

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S616

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00376

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245422		3. NAME AND ADDRESS OF FACILITY (L3) ELIM HOME - MILACA (L4) 730 SECOND STREET SOUTHEAST, PO BOX 157 (L5) MILACA, MN (L6) 56353		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2. STATE VENDOR OR MEDICAID NO. (L2) A695342500		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		6. DATE OF SURVEY February 4, 2013 (L34)		8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10. THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: <u>1.</u> Acceptable POC <u>2.</u> Technical Personnel <u>6.</u> Scope of Services Limit <u>3.</u> 24 Hour RN <u>7.</u> Medical Director <u>4.</u> 7-Day RN (Rural SNF) <u>8.</u> Patient Room Size <u>5.</u> Life Safety Code <u>9.</u> Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A (L12)			
12. Total Facility Beds 98 (L18)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)			
13. Total Certified Beds 98 (L17)					
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 98 (L37) (L38) (L39) (L42) (L43)					

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

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective January 24, 2013, the facility is certified for 98 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Timothy Rhonemus, HFE NEII (L19)		Date : 02/13/2013	18. STATE SURVEY AGENCY APPROVAL Colleen B. Leach, Program Specialist (L20)	
			Date: 03/28/2013	

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

19. DETERMINATION OF ELIGIBILITY <u>X</u> 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 02/01/1987 (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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE: (L28)		29. INTERMEDIARY/CARRIER NO. 03001 (L31)		30. REMARKS Posted 4/9/2013 ML	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 02/11/2013 (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5422

March 29, 2013

Ms. Laura Broberg, Administrator
Elim Home - Milaca
730 Second Street Southeast, PO Box 157
Milaca, Minnesota 56353

Dear Ms. Broberg:

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 January 24, 2013, the above facility is certified for:

98 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 98 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Colleen Leach". The signature is written in a cursive, flowing style.

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

February 13, 2013

Ms. Laura Broberg, Administrator
Elim Home - Milaca
730 Second Street Southeast, P.O. Box 157
Milaca, Minnesota 56353

RE: Project Number S5422023

Dear Ms. Broberg:

On January 2, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2012. 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 February 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 19, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 24, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 19, 2012, effective January 24, 2013 and therefore remedies outlined in our letter to you dated January 2, 2013, 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,

A handwritten signature in black ink that reads "Shellae Dietrich".

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

5422r113.rtf

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245422	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 2/4/2013
Name of Facility ELIM HOME - MILACA		Street Address, City, State, Zip Code 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353

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 F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC _____	Correction Completed 01/24/2013	ID Prefix F0309 Reg. # 483.25 LSC _____	Correction Completed 01/24/2013	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By BF/sd	Date: 02/13/13	Signature of Surveyor: 20794	Date: 02/04/13
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/19/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		



Protecting, Maintaining and Improving the Health of Minnesotans

February 13, 2013

Ms. Laura Broberg, Administrator
Elim Home - Milaca
730 Second Street Southeast, P.O. Box 157
Milaca, Minnesota 56353

Re: Enclosed Reinspection Results - Project Number S5422023

Dear Ms. Broberg:

On February 4, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 19, 2012, with orders received by you on January 9, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Shellae Dietrich".

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5422r113lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00376	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 2/4/2013
Name of Facility ELIM HOME - MILACA	Street Address, City, State, Zip Code 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>20830</u>	Correction Completed 01/24/2013	ID Prefix <u>21415</u>	Correction Completed 01/24/2013	ID Prefix <u>21800</u>	Correction Completed 01/24/2013
Reg. # <u>MN Rule 4658.0520 Subp. 1</u>		Reg. # <u>MN Rule 4658.0815 Subp. 2</u>		Reg. # <u>MN St. Statute 144.651 Subd. 4</u>	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____ State Agency	Reviewed By <u>BF/sd</u>	Date: <u>02/13/13</u>	Signature of Surveyor: <u>20794</u>	Date: <u>02/04/13</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: <u>12/19/2012</u>		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S616

