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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RP2S

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 **08/28/2014** (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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Brenda Fischer, HFE NE II — 08/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/16/2014 (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 09/24/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/19/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245127
August 29, 2014

Ms. Sharon Falknor, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Ms. Falknor:

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

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

Effective August 19, 2014 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.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 29, 2014

Ms. Sharon Falknor, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

RE: Project Number S5127024

Dear Ms. Falknor:

On July 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 19, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 10, 2014, effective August 19, 2014 and therefore remedies outlined in our letter to you dated July 24, 2014, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245127	A. Building B. Wing	8/28/2014

Name of Facility	Street Address, City, State, Zip Code
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **08/19/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **08/19/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/19/2014**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **08/19/2014**	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	Date:	Signature of Surveyor:	Date:
	BF/KJ	08/29/2014	10562	08/28/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/10/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: RP2S

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

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(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 **07/10/2014** (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:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 : 08/11/2014
Carol Bode, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 08/19/2014
Kate JohnsTon, Enforcement Specialist (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 08/19/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 0471

July 24, 2014

Ms. Sharon Falknor, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

RE: Project Number S5127024

Dear Ms. Falknor:

On July 10, 2014, 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) , as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - 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
Minnesota Department of Health
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 NO DATA, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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 signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 October 10, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900

St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Mille Lacs Health System

Addendum to Plan of Correction (POC):

All MDH survey deficiencies will have the completion date of 8/19/14.

F225 and F226

Effectiveness of corrective actions will be monitored by a monthly audit of at least one nursing assistant (NARs or TMAs) and one nurse (LPNS or RNs) per daytime, evening and NOC shifts (i.e. six persons total) assessing their knowledge of elopement policy and procedures. Audits will occur monthly for three months, then quarterly thereafter through July 2015. Social worker's report to quarterly QA team will contain audit results.

F279:

A list of all residents with a chronic skin condition will be created by 7/30/14. It will then be determined all residents with a chronic skin condition have a comprehensive plan of care documented in their individual Plan of Care. Responsibility DON

The results of the audit, determining all residents with a chronic skin condition have a Comprehensive Plan of Care documented in their individual care plan, will be reported at the LTC QA Quarterly Committee Meeting. Responsibility DON and RN Care Coordinators

F 282:

The LPN program supervisor will review the Maintenance Nursing logs every month to assess each resident's successful or unsuccessful participation in the program. The RN Care Coordinator will review the assessments and agree by cosigning the LPN reviews or making changes as needed and signing the review.

Results of audit will be reported at the LTC Quarterly QA Committee Meeting. Responsibility DON, LPN Maintenance Nursing Supervisor, RN Care Coordinators

F 311:

The LPN program supervisor will review the Maintenance Nursing logs every month to assess each resident's successful or unsuccessful participation in the program. The RN Care Coordinator will review the assessments and agree by cosigning the LPN reviews or making changes as needed and signing the review.

Results of audit will be reported at the LTC Quarterly QA Committee Meeting. Responsibility DON, Nursing Maintenance LPN Supervisor, RN Care Coordinators

8/11/14 accepted.

www.mlhealth.org
(320) 532-3154
FAX (320) 532-3111
200 Elm Street North
P.O. Box A
Onamia, Minnesota 56359-0800

Caring for body, mind and spirit.

F 318:

The LPN program supervisor will review the Maintenance Nursing logs every month to assess each resident's successful or unsuccessful participation in the program. The RN Care Coordinator will review the assessments and agree by cosigning the LPN reviews or making changes as needed and signing the review.

Results of audit will be reported at the LTC Quarterly QA Committee Meeting. Responsibility DON, LPN Maintenance Nursing Supervisor, RN Care Coordinators

F323

Social worker to report quarterly x2 to QA team indicating regarding results of chart audits pertaining to elopement risk assessments.

F 332:

AT least 10% of LPNs/TMAs will be observed on their medication pass per month until all LPNs/TMAs have had a Medication Pass Observation completed.

Results of the observation will be reported at the Quarterly QA Committee Meeting. Responsibility DON

DON signature Kathy Smith RN, DON Date 8/7/14

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

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 _____	AUG 04 2014 MN Dept of Health St Cloud 07/10/2014

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 The facility's plan of correction (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 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2)- (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	8/11/14 Re submission to POC accepted	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Penelope A Keeran
TITLE: Administrator
(X6) DATE: 8/11/14

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 _____ B. WING	07/10/2014

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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an incident of elopement and potential neglect immediately to the administrator, state agency (SA) and did not thoroughly investigate the incident to rule out potential neglect for 1 of 3 residents (R53) allegations of abuse prohibition reviewed. Findings Include: R53's significant change MDS dated 5/1/14, indicated R53 had declined in condition. The MDS indicated R53 had increased mood indicators of feeling down depressed, feeling tired/having little energy, moving too slowly or fidgety; R53 displayed no wandering behaviors. The MDS indicated R53's cognition had declined to moderate cognitive impairment and required increased physical assistance from staff with walking in the corridor, dressing and grooming; R53 remained independent with bed mobility, transferring and personal hygiene.	F 225	F 225/VA reporting delay; lack of thorough investigations_ All residents potentially affected; all changes to be LTC facility wide Corrective Measures RE R53, a report was submitted to OHFC and CEP on 7/10/14 by facility staff upon clarification that a report was indeed necessary. Report Tracking ID 71494; investigation followed with report submitted 7/14/2014. Response from OHFC dated 7/15/2014 indicated no further action necessary. RE R53, interventions (as indicated in Report 71494) included: "*With regards to this particular resident: a wander guard was placed on his wheel chair on 7/9 to be checked for proper functioning on a weekly basis, and a new elopement assessment was conducted as well. However, further care planning or other interventions are "on hold" as his health has been deteriorating considerably the past few days. His family has been present over this past weekend and family is requesting he not be sent to ER with staff awaiting confirmation from MD re "comfort cares only." Resident has been bed ridden much of the past three days, he has been experiencing increased restlessness and agitation, likely related to end of life issues and he is under close monitoring by staff. Is receiving morphine and Ativan and family is considering hospice care.* *Regarding the facility issues: a review of existing policies and training efforts is currently underway and is anticipated to*	

