Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 23, 2024

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

RE: CCN: 245127
Cycle Start Date: January 10, 2024

Dear Administrator:

On January 10, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nikki Sassen, BSN, RN
Regional Operations Supervisor
St. Cloud Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by April 10, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 10, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	C 01/09/2024

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
E 000	Initial Comments On 1/7/24 through 1/9/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/7/24 through 1/9/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed, found in Complainace, with NO deficiencies cited: H51278484C (MN00096814). The following complaints were reviewed found not in Compliance: H51278482C (MN00095852) with no deficiency cited. H51278483C (MN00092986) with no deficiency cited. H51278485C (MN00091544) with no deficiency cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/01/2024

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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F 000	Continued From page 1 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to routinely provide and document range of motion (ROM) exercises to maintain and prevent decline in current physical functioning for 1 of 1 resident (R18) reviewed for restorative therapies.	F 688	The Administrator and Director of Nursing will provide education to all nursing staff during a staff meeting to be held on February 13th and February 20th, 2024. The education provided will include why providing ROM and other restorative exercises is important, including risks and	2/21/24

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F 688	Continued From page 2 Findings include: R18's quarterly Minimum Data Set (MDS) dated 12/22/23, indicated R18 had moderately impaired cognition and diagnoses of multiple sclerosis (a chronic disease that affects the central nervous system but attacking myelin, a substance that protects nerve cells) and paraplegia (paralysis of the legs and lower body). R18 needed extensive assistance with activities of daily living (ADL's). R18 had impairments to both sides of upper and lower extremities and no rejection of cares. R18's care plan printed 1/9/24, indicated that R18 would participate in maintenance nursing range of motion (ROM) exercises to bilateral (both sides of body) upper and lower extremities daily. R18's physician orders printed 1/9/24, indicated maintenance nursing: ROM exercises on bilateral lower and upper extremities 7x/week. During record review, task documentation indicated that R18 had received PROM exercises on upper and lower extremities four out of the last 30 days. During interview on 1/9/24 at 10:30 a.m., nursing assistant (NA)-A stated NAs did not complete exercises with R18 and was not sure if R18 had a range of motion program. During interview on 1/9/24 at 12:18 p.m., registered nurse clinical manager (RN)-A stated the nursing assistants performed the ROM exercises for R18. During interview on 1/9/24 at 12:33 p.m., NA-B stated she assisted R18 with cares and did not	F 688	benefits. During the meeting and staff education, the expectations will be outlined on when these tasks should be be performed and how they are to be correctly documented in EMR. An EduCare module on ROM and client mobility, which covers the importance of ROM, has already been assigned. The resident identified has a ROM program established and this task is scheduled for the NAR's to complete daily per the resident's request. This task has been added to the nurses treatment record to oversee that this is being completed as ordered. The Director of Nursing will identify other residents with the potential to be affected by the same deficient practice by performing audits on all resident ROM and restorative nursing programs. A separate ROM policy will be established from our current Restorative Nursing policy to outline these expectations. This will be completed by the Director of Nursing. Quarterly audits will be performed by the RN Care Coordinators during the MDS assessment period for each resident to determine if the ROM or restorative nursing program is being completed as ordered. This will be incorporated into assessments completed for the MDS.	

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F 688	Continued From page 3 complete range of motion exercises with R18. During interview on 1/9/24 at 12:55 p.m., RN-B stated the nursing assistants are expected to complete the ROM exercises with the residents. RN-B stated the restorative nursing tasks have fallen by the wayside since the facility currently does not have any restorative nursing assistants. RN-B stated physical therapy was coming to reassess the therapy plans to see if ordered programs were appropriate for residents. RN-B was not able to provide specific dates when reassessment when this was to occur. RN-B confirmed that ROM exercises were not being done as ordered for R18. During interview on 1/9/24 at 1:42 p.m., director or nursing (DON) stated ROM exercises were previously being done by the maintenance nursing assistants and that due to staffing the facility had to eliminate that position. DON stated ROM exercises are assigned on the nursing assistants' tasks to complete and are expected to complete them. DON confirmed that R18 had not had ROM exercises completed as ordered. DON stated that it was important for R18 to have ROM exercise completed to maintain his highest level of functioning, especially since R18 was a paraplegic. DON stated R18 had not had any decrease in his ROM currently due to exercises not being completed. The facility policy "Nursing Maintenance Program" dated 6/21, indicated the facility to ensure that a Nursing Maintenance Program is an integral part of nursing care, and that nursing care strives to prevent deterioration and maintain optimal level of functioning and independence. Active and passive Range of Motion plans are	F 688		