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00376

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245422		3. NAME AND ADDRESS OF FACILITY (L3) ELIM HOME - MILACA (L4) 730 SECOND STREET SOUTHEAST, PO BOX 157 (L5) MILACA, MN (L6) 56353		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 695342500		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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 IMR 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE		FISCAL YEAR ENDING DATE: (L35) 09/30	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u>2. Technical Personnel</u> Compliance Based On: <u>3. 24 Hour RN</u> <u>4. 7-Day RN (Rural SNF)</u> <u>5. Life Safety Code</u> <u>6. Scope of Services Limit</u> <u>7. Medical Director</u> <u>8. Patient Room Size</u> <u>9. Beds/Room</u> X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)			
6. DATE OF SURVEY 12/19/2012 (L34)					
8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other					
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :					
12.Total Facility Beds 98 (L18)					
13.Total Certified Beds 98 (L17)					
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IMR 98 (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): See Attached Remarks					
17. SURVEYOR SIGNATURE Timothy Rhonemus, HFE-NEII		Date : 01/25/2013 (L19)		18. STATE SURVEY AGENCY APPROVAL Nicole Steege, Program Specialist 02/06/2013 (L20)	

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

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>	
22. ORIGINAL DATE OF PARTICIPATION 02/01/1987 (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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	

Page 2

Provider Number: 24-5422

Item 16 Continuation for CMS-1539

At the time of the standard survey completed on December 19, 2012, the facility was not in substantial compliance and the most serious deficiencies were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit after January 24, 2013.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 7358

January 2, 2013

Ms. Laura Broberg, Administrator
Elim Home - Milaca
730 Second Street Southeast, PO Box 157
Milaca, Minnesota 56353

RE: Project Number S5422023

Dear Ms. Broberg:

On December 19, 2012, 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:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
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 January 28, 2013, 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 March 19, 2013 (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 June 19, 2013 (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

Elim Home - Milaca

January 2, 2013

Page 5

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

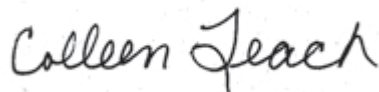
Elim Home - Milaca

January 2, 2013

Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Colleen Leach". The ink is dark and the signature is fluid.

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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.	F 000	"Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the Facility's allegation of compliance."	01/02/2013 PROVED 0938-0391
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	F156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES It is the policy of the facility to provide the required Notice of Medicare Beneficiary's Rights to Appeal and Expedited Appeal upon the termination of Medicare benefits. A denial notice was mailed to Resident 70 on 01/11/2013. Records of all residents for whom a Medicare stay ended between 12/19/2012-01/24/2013 were reviewed.	01/02/2013 PROVED 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Kenna Brober* TITLE *Administrator* (X6) DATE *1-14-13*

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.

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

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

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Notice of Medicare Beneficiary's Rights to Appeal and Expedited Appeal upon the termination of Medicare benefits for 1 of 2 residents (R70) in the sample who was receiving the Medicare A	F 156		01/02/2013 APPROVED 0938-0391 01/02/2013 APPROVED 0938-0391	

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

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE Page 3 of 8	
F 156	Continued From page 3 benefit. Findings include: On 12/19/2012 at 9:05 a.m., the facility's director of the business office (DBO) was interviewed and provided a list of three residents that had been discharged from the facility on Medicare in the past six months. R70 was not provided a Notice of Medicare Non-Coverage (CMS-10123) prior to R70 stopping physical therapy, then discharging home which was verified by DBO. DBO stated that she never knew they were supposed to give any kind of notice when a resident was being discharged to home. R70's Resident Progress Note on 10/30/2012 by social services indicated a discharge meeting was held with OT, SS, RN, R70 and his son. The team recommended that R70 be discharged to home on 11/6/2012 with Heritage Home Care services and social services would continue to monitor. A physical therapy Updated Plan of Progress for Outpatient Rehabilitation dated 11/6/2012 indicated R70 had made excellent progress towards functional outcomes and goals and reached his maximum potential with goals. The plan was to discharge to home with family assistance and home care services. During interview on 12/19/2012 at 9:35 a.m., DOB stated R70 had a plateau with therapy and knew that therapy wasn't going to be able to help him anymore, so he decided to go home. DOB went on to say that R70 did not get a letter, he met his goals and chose to go home. Facility policy titled Beneficiary Notices, dated November 2012, indicated "it is the policy of the facility to follow the CMS regulations for notification of beneficiaries when a Medicare stay will be ending. The beneficiary is notified using	F 156			