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F 225	Continued From page 2 R53's care plan dated 5/16/14, identified R53 had, "Potential for elopement m/b [manifested by] independently mobile and elopement risk assessment score of 3." The care plan further identified a goal that R53 "...will remain safely within facility and/or on premises except when accompanied by family, friends and/or staff elsewhere." R53's Elopement Risk Assessment dated 7/24/13, identified R53 was at moderate risk for elopement which was identified on the care plan. Review of R53's nursing progress notes from 7/1/14, through 7/9/14, indicated the following: -A progress note dated 7/3/14, written at 8:20 p.m. indicated, "Resident very confused this shift. Stated he was going to the circus. He thought it was day time. Didn't realize he took his pills. Ask [sic] resident if the pills went down he said what pills. So asked again and resident stated you gave me pills. Resident has had an increased confusion level." -A progress note dated 7/4/14, written at 1:35 p.m. indicated, "Resident very confused this shift. Standing up in the hallway without assistance. Security guard brought resident back after he found him over by lake song [sic](an assisted living building that is separate from the nursing home, but attached to the building) and he didn't know what he was doing over there." There was no indication in the record that R53 had eloped, prior to 7/4/14, and this was his first incident. On 7/9/14, at 9:37a.m. registered nurse (RN)-D stated she was unaware R53 had been out of the building without staff knowledge and directed the surveyor to "visit with" the social worker regarding information on elopement and the facility process	F 225	Current Missing Persons policy was immediately reviewed and staff was educated accordingly via email on 7/15/14 and at a joint Nurse/NAR meeting on 7/15/14 by DON and SW with regards to elopement being a type of neglect, the need to report such incidents immediately as with other possible abuse and/or neglect issues. Also: facility wide Missing Person "codes" were posted for staff as well as copied and distributed to staff. Review existing Elopement Risk Assessment, Missing Persons and Vulnerable Adult policies and procedures for compliance with federal and state laws and rules as well as "best practices" with regards to elopement and how it pertains to neglect. Include in this a review of documentation procedures with regards to the clinical record. Amend policies and procedures as needed. Responsible: SW, DON and ADMIN Review internal reporting procedures. Update reporting forms with regards to elopement and assure they are readily accessible to staff. Responsible: SW. Provide education on Elopement Prevention and Intervention to all current LTC employees via email. Responsible: SW Provide education on Elopement Prevention and Intervention to all Nurses and Nurses' aides at staff meetings. Responsible: SW Include education on Elopement Prevention and Intervention in Facility Wide New Employee Orientation (NEO) provided monthly by Social Worker. Responsible: SW	July 15, 2014 August 15, 2014 August 15, 2014 August 15, 2014. Sept. 12, 2014 monthly – ongoing.

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F 225	Continued From page 3 with it. On 7/9/14, at 9:44a.m. licensed social worker (LSW)-A stated she was unaware of the 7/4/14 incident. LSW-A stated R53 did not have a Wanderguard in place and felt this was new behavior for him. LSW-A stated R53 "used to live at Lake Song" and "was probably thinking he was going home." LSW-A further stated she would consider this event an elopement and "...we need to assess it." On 7/9/14, at 12:31 p.m. the director of nursing (DON) and LSW-A were interviewed at the same time. DON stated she was unaware the elopement occurred as the nurse working that day was new and had not sent out an "alert" via e-mail to alert staff of the event. DON stated he [R53] was "not under our supervision... so it would be considered an elopement." The DON stated staff were educated about the VA (vulnerable adult) policy, but did not think elopement was discussed. DON further stated staff received a "pocket card" that listed the "codes" on it and procedure for how to handle them, a missing person was identified as a "Code White." Both the DON and LSW-A verified neither the administrator, nor the SA were immediately notified of the elopement and confirmed the incident was not thoroughly investigated to rule out potential neglect. On 7/9/14, at 1:13 p.m. the facilities manager (FM)-A stated he "doesn't define elopement" during new employee orientation and he "relies on the common sense" of the nursing staff to go to the disaster manual and "see what to do" if an event occurred.	F 225	Include education on Elopement Prevention and Intervention during 1:1 orientation provided to all new LTC staff regarding VA reporting processes. Responsible: SW SW (LSW-A) will be provided opportunity and means to attend local regional MNHSWA meetings on a regular basis (at least quarterly) to assist her in developing and maintaining best practices with regards to vulnerable adult investigations, reporting, interventions, etc. Responsible: DON, Admin, SW <u>Monitoring Plan for Corrective Actions</u> Updated policies will be available for access by all staff per intranet and policy book; copies provided at each nurses' station in updated Vulnerable Adult Manuals. All staff will be asked to sign that they have received or have access to updated policies/procedures. NEO presentation materials and powerpoint presentation will be updated to include content on elopement. Social worker to report quarterly to QA team indicating number of social service incident reports received, types of allegations, outcome of investigations and timeline of reporting/investigation procedures. See attachment A Social worker to provide brief synopsis or summary of MNHSWA meetings' content to supervisors upon request.	During each new employee's orientation period. At least qrtrly - ongoing August 31, 2014 August 12, 2014 Qrtrly as of Aug, 2014 and ongong Every other month - ongoing

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F 225	Continued From page 4 On 7/10/14, at 9:05a.m. the administrative assistant (AA)-A stated R53 "goes out the front door to sit outside" approximately once a week. AA-A further stated to her knowledge, R53 "has never been hurt outside", but "[AA-A] doesn't sit at the desk all day long to monitor him [R53] either." On 7/10/14, at 10:46 a.m. DON stated R53 was adequately supervised, "...as much as the rest of them [facility residents] are." DON further confirmed this was the only time R53 had left the facility and the incident should have been reported immediately to the administrator and SA as there was "potential for harm," and agreed a thorough investigation should have been completed. A Missing Person policy dated 3/2014, indicated "Missing Person" was defined as "a patient or resident staff are unable to locate" in their area/room. Further, the policy indicated staff were to search the immediate area, and report the missing person to the charge nurse, who reported it, "as needed," to law enforcement and "pages overhead" the details to aide in the search for the missing person. The Vulnerable Adult Policy dated as reviewed/revised on 1/14, identified who was a mandated reporter and directed any reporter with knowledge of "abuse or neglect of a resident...shall immediately report such an occurrence." The policy directed, "The reporting of alleged violations involving mistreatment, abuse, neglect...require that the facility must ensure that the alleged violations are reported immediately to the Administrator of the facility..." The policy identified a list of designees to report	F 225		