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F 688	Continued From page 4 directed per nursing recommendation. Residents may receive the appropriate treatment by a Rehab Aide or by a member of the nursing staff.	F 688		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess for and identify past trauma (PTSD) for 1 of 1 resident (R8) who had a history of multiple past traumatic experiences. Findings include: R8 was re-admitted the the facility from Senior Services (geriatric-psych services - SCS) on 11/14/23 where he had been admitted due to behaviors of striking out, yelling, biting and other threatening behaviors. R8's admission Minimum Data Set (MDS) dated 11/20/23, identified resident as being severely cognitively impaired, Alzheimer's type dementia, and behaviors were noted in the look back period. R8's Behavior Care Area Assessment (CAA) worksheet (dated 11/20/23) documented the following: "Resident's behavior symptoms not currently directed at other residents. Behaviors occur most with staff and with cares. He will	F 699	Administrator and DON will provide staff education on the importance of trauma informed care at staff meeting on February 13th and February 20th, 2024. Trauma informed care education will include why trauma informed care is important, what our process will be for providing trauma informed care, and how to determine previous traumas and establish appropriate resident centered care plans. Educare module covering trauma informed care has been assigned. Trauma informed care policy and procedure will be established by the Director of Nursing. Policy and Procedure will reflect trauma informed care practices. The corrective action will be accomplished	2/21/24

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F 699	Continued From page 5 swear, verbally and physically threaten, hit or kick out, grab on to things and not let go. At this point, cares have been able to be competed." The CAA went on to document: "Resident has some trauma in his history, it is not totally clear due to his inability to fully state and his ex-wife not knowing details but does appear to be afraid and is resistive with personal cares." R8's Vulnerable Adult Assessment (dated 11/14/23) documented the following trauma history: "Family shared that he was sexually assaulted as a child. Yes, hitting his ex-wife. Was in prison for vehicular homicide. Was stabbed in the right wrist and shot in the left leg in two different instances. Resident also has a long [history] of alcohol abuse." In review of R8's behavior care plan concern (last revised 1/24/23) identified: "Alteration in Mood/Behavior [related to] dementia Mood/Behavior [with history of] wandering, [history of] verbally and physically abusive behavior [examples given] yelling, hitting out, biting. Date Initiated: 01/24/23". R8's care plan had no mention of his history of multiple traumatic experiences. During a telephone interview on 1/8/24 at 12:08 p.m., Family member (FM)-A stated she only knew of R8 being the outcome of his mother being raped. FM-A stated FM-B would know more of R8's life history. During a telephone interview on 1/8/24 at 12:14 p.m., FM-B stated she did not get to know her father until in her 20s but was aware her father was the outcome of his mother being raped by a	F 699	by completing a Trauma History Screen upon admission and as needed. This will be completed with the resident if able. If resident is unable to participate in the Trauma History Screen, the SW will conduct the screen with the resident's representative. Based on identified trauma history, the IDT will implement a care plan with interventions specific to the resident's needs. In this specific instance, R8's care plan has been updated to reflect his previous trauma history. The facility will identify other residents at risk by performing an audit on all resident charts for a completed Trauma History Screen. The Trauma History Screen will then be completed for those residents identified who have not had this screen completed upon admission. This will be completed by the SW and DON/RNCCs. The facility will monitor the effectiveness of the corrective action during quarterly care plan reviews and resident care conferences. The IDT team will determine if the current plan of care established has been adequate in reducing traumatic experiences for the residents identified via initial screening.	

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F 699	Continued From page 6 white man. FM-B stated in those times, Native American children were taken from their families and placed in boarding schools. FM-B stated R8 had expressed to her and other family members, he had been sexually abused by 1-2 males during his boarding school years. FM-B further stated, throughout his life, R8 had been harassed and physically beaten while he was of mixed ethnicity. During observation of R8's morning cares on 1/9/24 at 6:49 a.m., the home health aid / hospice aid (NA)-M entered resident's room to perform cares. NA-M stated she was here to provide R8's morning shower and any other cares needed. NA-M stated R8 will grab out at the Hoyer lift bar (mechanical lift) and at his sheets and lift straps but had never struck out at her. A facility nursing assistant (NA-A) then entered the room to assist NA-M. As R8 was being cleaned and prepared for Hoyer lift transfer to the shower chair, R8 was grabbing out at staff and the Hoyer lift sling bar. NA-A placed one of the sling straps in R8's hand, so the NAs could continue positioning R8 for the transfer. Once in the shower chair, NA-M placed a shower drape and took resident down the hall to the enclosed shower room. NA-M could be heard through the shower room door, talking with R8, explaining what she was doing. No resident behavior was overheard during the showering process. During interview on 1/9/24 at 11:33 a.m., NA-A stated R8's behaviors have improved since he returned for SCS back in November 2023. NA-A stated R8 used to get angry, grabbing a hold of staff arms, swinging out at staff and pulling on the curtains. NA-A state occasionally they would place the lift she straps in his hands to calm R8, however that did not always work. NA-A stated	F 699		