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

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	Continued From page 4 the current version of the CMS required form and is given to the beneficiary at least 2 days prior to the date that the facility has determined to be the last Medicare-covered date." Even though R70 had a planned discharge, the facility did not give them a Notice of Medicare Non-Coverage (CMS-10123) two days before the discontinuation of skilled services.	F 156		12/19/2013 APPROVED 0938-0391	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure complete and accurate documentation of oral intake amounts for 1 of 1 residents (R21) who received hemo-dialysis. Findings include: R21 has end stage renal disease (ESRD) and was limited to 1700 cubic centimeters (cc) of fluids in a 24 hours period. The facility's staff were not accurately recording intake for this resident to ensure R21 received his fluid restriction of 1700 cc. R21 had the diagnoses of ESRD, diabetes,	F 309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING It is the policy of the facility that complete and accurate documentation of oral intake amounts is done daily for residents who receive hemodialysis. Complete and accurate oral intake is being documented daily for Resident 21. The care plan has been updated and the deficiency corrected.	12/19/2013 APPROVED 0938-0391	

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

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

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

PRINTED: 01/02/2013
FORM APPROVED:
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 6 During interview on 12/18/12 at 4:36 p.m., both licensed practical nurse (LPN)-B and trained medical assistant (TMA)-B stated they write down on their shift sheets the amounts of fluids offered during their shift and enter it into the electronic record under vitals. Review of the electronic medical record for R21 identified the following for the last 10 days for daily totals: 12/18/12 - as off 1453 entry = 1200cc, 12/17/12 - = 820 cc, 12/16/12 - = 420 cc, 12/15/12 - = 480 cc, 12/14/12 - = 550 cc, 12/13/12 - = 1440 cc, 12/12/12 - = 560 cc, 12/11/12 - = 270 cc, 12/10/12 - = 1200 cc and 12/09/12 - = 1020 cc. The facility's policy, entitled: Intake and Output (dated 09/21/2005), indicated that the nursing assistants were to record I&O on their group sheets, transcribe on to a I&O sheet at the nurses station and the nurses were to monitor the I&O being recorded. The policy went on to indicate that the night nurse were to tabulate totals for each day. During interview on 12/18/12 at 5:15 p.m., a facility registered dietitian (RD)-D verified that the facility should be tabulating the daily fluid intake amounts and placing them in the electronic record. After RD-D reviewed this record, she stated the recorded information was not complete. During interview on 12/18/2012 at 5:30 p.m., the unit's care manager (CM-A), verified the facility's policy of recording and tabulating I&O's in the electronic record. CM-A, after reviewing the electronic record for R21, stated that the amounts	F 309	Nurse Managers are responsible for compliance. Director of Nursing is responsible for overall compliance. Completion date January 24, 2013.	01/02/2013 APPROVED 0938-0391	

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

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA	STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 entered were inaccurate, while to her observations and knowledge, R21 consumes all of their fluids that are offered, and was unsure how much fluid R21 was actually consuming. No further information was provided.	F 309		

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

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2012	
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA				STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
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 Elim Home Milaca 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. Elim Home Milaca is a 1-story building with small partial basement. The basement is not used by the nursing home residents. The building was constructed in 1963, with additions in 1973 77 & 89. A chapel and connector link to the assisted living unit was constructed in 2006. The original building and the additions are all Type I (111) construction. Therefore, the facility was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 98 beds and had a census of 86 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) 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.

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

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245422		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ELIM HOME MILACA B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2012	
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA				STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
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, Elim Home Milaca 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 18 New Health Care. Elim Home Milaca is a one (1) story building with no basement. The building construction type has been determined to be Type II (111). This inspection only reflects the building that was constructed in 2004 and consisted of 4 resident rooms and a dining room. In 2006 a chapel addition was added with a connector link to the assisted living building. The chapel and the assisted living are separated by 2 hours fire resistive rating, with 1.5 hour doors. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a licensed capacity of 98 beds and had a census of 86 at the time of inspection. The requirement at 42 CFR, Subpart 483.70(a) 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.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 7358

January 2, 2013

Ms. Laura Broberg, Administrator
Elim Home - Milaca
730 Second Street Southeast, PO Box 157
Milaca, Minnesota 56353

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5422023

Dear Ms. Broberg:

The above facility was surveyed on December 17, 2012 through December 19, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Elim Home - Milaca

January 2, 2013

Page 2

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division, #212, St. Cloud, Minnesota 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Colleen Leach". The signature is written in a cursive, flowing style.