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F 225	Continued From page 5 allegations of mistreatment to in the administrator's absence. The policy further directed to report the alleged incidents to the SA and appropriately identified the reporting procedure.	F 225	F226/ Failed to implement current VA policy	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize the Vulnerable Adult policy (abuse prevention policy) for 1 of 3 residents (R53) who's elopement incident from the facility was not reported immediately to the administrator and State agency (SA); failed to thoroughly investigate the incident as directed by the policy. Findings Include: The facility Vulnerable Adult policy, dated 1/2014, identified, "All alleged violations are thoroughly investigated." The policy further stated, "Upon discovery of an alleged incident that is considered reportable following a brief evaluation, facility staff will immediately contact the appropriate agencies, in most cases this is the CEP and Minnesota Department of Health." Further on, the policy directed, "The reporting of alleged violations involving mistreatment, abuse, neglect...require	F 226	All residents at risk of elopement are potentially affected by deficient practice; corrective action needs to be systemic and LTC facility wide. Corrective Measures RE R53, a report was submitted to OHFC and CEP on 7/10/14 by facility staff upon clarification that a report was indeed necessary. Report Tracking ID 71494; investigation followed with report submitted 7/14/2014. Response from OHFC dated 7/15/2014 indicated no further action necessary. RE R53, interventions (as indicated in Report 71494) included: "*With regards to this particular resident: a wander guard was placed on his wheel chair on 7/9 to be checked for proper functioning on a weekly basis, and a new elopement assessment was conducted as well. However, further care planning or other interventions are "on hold" as his health has been deteriorating considerably the past few days. His family has been present over this past weekend and family is requesting he not be sent to ER with staff awaiting confirmation from MD re "comfort cares only." Resident has been bed ridden much of the past three days, he has been experiencing increased restlessness and agitation, likely related to end of life*	

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F 226	Continued From page 6 that the facility must ensure that the alleged violations are reported immediately to the Administrator of the facility..." The policy identified a list of designees to report allegations of mistreatment to in the administrator's absence and directed to report the alleged incidents to the SA and appropriately identified the reporting procedure. R53's significant change Minimum Data Set (MDS), dated 5/1/14, indicated R53 had a diagnosis of depression, displayed no wandering behaviors during the review period, and had moderate cognitive impairment. R53's care plan, dated 5/16/14, identified R53 had, "Potential for elopement m/b [manifested by] independently mobile and elopement risk assessment score of 3." The care plan further identified a goal that R53 "...will remain safely within facility and/or on premises except when accompanied by family, friends and/or staff elsewhere." R53's Elopement Risk Assessment dated 7/24/13, identified R53 to be at moderate risk for elopement. R53's progress note, dated 7/4/14, indicated R53 was "...very confused this shift. Standing up in the hallway without assistance. Security guard brought resident back after he found him over by lake song (an assisted living building that is separate from the nursing home, but attached to the building) and he didn't know what he was doing over there." The clinical record lacked evidence the elopement was immediately reported to the administrator and SA as directed by the abuse prevention policy. Als.o, there was no indication the incident had been thoroughly investigated.	F 226	*issues and he is under close monitoring by staff. Is receiving morphine and Ativan and family is considering hospice care.* *Regarding the facility issues: a review of existing policies and training efforts is currently underway and is anticipated to assure appropriate procedures for responding to elopement situations are in place for future situations with this or other residents.* *In the meantime, the current Elopement Risk Assessment policy will be implemented and a monitoring mechanism is already in place by SW to assure the current ERA is completed in a timely fashion. SW will review the existing policy and procedures with all nurses and aides at LTC Nursing Staff Meeting on 7/15 at 2:15 p.m.* *SW is researching CMS guidelines as well as F 323 and 42 CFR 483.25 (h) 1 & 2, best practices via JCAHO , ECRI.org, BRIGGS, and other resources. The good news is, thankfully, there was no injury sustained in this recent incident but it has produced significant awareness of the need to address the issue. Hence, this has been a positive learning experience and this SW, for one, is glad to have this opportunity to help our team develop a more thorough plan and approach to preventing further elopement episodes in the facility and also assuring appropriate response plans are in place."* Review internal reporting procedures. Update reporting forms with regards to	7/15/14

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F 226	Continued From page 7 On 7/9/14, at 9:37a.m. registered nurse (RN)-D stated she was unaware R53 had been out of the building without staff knowledge. RN-D further stated to visit with the social worker regarding information on elopement and the facility process. On 719/14, at 9:44a.m. licensed social worker (LSW)-A stated she was unaware of the incident. LSW-A stated R53 did not have a Wanderguard in place and felt this was new behavior for him. LSW-A further stated she would consider this event an elopement and "...we need to assess it." On 7/9/14, at 12:31 p.m. the director of nursing (DON) stated she was unaware the incident occurred as the nurse working that day was new and had not sent out an alert via e-mail alerting staff to the event. The DON stated he was not under our supervision so it would be considered an elopement which has never happened to R53. The DON stated staff are educated about the VA (vulnerable adult) policy, but did not think anything regarding elopement was discussed. On 7/10/14, at 10:46 a.m. the DON stated R53 was adequately supervised, "...as much as the rest of them are." DON confirmed the incident should have been reported immediately to the administrator and SA as potential neglect, and an investigation should have been conducted as directed by the policy.	F 226	elopement and assure they are readily accessible to staff. Responsible: SW Provide education on Elopement Prevention and Intervention to all current LTC employees via email. Responsible: SW Provide education on Elopement Prevention and Intervention to all Nurses and Nurses' aides at staff meetings. Responsible: SW Include education on Elopement Prevention and Intervention in Facility Wide New Employee Orientation (NEO) provided monthly by Social Worker. Responsible: SW <u>Monitoring Plan for Corrective Actions</u> Updated policies will be available for access by all staff per intranet and policy book; copies provided at each nurses' station in updated Vulnerable Adult Manuals. All staff will be asked to sign that they have received or have access to updated policies/procedures. NEO presentation materials and powerpoint presentation will be updated to include content on elopement. Social worker to report quarterly to QA team indicating number of social service incident reports received, types of allegations, outcome of investigations and timeline of reporting/investigation procedures.	August 15, 2014 August 15, 2014 Sept. 12, 2014 Monthly – ongoing August 31, 2014 August 12, 2014 Qrtrly as of Aug, 2014 and ongong
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	See page 9 (following page) for POC regarding F279	

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F 279	Continued From page 8 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 skin care plan to include a chronic condition and appropriate interventions for 1 of 4 residents (R53) reviewed for skin concerns. Findings Include: On 7/8/14, at 9:53a.m. R53 was observed to have a Band-Aid on the back of his head containing a spot of dried blood. At 2:42 p.m. R53 had no Band-aid on the back of his head. A dime sized scabbed area was observed in the location of the Band-Aid. At the time of the observation, R53 stated he was unsure of how "it [scabbed area]" was sustained.	F 279	Plan of correction for F279 A comprehensive skin care plan was developed and entered into resident (R53) care plan. Responsibility: Care Coordinators and DON A list of all residents with a chronic skin condition will be created. Responsibility: DON An audit will be completed every week x 1 month, then every month x6 months to affirm a comprehensive skin care plan is documented in each of these residents' care plan. Responsibility: Care Coordinators and DON See attachment B	7/9/14 7/30/14 2/1/15