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F 699	Continued From page 7 R8 would occasionally have an angered look, with other times a look of fear. Staff would try to talk R8 through cares, and reapproach at a later time if needed. NA-A stated since R8 had returned from SCS, R8 still occasionally has the look of anger or fear, but does not grab out / swing out as frequently. In an interview on 1/9/24 at 1:15 p.m., the facility's licensed social worker (LSW) and R8's nursing care manager (RN)-A stated they were aware of the documentation in R8's Vulnerable Adult Assessment when he returned from SCS. LSW stated the information has been included in R8's discharge summary from SCS and family mentioned R8's trauma during the care conference after R8's readmission. LSW stated she reached out to FM-A, who only knew of R8's mother's rape. Both LSW and RN-A stated they did not investigate R8's trauma history further, neither with SCS or other family members. LSW stated she only performed the Trauma Risk Assessment upon any resident's initial admission to the facility, when R8 was admitted on 1/5/23. LSW stated upon re-admission from SCS, only the Vulnerable Adult section of the assessment had been completed. A facility policy in regards to the assessment of trauma informed care and the care planning of was request, but not provided. The LSW and director of nursing (DON) stated the facility lack a policy for this process.	F 699		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform	F 851		2/21/24

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F 851	Continued From page 8 format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).	F 851		

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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 851	Continued From page 9 §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 4), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: Payroll Based Journal (PBJ) Casper Report 1705D identified the following dates triggered: 7/2/23, 8/20/23, 8/26/23, 8/27/23, and 9/4/23 for failure to have licensed nurse coverage 24 hours per day. Daily staff schedules on the above-mentioned dates identified licensed nursing staff including registered nurses had worked and therefore the data submitted in the PBJ to CMS was	F 851	Facility will complete correct entry of PBJ through the online CASPER reporting. The procedure to maintain compliance and correct data entry for both facility and contract labor will be as follows: 1. PBJ reporting will be completed on a quarterly basis and follow the established guidelines and dates for reporting PBJ information. 2. A quarterly meeting will be set with the SNF administrator, HRIS payroll analyst, and designated administrative personnel to make sure PBJ information is reported correctly prior to submission. 3. HRIS report will be ran by the HRIS analyst quarterly to submit information on MLHS employees. 4. All contracted labor hours will be entered manually into CASPER. All	

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 _____	C 01/09/2024

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 851	Continued From page 10 inaccurate. During interview on 1/8/24 at 8:41 a.m., administrator stated the reporting was the facility's error as the agency staff are not reflected in the report. During interview on 1/9/24 at 12:10 p.m., administrator stated the payroll coordinator generates a report from the payroll system, with information on report that is uploaded in the PBJ portal. Administrator stated it was realized the agency staff are not reflected on that report, so their hours were not getting uploaded into the PBJ portal. Administrator stated the human resource staff who was responsible for submitting data is not available for interview. Administrator confirmed the information that was submitted for fiscal year Quarter 4 2023 was inaccurate. A facility payroll-based journal policy was requested and was not received.	F 851	invoices for the reporting period, which includes employee position and hours, will be reviewed and entered manually to Casper A policy and procedure has already been created	

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	245127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/10/2024**

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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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/10/2024, At the time of this survey, Mille Lacs Health System was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division	K 000		

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

Electronically Signed | 02/01/2024

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 _____	**01/10/2024**

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

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

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K 000	Continued From page 2 smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 34 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		2/6/24

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/10/2024 at 11:40 AM, it was revealed by observation that the lock-out switch installed on the residential stove located in dining area was not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenanc Supervisor and Administrator verified this deficient finding at the time of discovery.	K 324	This work has been completed as of 1/31/24 by our electrician. A picture of the completed work and a description of the electrician's work will be sent to the Fire Marshal via email. In addition, the Certified Dietary Manger and dietary staff will be educated on the changes to the function of the residential stove, which now has a lock-out switch with a 120 minute shut off.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 11, 2024

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

RE: CCN: 245127
Cycle Start Date: January 9, 2024

Dear Administrator:

On January 26, 2024, March 21, 2024, and April 3, 2024, the Minnesota Department of Health completed revisits to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Correction of the Life Safety Code deficiency cited at the time of the January 9, 2024 survey, has also been verified. Your plan of correction for this deficiency has been approved.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 11, 2024

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

Re: Reinspection Results
Event ID: NJ9H12

Dear Administrator:

On February 26, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 9, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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