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On, December 17th, 18th and 19th, 2012; surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.		

Minnesota Department of Health

TITLE

(X6) DATE

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

STATE FORM

6899

S61611

If continuation sheet 1 of 11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From page 1 Monitoring, Licensing and Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 830	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure complete and accurate documentation of oral intake amounts for 1 of 1 residents (R21) who received hemo-dialysis. Findings include: R21 has end stage renal disease (ESRD) and was limited to 1700 cubic centimeters (cc) of fluids in a 24 hours period. The facility's staff were not accurately recording intake for this resident to ensure R21 received his fluid restriction of 1700 cc. R21 had the diagnoses of ESRD, diabetes, chronic pain syndrome, obesity, hyperparathyroidism and anxiety. A quarterly minimum data set (MDS), dated 09/14/12, indicated that R21 was on a therapeutic diet and received hemo dialysis. The Care Area Assessment (CAA), dated 03/26/2012, listed pertinent diagnoses and the "Analysis of Findings": "Triggered for BMI. Resident with chronically elevated BMI 42. Up 6 pounds since admission. See RD assessment 3/22." During meal observation on 12/18/12 at 1200 noon, the following fluids were observed to be consumed by R21: 6 ounces (oz) (240cc) coffee, a 4 oz (120 cc) juice apple, and a clear glass 4 oz (120 cc) of water. On the same day, at the evening meal served at 4:45 p.m., R21 received the following fluids: 4 oz (120 cc) of water, and 4 oz (120 cc) juice).	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 830	Continued From page 3 Review of the physician's orders the following was documented for diet instructions (dated 08/08/12 and 08/09/12): "Diet: Renal with 1500 cubic centimeters (cc) fluid restriction." On 12/17/12, the facility received a faxed order from R21's dialysis unit to increase her fluid restriction to 1700 cc per day. The Medication Record (MAR) identified food service had a breakdown of fluid served for each meal, supplementation and nursing offerings. Food service was to serve R21 breakfast 300 cc, lunch 240 cc, supper 240 cc, afternoon supplement 240 cc, which left 680 cc for nursing to provide for a daily total of 1700 cc. The care plan, last updated 12/17/12 included the recent fluid upgraded amount. During interview on 12/18/12 at 4:36 p.m., both licensed practical nurse (LPN)-B and trained medical assistant (TMA)-B stated they write down on their shift sheets the amounts of fluids offered during their shift and enter it into the electronic record under vitals. Review of the electronic medical record for R21 identified the following for the last 10 days for daily totals: 12/18/12 - as off 1453 entry = 1200cc, 12/17/12 - = 820 cc, 12/16/12 - = 420 cc, 12/15/12 - = 480 cc, 12/14/12 - = 550 cc, 12/13/12 - = 1440 cc, 12/12/12 - = 560 cc, 12/11/12 - = 270 cc, 12/10/12 - = 1200 cc and 12/09/12 - = 1020 cc. The facility's policy, entitled: Intake and Output (dated 09/21/2005), indicated that the nursing assistants were to record I&O on their group sheets, transcribe on to a I&O sheet at the nurses station and the nurses were to monitor the I&O	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 830	Continued From page 4 being recorded. The policy went on to indicate that the night nurse were to tabulate totals for each day. During interview on 12/18/12 at 5:15 p.m., a facility registered dietitian (RD)-D verified that the facility should be tabulating the daily fluid intake amounts and placing them in the electronic record. After RD-D reviewed this record, she stated the recorded information was not complete. During interview on 12/18/2012 at 5:30 p.m., the unit's care manager (CM-A), verified the facility's policy of recording and tabulating I&O's in the electronic record. CM-A, after reviewing the electronic record for R21, stated that the amounts entered were inaccurate, while to her observations and knowledge, R21 consumes all of their fluids that are offered, and was unsure how much fluid R21 was actually consuming. No further information was provided. SUGGESTED PERIOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents receiving the appropriate care and services for hemo-dialysis. The director of nursing or designee could educate all appropriate staff on these policies and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) Days	2 830			
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program	21415			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
21415	Continued From page 5 Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be	21415			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