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F 279	Continued From page 9 A nursing progress note dated 1/16/14, indicated R53 scratched the top of his scalp with his fingernails causing it to bleed. The note further directed to apply bacitracin (an antibiotic ointment) and a band-aid as needed. R53's care plan dated 5/16/14, indicated R53 had potential for alterations in skin related to weakness and bowel incontinence. The care plan further identified R53 would maintain intact skin integrity, along with interventions of "skin repair as ordered", "cleanse perineal area well with each incontinence episode", "weekly bath skin audit", and "inspect skin dly [daily] with cares." The care plan did not address a scalp wound or any treatments for this area. A nursing progress note dated 7/6/14, indicated R53 had picked at the scab causing it to bleed on his pillowcase. On 7/9/14, at 7:41 a.m. licensed practical nurse (LPN)-D stated R53 had a treatment completed every evening to check on his scalp wound. LPN-D stated R53 had a history of picking at the scalp wound causing it to bleed. LPN-D stated R53 had the wound "...for quite some time." On 7/9/14, at 9:24a.m. registered nurse (RN)-D stated R53 had the wound for quite some time "since January 2014," and R53 picked at it frequently, causing it to break open. RN-D stated when skin issues develop, "They are placed on a short term care plan." RN-D stated the nursing assistants were made aware of the care plan by their "aide sheets," but further stated the sheets were not considered part of the care plan. RN-D stated R53's scalp wound was considered a "chronic" condition and should have been listed	F 279		

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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 279	Continued From page 10 on his care plan. RN-D then stated, "Nobody ever looks at them anyway." On 7/10/14, at 9:14a.m. the director of nursing (DON) stated staff should update the RN on the unit if they had skin concerns and R53's condition of picking at his head should be identified on R53's care plan. A Care Plan Procedure policy dated 3/2014, indicated, "Current and periodic updating and documentation of residents' needs provides for increased quality and continuity of care." The purpose of the policy was defined as "to develop and maintain a comprehensive written plan of care for each resident to assess, plan for, and meet residents' health care needs."	F279		
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 record review, the facility failed to follow a plan of care and consistently offer restorative rehabilation services for 3 of 5 residents (R3, R15, R53) reviewed for rehabilitation. Findings include: R3 had diagnoses, from the quarterly Minimum Data Set (MDS), dated 5/27/2014, which included	F282		

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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	07/10/2014

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 282	Continued From page 11 rheumatoid arthritis. The MDS also identified that R3 required assistance for ambulation, and had intact cognition. During observation on 7/9/2014, between 7:00 a.m. and 10:00 a.m., on the north wing of the facility, R3 was not observed ambulating. On 7/10/2014 between 8:30 a.m. and 11:25 a.m. on the north wing of the facility, R3 was not observed ambulating. R3's care plan (CP), revised on 6/9/2014, addressed alteration in mobility, and that R3 needed assistance with ambulation daily. The CP listed as a goal, and directed, that R3 would continue to ambulate with restorative nursing as ordered. In an interview on 7/10/2014 at 10:00 a.m., R3 stated he did not like to walk, that he has refused to participate, but lately, "...in the past days for sure," has not been offered walking with the staff. A review of the Mille Lacs Long Term Care, Restorative Nursing Program Ambulation log sheets for R3, indicated the following: Apri12014: R3 ambulated 18 days; refused 5 days; was ill 1 day; was marked LOA (leave of absence) 1 day; and 5 days were unmarked. May 2014: R3 ambulated on 8 days; refused on 12 days; was ill 1 day; was marked LOA on 2 days; and 8 days were unmarked. June 2014: R3 ambulated 2 days; refused 12 days; and 16 days were unmarked. July 2014: R3 refused on July 1st; remaining days through 7/10/2014, were unmarked. In an interview on 7/10/2014 at 8:09a.m., nursing assistant (NA)-B stated the "restorative aides"	F 282	The following plan of corrections is for F282, F 311, F318 A Maintenance Nursing (Restorative) meeting was previously planned by the LPN Nursing Maintenance program supervisor and took take place on 7/21/14. The meeting included discussion regarding program changes, documentation for the program, and staffing. This will be for all residents. The Maintenance (Restorative) NARs have returned to their positions following a maternity leave and a medical leave simultaneously. Responsibility: LPN supervisor, Care Coordinators, DON See attachment C. As a result of the above meeting the new schedule/times for Maintenance (Restorative) NARs is implemented to better serve residents on a nursing maintenance program. Responsibility: LPN Maintenance Nursing Supervisor, DON A LPN had been previously selected to oversee/supervise the Maintenance Nursing program. RN Care coordinators oversee the LPN. The LPN was previously scheduled and will attend a 3 day training program specifically for Nursing maintenance programs and oversight in September 2014. For all residents, including those residents interviewed/reviewed by MDH surveyors, an audit of the Nursing Maintenance (Restorative) program documentation log will be completed every day x1 week then every week x4 months, starting 8/4/14, to assure assigned Nursing Maintenance (Restorative) duties are being performed as written for each resident. Responsibility: LPN Maintenance Nursing Supervisor, DON	7/21/14 8/11/14 9/30/14 12/1/14

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	245127	A. BUILDING _____ B. WING	07/10/2014

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 282	Continued From page 12 were to do walking, range of motion (ROM) and strengthening programs for the residents. NA-B stated that the restorative nursing was getting missed, especially the "past few weeks," because the aides who were working the program, "were both on leave." NA-B verified R3 was on a "walking program," to be completed by restorative nursing, which was not being completed. During in interview on 7/10/2014 at 9:50a.m., registered nurse (RN)-C stated the restorative program was in "upheaval at this time," and the facility was aware of the problem. RN-C stated one [restorative] aide was on leave, and the other left for another position. RN-C said the floor aides were encouraged to pick up the slack, and complete the walking and ROM, but said "I admit it is missed" and the "rehab does not get done." RN-C said there was currently a weakness with restorative nursing, and the facility was "trying to address the problem." R15's quarterly MDS dated 1/29/14 identified moderate cognitive impairment, needed staff assistance for activities of daily living and had upper and lower extremity mobility impairments. R15 was observed on 7/7/14, at 7:41 p.m. with her hands and fingers in a curled position. R15's plan of care last reviewed 5/16/14 identified a problem with mobility, related to arthritis and weakness. The staff were directed to use a Hoyer lift for transfers and to complete, "Restorative nursing as ordered." Review of the physician orders dated 6/18/14 identified upper and lower extremity range of motion three times a week.	F 282	See attachment D. The LPN program supervisor will review the Nursing Maintenance logs every month to assess each resident's successful or unsuccessful participation in the program. Changes will be documented. For all residents, including those interviewed/reviewed by MDH surveyors, an audit of the Nursing Maintenance program documentation and shared with the RN Care Coordinator for further follow up if needed. Responsibility: LPN Maintenance Nursing Supervisor, Care Coordinators, DON	Ongoing Ongoing

