed to have approximately nine scrapings on the wall with missing paint in the resident's bathroom above the light switch. There were also two small gouges in the sheetrock behind the resident's door in her room.

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F 465	Continued From page 39 When interviewed on 8/24/16, at 7:10 a.m. NA-D stated there were two dents on the wall behind the door in RM 24. There was also paint missing on the wall in the bathroom. NA-D stated the wall needed to be repaired and the wall was an eyesore. During interview on 8/24/16, at 8:27 a.m. the FM stated there were two gouges on the lower portion of the wall in RM 24 that measured 3/4" x 1/2" and 1/2" x 3/8" In addition, the FM stated something must have been taped to the bathroom wall, then removed, causing the paint to come off. The FM stated the area with paint missing in the bathroom measured 12" x 15" and the damage to the walls in RM 24 needed to be repaired. On 8/22/16, at 3:56 p.m. RM 19 was observed to have a large area with paint missing on the wall near the outside of the resident's bathroom door near the resident's bed. When interviewed on 8/24/16, at 7:14 a.m. NA-D stated there was scraping on the wall in RM 19 near the resident's bed. NA-D stated the wall did not look very nice and this should have been reported and repaired a long time ago. During interview on 8/24/16, at 8:35 a.m. the FM stated there was an area of scraping on the west wall near the resident's bathroom in RM 19. It measured 18' x 26" and needed to be repaired. On 8/22/16, at 10:22 a.m. RM 14 was observed to have several scrapes on the wall located behind the resident's recliner.	F 465		

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When interviewed on 8/24/16, at 7:27 a.m. NA-D stated there were several scrapes and gouges in the wall behind the resident's recliner. NA-D added, the damage was probably caused from the resident's recliner hitting the wall, the wall did not look very nice, and it was an eye sore.

During interview on 8/24/16, at 8:31 a.m. the FM stated there was wall damage that measured 15" x 5" caused from the brass button on the back of the resident's recliner in RM 14. Further, the FM stated the wall needed to be repaired, mudded, and repainted, and added, the wall did not look good.

When interviewed on 8/24/16, at 6:50 a.m. NA-D stated if staff find damage in a resident's room a Facility Dude report (reporting system/work order the facility used to report damage) should be completed on the computer. During a subsequent interview on 8/24/16, at 7:29 a.m. NA-D stated all of the wall damage is an "eye sore" and "definitely needs to be repaired." In addition, a Facility Dude report "should have been completed" on all these damaged walls and maintenance should have repaired these issues. Further, most of the wall damage has been this way for a "very long time."

During interview on 8/24/16, at 8:02 a.m. FM stated the facility had on online Facility Dude reporting system that allowed staff to generate a work ticket for repairs or anything else the maintenance department needed to look at. After the form was completed, the maintenance department received the work orders, prioritized the issues, and fixed the issue as soon as possible. The FM also stated he "cannot always rely on staff reporting", so he completed a monthly safety walk through of the facility and

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	245127	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 DEFICIENCY)	(X5) COMPLETION DATE
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reported his findings to the safety committee monthly. The FM stated, "I do not look at each room every month as I cannot get into each room." In a subsequent interview on 8/24/16, at 9:16 a.m. the FM stated, I currently "do not" have work orders on any of the rooms noted with damage. The FM added, "I don't know" why staff was not filling out the Facility Dude forms online. Each of the issues of damage to the walls "should have" been reported by the staff on Facility Dude. Further, the FM stated, "I feel this this is a problem" and I will need to follow-up and provide staff education on when a Facility Dude form is required. In addition, the FM added, the audit sheet currently used each month "does not include cosmetic wall issues" so "I will have to add cosmetic wall issues to the audit form."

When interviewed on 8/24/16, at 2:58 p.m. the director of nursing (DON) stated there was "obvious wall damage" noted in some resident rooms and the damage needed to be repaired as soon as possible.

A Facility Maintenance and Repairs policy revised 7/16, identified, "the facilities and maintenance engineer walk our facility monthly in search of needed repairs, all items are logged on a form that is presented to our Safety committee in a monthly report. Any repairs found are assigned to maintenance staff, these repairs usually are reported on our facility dude for tracking purposes to make sure reported issues are completed. Staff can also call our maintenance shop to report repairs needed."

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	245127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/24/2016**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/20/2016

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

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	245127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/24/2016**

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MILLE LACS HEALTH SYSTEM	**200 NORTH ELM STREET** **ONAMIA, MN 56359**

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K 000	Continued From page 1	K 000		

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

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

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

2. The actual, or proposed, completion date.

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

Mille Lacs Health Center is a 1-story building with no basement. The original building was constructed in 1961 with an addition constructed in 1971. The 1961 building is of type II(111) construction and the 1971 building is type II(111) construction. Therefore, the nursing home was inspected as one building. From 2002-2004 the facility under went a complete renovation. A hospital, properly separated, is connected to the nursing home.

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

The facility has a licensed capacity of 57 beds

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K 000	Continued From page 2 and had a census of 45 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. 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. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.6.3.2. This deficient practice could affect 10 of 57 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 9:00 AM to 1:00 PM on 08/24/2016, observations revealed that there was	K 018	K018 Kick down door hold on Beauty Shop door On 8/25/16 maintenance staff removed the kick down door hold from the door of the beauty shop by Gerald Vogtlin, Facilities Maintenance Director. A door hold open mechanism was ordered and installed on 9/16/16. Responsible Parties: Facilities Manager or designee	9/16/16

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K 018	Continued From page 3 an unapproved kick-down door hold open devise holding the corridor door to the beauty shop in the open position. This deficient condition was verified by a Maintenance Supervisor.	K 018	Completion Date: 9/16/16	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 12 of 35 residents, as well as an undetermined number of staff, and visitors Findings include: On facility tour between 9:00 AM to 1:00 PM on 08/24/2016, observation revealed, that the smoke detector located in the memory care unit outside of the storage room was installed within 36 inches of a HVAC vent diffuser.	K 052	K052 Smoke detector located in the memory care unit was installed within 36 inches of a HVAC vent diffuser. On 8/25/16 the smoke detector was moved over 24 inches, therefore complying with the 36 inch requirement to be away from the HVAC vent diffuser, as witnessed by Gerald Vogtlin, Facilities Maintenance Director. Responsible Parties: Facilities Manager Completion Date: 8/25/16	8/25/16

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K 052	Continued From page 4 This deficient condition was verified by a Maintenance Supervisor.	K 052		