21415	Continued From page 6 non-infectious. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to assure that baseline tuberculosis screening results were recorded for 2 of 5 employees (E-A and E-B) whose records were reviewed. Findings include: Review of the facility policy titled "Tuberculosis Monitoring Program - Staff/Volunteers" dated 12/19/12 indicated all employees "will be screened for tuberculosis (TB) to ensure the safety of our residents". The policy went on to say "An employee may begin working with patients after negative TB tuberculin screening test (TST) (i.e., first step)". Employee-A (E-A) was hired on 12/11/12. E-A's file revealed documentation of a first step mantoux administered on 12/11/12 with no documented results. An interview with registered nurse (RN-B) on 12/19/12 at 9:00 a.m. verified the employee was working on 12/18/12, was administered a second first step tuberculosis (TB) test and had direct contact with residents between 12/11/12 -	21415			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
21415	Continued From page 7 12/18/12. Employee-B (E-B) was hired on 12/3/12. E-B's file revealed documentation of a first step mantoux administered on 12/3/12 with no documented results. E-B received a second first step mantoux test administered on 12/12/12 with no documented results. An interview with RN-B on 12/19/12 at 10:10 a.m. verified the employee was working in the facility since the first TB test on 12/3/12 with direct contact with patients. RN-B further stated it is the facility's expectation that on day one of hire at employee orientation, all employee's are given a first step TB test and are to have the results read within 2-3 days. EB verified that the facility did not follow its policy that no employee have contact with patients until after a negative TB test was documented. No further information was provided. TO COMPLY: The facility's director of nursing or designee could educate the nursing staff assigned to provide and record the tuberculosis skin tests, on what needs to be documented and where. CORRECTION: Fourteen (14) days	21415			
21800	MN St. Statute 144.651 Subd. 4 Patients & Residents of HC Fac. Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of	21800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
21800	Continued From page 8 treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Notice of Medicare Beneficiary's Rights to Appeal and Expedited Appeal upon the termination of Medicare benefits for 1 of 2 residents (R70) in the sample who was receiving the Medicare A benefit. Findings include: On 12/19/2012 at 9:05 a.m., the facility's director of the business office (DBO) was interviewed and	21800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
21800	Continued From page 9 provided a list of three residents that had been discharged from the facility on Medicare in the past six months. R70 was not provided a Notice of Medicare Non-Coverage (CMS-10123) prior to R70 stopping physical therapy, then discharging home which was verified by DBO. DBO stated that she never knew they were supposed to give any kind of notice when a resident was being discharged to home. R70's Resident Progress Note on 10/30/2012 by social services indicated a discharge meeting was held with OT, SS, RN, R70 and his son. The team recommended that R70 be discharged to home on 11/6/2012 with Heritage Home Care services and social services would continue to monitor. A physical therapy Updated Plan of Progress for Outpatient Rehabilitation dated 11/6/2012 indicated R70 had made excellent progress towards functional outcomes and goals and reached his maximum potential with goals. The plan was to discharge to home with family assistance and home care services. During interview on 12/19/2012 at 9:35 a.m., DOB stated R70 had a plateau with therapy and knew that therapy wasn't going to be able to help him anymore, so he decided to go home. DOB went on to say that R70 did not get a letter, he met his goals and chose to go home. Facility policy titled Beneficiary Notices, dated November 2012, indicated "it is the policy of the facility to follow the CMS regulations for notification of beneficiaries when a Medicare stay will be ending. The beneficiary is notified using the current version of the CMS required form and is given to the beneficiary at least 2 days prior to the date that the facility has determined to be the last Medicare-covered date." Even though R70 had a planned discharge, the facility did not give them a Notice of Medicare	21800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2012
NAME OF PROVIDER OR SUPPLIER ELIM HOME - MILACA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SECOND STREET SOUTHEAST, PO BOX 157 MILACA, MN 56353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
21800	Continued From page 10 Non-Coverage (CMS-10123) two days before the discontinuation of skilled services. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are requesting a demand bill are given the appropriate medicare denial letter and non-coverage forms. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800			