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 13 Review of R15's Restorative Nursing Program sheets identified range of motion three times a week. Review of the July 2014 sheets identified ROM was completed once out of 11 days. The June 2014 sheets identified ROM was completed seven times out of 31 days. An interview on 7/9/14 7:00a.m. nursing assistant (NA)-F stated, she was unsure about R15's ROM, because she works the night shift. At 7:13 a.m. NA-G stated, the restorative aides complete the range of motion program. An interview on 7/9/14 7:17a.m. registered nurse (RN)-D stated, they have directed the NA's to complete the rehabilitation program, but this was not getting completed as directed by the care plan. R53's significant change Minimum Data Set (MDS), dated 5/1/14, indicated R53 required extensive assistance with ambulation, and was unsteady without other human assistance during ambulation. R53's care plan dated 5/16/14, identified an alteration in mobility related to a history of compression fractures, weakness, and degenerative joint disease. The care plan further indicated R53 needed assistance with ambulation and listed, "Restorative nursing as ordered" as an intervention. On 7/10/14, at 10:18 a.m. R53 stated he did not think staff or nurses walked with him and stated, "I don't think so." R53 further stated "nobody"	F 282		

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

(X4)1D 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 282	Continued From page 14 helped him complete his exercises that he recalled. R53's Restorative Nursing Program flow sheet dated July 2014, indicated R53 was to ambulate everyday as tolerated, and had lower extremity exercises to be completed "7x weekly [7 times weekly]." The foresheet indicated R53 ambulated 56 feet in 3 minutes on 7/1/14, and R53 refused lower extremity strengthening on the same date out of 10 opportunities. The remainder of the flow sheet was blank. No notes were documented on the foresheet indicating why R53 did not complete the ordered exercises or ambulation. R53's Restorative Nursing Program foresheet dated June 2014, indicated R53 was to ambulate everyday as tolerated, and had lower extremity exercises to be completed "7x weekly." The foresheet indicated R53 ambulated zero days, refused to ambulate 13 days, was on LOA (leave of absence) 2 days, and was ill or sleeping 1 day out of 30 opportunities to ambulate. The foresheet further stated R53 completed lower extremity strengthening exercises no days, refused exercises 13 days, was on LOA 2 days, and was ill or sleeping 1 day out of 30 opportunities for strengthening. There were no notes documented on the foresheet indicating why R53 did not complete the ordered exercises or ambulation program. R53's Restorative Nursing Program foresheet, dated May 2014, indicated R53 was to ambulate everyday as tolerated, and had lower extremity exercises to be completed "7x weekly." The foresheet indicated R53 completed ambulation on 15 days, refused ambulation on 5 days, was on LOA on 3 days, and was ill on 1 day out of 31	F 282		

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F 282	Continued From page 15 opportunities for ambulation. The foresheet further stated R53 completed lower extremity strengthening exercises 15 days, refused exercises 5 days, was on LOA 4 days, and was ill on 1 day. The foresheet had a note which indicated R53 had company on 5/18/14, and was tired on 5/31/14, out of 31 opportunities for strengthening. On 7/10/14, at 10:00 a.m. nursing assistant (NA)-E stated the facility had two restorative aides, but one was on maternity leave currently. NA-E reviewed a binder called the "restorative book" located at the nurses station. NA-E stated the NA's were currently responsible for completing the restorative programs as the two restorative aides were not working. NA-E further stated the NA's completed the exercises as ordered, but did not document it. NA-E stated R53 did not walk yesterday (7/9/14) and confirmed R53 had not walked on 7/10/14 yet. On 7/10/14, at 10:21 a.m. licensed practical nurse (LPN)-D stated, "The restorative program is kind of in a mess right now." LPN-D stated both restorative aides were not working, and she had just assumed the restorative program about one month prior. LPN-D further stated the restorative exercises were likely not completed in the last two weeks as the restorative aides were not working. When interviewed on 7/9/14 8:11a.m. director of nursing (DON) confirmed the rehabilitation program was not being completed as directed by the care plan. The facility Care Plan Procedure policy, reviewed	F 282		

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	245127	A. BUILDING _____ B. WING	F318 07/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359 NO 0938-0391

(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 282	Continued From page 16 3/14, indicated under the "Purpose" section, "To develop and maintain a comprehensive written plan of care for each resident to assess, plan for, and meet residents' health care needs."	F282	The following plan of corrections is for F282, F311, F318	
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 by: Based on observation, interview and record review, the facility failed to consistently offer restorative ambulation services for 2 of 5 residents (R3, R53) reviewed for rehabilitation. Findings include: R3 had diagnoses, from the quarterly Minimum Data Set (MDS), dated 5/27/2014, which included rheumatoid arthritis. The MDS also identified that R3 required assistance for ambulation, and had intact cognition. During observation on 7/9/2014, between 7:00 a.m. and 10:00 a.m., on the north wing of the facility, R3 was not observed ambulating. On 7/10/2014 between 8:30a.m. and 11:25 a.m. on the north wing of the facility, there was no indication that R3 had ambulated nor did staff offer R3 to ambulate during these time frames. A review of Admission Orders, Mille Lacs Long Term Care Center, dated 11/19/2013, indicated R3 was to have a physical therapy (PT)	F 311	A Maintenance Nursing (Restorative) meeting was previously planned by the LPN Nursing Maintenance program supervisor and took take place on 7/21/14. The meeting included discussion regarding program changes, documentation for the program, and staffing. This will be for all residents. The Maintenance (Restorative) NARs have returned to their positions following a maternity leave and a medical leave simultaneously. Responsibility: LPN supervisor, Care Coordinators, DON See attachment C. As a result of the above meeting the new schedule/times for Maintenance (Restorative) NARs is implemented to better serve residents on a nursing maintenance program. Responsibility: LPN Maintenance Nursing Supervisor, DON A LPN had been previously selected to oversee/supervise the Maintenance Nursing program. RN Care coordinators oversee the LPN. The LPN was previously scheduled and will attend a 3 day training program specifically for Nursing maintenance programs and oversight in September 2014.	7/21/14 8/11/14 9/30/14

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F 311	Continued From page 17 evaluation for "transfer" and a "restorative nursing" screen. A progress note, dated 11/20/2014, indicated the screen for restorative care was completed on 11/19/2013. The response in that note was: "Patient [R3] is to ambulate with restorative aides, with 4WW [4-wheeled walker] ...up to 40 feet daily, progressing as tolerated." R3's care plan (CP) dated as revised on 6/9/14, addressed alteration in mobility, and that R3 needed assistance with ambulation daily. The CP listed as a goal, and directed, that R3 would continue to ambulate with restorative nursing as ordered. On 7/10/2014 at 10:00 a.m., R3 stated he did not like to walk, and that it was more "painful to walk in the weather of late." R3 said when he did walk with staff, he did so with his walker and was "generally around 10 a.m., and in the afternoons around 2 p.m." R3 stated he has refused to participate, but lately, "...in the past days for sure," has not been offered walking with the staff. A review of the Mille Lacs Long Term Care, Restorative Nursing Program Ambulation Jog sheets for R3, indicated the following: April2014: R3 ambulated 18 days; refused 5 days; was ill 1 day; was marked LOA (leave of absence) 1 day; and 5 days were unmarked, out of 30 opportunities. May 2014: R3 ambulated on 8 days; refused on 12 days; was ill1 day; was marked LOA on 2 days; and 8 days were unmarked out of 31 opportunities. June 2014: R3 ambulated 2 days; refused 12 days; and 16 days were unmarked out of 30 opportunities.	F 311	For all residents, including those residents interviewed/reviewed by MDH surveyors, an audit of the Nursing Maintenance (Restorative) program documentation log will be completed every day x1 week then every week x4 months, starting 8/4/14, to assure assigned Nursing Maintenance (Restorative) duties are being performed as written for each resident. Responsibility: LPN Maintenance Nursing Supervisor, DON	12/1/14

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F 311	Continued From page 18 July 2014: R3 refused on July 1st; remaining days through 7/10/2014, were unmarked, out of 10 opportunities. On 7/10/2014 at 8:09a.m. nursing assistant (NA)-B stated the "restorative aides" were to do walking, range of motion (ROM) and strengthening programs for the residents. NA-B verified R3 was on a "walking program," but was unsure if he had been assisted to walk of late, as R3 often refused. NA-B said the [restorative] aides kept track of what each resident did every day, how far they walked, or what the resident had done for ROM. NA-B stated that the restorative nursing was getting missed, especially the "past few weeks," because the aides who were working the program, "were both on leave." On 7/10/2014 at 9:50a.m. registered nurse (RN)-C stated the restorative program was in "upheaval at this time," and the facility was aware of the problem. RN-C stated one [restorative] aide was on leave, and the other left for another position. RN-C said the floor aides (NAs) were encouraged to pick up the slack, and complete the walking and ROM, and stated, "I admit it is missed" and the "rehab does not get done." RN-C stated there was currently a weakness with restorative nursing, and the facility was "trying to address the problem." R53's significant change Minimum Data Set (MDS), dated 5/1/14, indicated R53 required extensive assistance with ambulation, had arthritis, and was unsteady without other human assistance during ambulation.	F 311		

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F 311	Continued From page 19 R53's care plan, dated 5/16/14, identified an alteration in mobility related to a history of compression fractures, weakness, and degenerative joint disease. The care plan further indicated R53 needed assistance with ambulation, and listed, "Restorative nursing as ordered" as an intervention. On 7110/14, at 10:18 a.m. R53 stated he did not think staff or nurses walked with him and stated, "I don't think so." R53 further stated "nobody" helped him complete his exercises that he recalled. R53's Restorative Nursing Program flow sheet dated July 2014, indicated R53 was to ambulate everyday as tolerated, and had lower extremity exercises to be completed "7x weekly (7 times weekly]." The foresheet indicated R53 ambulated 56 feet in 3 minutes on 7/1/14, and R53 refused lower extremity strengthening on the same date out of 10 opportunities. The remainder of the flow sheet was blank. No notes were documented on the foresheet indicating why R53 did not complete the ordered exercises or ambulation. R53's Restorative Nursing Program foresheet dated June 2014, indicated R53 was to ambulate everyday as tolerated, and had lower extremity exercises to be completed "7x weekly." The foresheet indicated R53 ambulated zero days, refused to ambulate 13 days, was on LOA (leave of absence) 2 days, and was ill or sleeping 1 day out of 30 opportunities to ambulate. The foresheet further stated R53 completed lower extremity strengthening exercises no days, refused exercises 13 days, was on LOA 2 days, and was ill or sleeping 1 day out of 30 opportunities for strengthening. There were no	F 311		

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F 311	Continued From page 20 notes documented on the foresheet indicating why R53 did not complete the ordered exercises or ambulation program. R53's Restorative Nursing Program foresheet, dated May 2014, indicated R53 was to ambulate everyday as tolerated, and had lower extremity exercises to be completed "7x weekly." The foresheet indicated R53 completed ambulation on 15 days, refused ambulation on 5 days, was on LOA on 3 days, and was ill on 1 day out of 31 opportunities for ambulation. The foresheet further stated R53 completed lower extremity strengthening exercises 15 days, refused exercises 5 days, was on LOA 4 days, and was ill on 1 day. The foresheet had a note which indicated R53 had company on 5/18/14, and was tired on 5/31/14, out of 31 opportunities for strengthening. When interviewed on 7/10/14, at 10:00 a.m., nursing assistant (NA)-E stated the facility has two restorative aides, however one was not working as she was on maternity leave. NA-E reviewed a binder called the "restorative book" located at the nurses station. NA-E stated the NA's are responsible for completing the restorative programs when the restorative aides were not working. NA-E further stated the NA's complete the exercises as ordered, but do not document it. During interview on 7/10/14, at 10:21 a.m., licensed practical nurse (LPN)-D stated "...the restorative program is kind of in a mess right now." LPN-D stated both restorative aides were not working, and she had just assumed the restorative program about one month prior. LPN-D further stated the restorative exercises	F 311		

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F 311	Continued From page 21 were likely not completed in the last two weeks as the restorative aides were not working, and the nursing assistants are expected to document the exercises if they complete them. When interviewed on 7/10/14, at 11:35 a.m., the rehabilitation manager (RM) stated nursing decided who gets placed on a restorative program and oversees it. RM stated residents are set-up with a maintenance program if they plateau during therapy. RM further stated the facility lacked a consistent, quality program regarding their restorative nursing program, "...our program is deficient." The facility Maintenance Program policy, reviewed 5/14, indicated "Active and passive range of motion and ambulation plans" were directed per nursing recommendation. Further, a nursing maintenance program was "...an integral part of nursing care and...strives to prevent deterioration and maintain optimal levels of functioning and independence."	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318		

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	07/10/2014

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 318	Continued From page 22 Based on observation, interview and document review, the facility failed to provide range of motion (ROM) for 1 of 1 resident (R15) reviewed for ROM services. Findings include: R15's quarterly MDS dated 1/29/14 identified moderate cognitive impairment, needed staff assistance for activities of daily living and had upper and lower extremity mobility impairments. R15 was observed on 7fl/14, at 7:41 p.m. with her hands and fingers in a curled position. R15's plan of care last reviewed 5/16/14 identified a problem with mobility, related to arthritis and weakness. The staff were directed to use a Hoyer lift for transfers and to complete, "Restorative nursing as ordered." Review of the physician orders dated 6/18/14 identified upper and lower extremity range of motion three times a week. Review of R15's Restorative Nursing Program sheets identified range of motion three times a week. Review of the July 2014 sheets identified ROM was completed once out of 11 days. The June 2014 sheets identified ROM was completed seven times out of 31 days. An interview on 7/9/14 7:00a.m. nursing assistant (NA)-F stated, she was unsure about R15's ROM, because she works the night shift. At 7:13a.m. NA-G stated, the restorative aides complete the range of motion program. An interview on 7/9/14 7:17a.m. registered nurse (RN)-D stated, part of the restorative	F 318	The following plan of corrections is for F282, F311, F318 A Maintenance Nursing (Restorative) meeting was previously planned by the LPN Nursing Maintenance program supervisor and took take place on 7/21/14. The meeting included discussion regarding program changes, documentation for the program, and staffing. This will be for all residents. The Maintenance (Restorative) NARs have returned to their positions following a maternity leave and a medical leave simultaneously. Responsibility: LPN supervisor, Care Coordinators, DON See attachment C. As a result of the above meeting the new schedule/times for Maintenance (Restorative) NARs is implemented to better serve residents on a nursing maintenance program. Responsibility: LPN Maintenance Nursing Supervisor, DON A LPN had been previously selected to oversee/supervise the Maintenance Nursing program. RN Care coordinators oversee the LPN. The LPN was previously scheduled and will attend a 3 day training program specifically for Nursing maintenance programs and oversight in September 2014.	7/21/14 8/11/14 9/30/14

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F 318	Continued From page 23 nursing problem was that the persons responsible to complete this program were both out on leave. They have directed the NA's to complete the rehabilitation program, but this was not getting completed. When interviewed on 7/9/14 8:11a.m. director of nursing (DON) confirmed the rehabilitation program was not being completed. When interviewed on 7/10/14, at 11:35 a.m., the rehabilitation manager (RM) stated nursing decided who gets placed on a restorative program and oversees it. RM stated residents are set-up with a maintenance program if they plateau during therapy, but lacked a consistent, quality program regarding their restorative nursing program, "...our program is deficient." The facility Maintenance Program policy, reviewed 5/14, indicated "Active and passive range of motion and ambulation plans" were directed per nursing recommendation. Further, a nursing maintenance program was "...an integral part of nursing care and...strives to prevent deterioration and maintain optimal levels of functioning and independence."	F 318	For all residents, including those residents interviewed/reviewed by MDH surveyors, an audit of the Nursing Maintenance (Restorative) program documentation log will be completed every day x1 week then every week x4 months, starting 8/4/14, to assure assigned Nursing Maintenance (Restorative) duties are being performed as written for each resident. Responsibility: LPN Maintenance Nursing Supervisor, DON	12/1/14
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323/Failed to conduct elopement assessment and Implement interventions to provide supervision and safety. All residents at risk of elopement are potentially affected by deficient practice; corrective action needs to be systemic and LTC facility wide. Corrective Measures Re R53, an elopement assessment was	

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F 323	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately assess the risk for elopement and implement interventions to provide supervision and safety for 1 of 1 residents (R53) who had eloped from the facility. Findings Include: R53's significant change Minimum Data Set (MDS) dated 5/1/14, indicated R53 had a diagnosis of depression, and had moderate cognitive impairment. R53's care plan dated 5/16/14, identified R53 had, "Potential for elopement mlb [manifested by] independently mobile and elopement risk assessment score of 3." The care plan further identified a goal that R53 "...will remain safely within facility and/or on premises except when accompanied by family, friends and/or staff elsewhere." The care plan listed interventions including: encourage frequent visits from family, follow the mobility care plan as outlined, and offer alternate activities and social interactions when his pain or weakness make it difficult for him to attend regular activities. R53's Elopement Risk Assessment dated 7/24/13, identified R53 was at moderate risk for elopement. R53's progress note dated 7/4/14, indicated R53 was "...very confused this shift. Standing up in the hallway without assistance. Security guard brought resident back after he found him over by	F 323	conducted by SW on 7/9/14 upon learning of the need to do so. A review of all current residents is underway by SW with new elopement assessments being conducted for every current resident who has not had one done in the previous 90 days, to assure that all current elopement assessments are up to date. Responsble: SW. Review existing Elopement Risk Assessment tool for compliance with federal and state laws and rules as well as "best practices" with regards to elopement, frequency and scope of assessments and appropriate care plan interventions. Include in this a review of documentation procedures with regards to the clinical record and care plan. Amend policies and procedures as needed. Responsible: SW Educate nursing staff re new tools and policies developed as a result of this review; assure understanding of shared responsibility by all nursing and social services staff to assess elopement risk as needed and as indicated per policy. Responsible: SW and DON Complete development of a working monitoring tool to assist staff in tracking elopement assessments to assure they are completed as per policy. Responsible: SW	July 9, 2014 August 8, 2014 August 15, 2014 Sept. 12, 2014 August 15, 2014

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F 323	Continued From page 25 Jake song (an assisted living building that is separate from the nursing home, but attached to the building) and he didn't know what he was doing over there." There was no indication in the record that R53 had eloped, prior to 7/4/14, and this was his first incident. On 7/9114, at 9:37a.m. registered nurse (RN)-D stated she was unaware R53 had been out of the nursing home without staff knowledge. RN-D further stated to visit with the social worker regarding information on elopement and the facilities process with it. On 7/9/14, at 9:44a.m. licensed social worker (LSW)-A stated she was unaware of the incident. LSW-A stated R53 did not have a wanderguard in place and felt this was new behavior for him. LSW-A stated she would consider this event an elopement and "...we need to assess it." LSW-A further stated she was unsure if a wanderguard would be an appropriate intervention for R53. During an on 7/9/14, at 12:31 p.m., the director of nursing (DON) stated she was unaware the incident had occurred on 7/4/14, five days ago, as the nurse working that day was new and had not sent out an alert via e-mail alerting senior staff to the event. The DON stated he (R53) was not under supervision so it would be considered an elopement. On 7/9/14, at 1:28 p.m. DON stated the plan to provide safety for R53 was to follow-up with the nurse who had been working that shift. The DON confirmed that R53 should have been reassessed to determine, how long the resident was missing, how R53 got over to Lake Song an assisted living facility which was adjacent to facility, and if he	F 323	Monitoring Plan for Corrective Actions Nursing and Social Services Staff will be asked to sign that they have awareness of the shared responsibility to conduct elopement risk assessments in accordance with needs and policy. Quarterly audit x2 (i.e for six months) of all current residents' PCC charts to see if elopement risk assessments are current. Quarterly audit x2 (i.e. for six months) of all current residents' with significant changes per MDS to see if elopement risk assessments are current AND if care plan interventions are adjusted in accordance with elopement risk. See attachment A	Sept. 15, 2014 Nov. 2014 and Feb. 2015 for Aug-Oct and Nov – Jan.

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F 323	Continued From page 26 went outside to get to the building. There was no indication that R53 wandering had been comprehensively reassessed after the 7/4/14 incident to determine what interventions could be implemented to ensure his safety. On 7/10/14, at 9:05a.m. the administrative assistant {AA}-A stated R53 goes ands sits outside in the entrance area of the facility, typically once a week. AA-A further stated R53 has never been hurt outside to her knowledge, but doesn't sit at the desk all day long to monitor him either. A Elopement Risk Assessment policy, dated 3/2014, indicated an intent to "...establish uniform guidelines in identifying and providing safety to residents who are at risk to wander." The policy further stated residents should be reassessed quarterly if identified as 'high risk' to elope, and when there is a change in clinical status. During interview on 7/9/14, at 12:31 p.m., LSW-A stated she was not aware of the policy nor had it been followed. Although R53 had eloped on 7/4/14 the facility failed to comprehensively reassess R53 elopement risk to determine appropriate interventions so ensure R53 received adequate supervision to prevent potential accidents.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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F 332	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of less than 5% for 2 of 9 residents (R46, R19) observed for safe medication administration. The facility's medication error rate was 7.4%. Findings Include: During observation of medication administration on 7/8/14, at 3:06p.m. the trained medication aide (TMA)-A was observed to prepare R46's medications for administration. TMA-A removed Metformin (a medication used to treat high blood sugars) from the medication cart and prepared it for administration. The medication label stated "...take with food." TMA-A approached R46 to give the medication and was stopped by the surveyor at the point of administration. TMA-A stated she was trained to give Metformin at that time. TMA-A stated she typically tries to give it when R46 was having a cookie or a snack, but stated it was not a meal. TMA-A further stated the supper meal started at 5:00 p.m. R46's signed physician orders dated 6/16/14, indicated "Metformin (Gfucophage) 250 mg By mouth (PO)- AM/PM: take with meals." On 7/8/14, at 3:23p.m. TMA-A was observed to prepare R19's medication for administration. TMA-A removed gemfibrozif (a medication used to treat cholesterol) from the medication cart and prepared it for administration. The medication label directed "...give 30 min (minutes) prior to breakfast/supper." TMA-A approached R19 to	F 332	For F332 Plan of correction The DON discussed, with TMA-A, the F332 deficiency and why the medication she had given was in error as it was to be given with meals. It was discussed with TMA-A, the next shift she worked 7/14/14, there are medications that have special instruction on when and how to be administered and it is a physician order. The person administering the meds must comply with that order. It was also discussed the five rights of residents in receiving medication. A medication pass observation will be completed by a LTC nurse for TMA-A and documented per attachment E. The nurse will educate as well as observe the medication administration pass of TMA-A. The nurse will document the education given to TMA-A on the medication administration pass. See attachment E A Nurses/TMA/NAR meeting was held on 7/15/14. It included an educational piece for nurses on medication administration times and instructions for administration. A copy of meeting minutes was emailed to all staff. When read, staff is to sign their name as having read them. Another educational session on medication administration will be mandatory for all nurses/TMAs. It will follow attachment E expectations.	7/14/14 8/5/14 7/15/14 8/15/14 9/30/14

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F 332	Continued From page 28 give the medication and was stopped by the surveyor at the point of administration. R19's signed physician orders, dated 6/17/14, indicated, "Gemfibrozil 600mg By mouth (PO) - AM/PM: Give 30 min prior to breakfast/supper." TMA-A re-approached R19 with several medications, including the gemfibrozil, crushed in applesauce and administered them at 3:26 p.m. TMA-A verified she gave the medication despite the label and order directing to give 30 minutes prior to meals. On 7/8/14, at 3:34p.m. registered nurse (RN)-C stated R46's Metformin and R19's gemfibrozil should have been given closer to the meal hour. RN-C stated "...it [the identified medications] shouldn't have been given." RN-C further stated TMA staff were trained "like a nurse" for medication administration. On 7/10/14, at 9:43a.m. the director of nursing (DON) stated not administering medications with or before meals as ordered would be considered a medication error by standards of practice, "...I think we need some education here." The DON further stated she would have to speak with the facility pharmacist regarding if a cookie was considered adequate food intake when providing medications that were prescribed to be given with meals. On 7/10/14, at 9:54a.m. the pharmacist stated their typical practice would be to give medications like Metformin and gemfibrozil around 8:00 a.m. and 5:00 p.m. The pharmacist further stated those medications should be given closer to meals to help with the digestive side effects of the medications.	F 332		

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

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F 332	Continued From page 29 A Long Term Care - Medication Administration at Non-Routine Times policy dated 3/2014, indicated, "Optimal absorption of medications can be achieved when administered at appropriate times." The procedure section directed, "Dispense medications according to administration times and any administration guidelines." The Metformin Hydrochloride: Package Insert and Label Information dated as last revised on 7nt14, directed the medication "should be given in divided doses with meals...to reduce gastrointestinal side effects ." The Gemfibrozil: Package Insert and Label Information dated as last revised on 1/8/14, directed to administer the medication "administered in two divided doses 30 minutes before the morning and evening meals."	F 332		

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	245127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/08/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Mille Lacs Health System C & NC was found 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. 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 and had a census of 50 at the time of the survey. The requirement at 42 CFR Subpart 483.70 is MET.	K 000		

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.