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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SW9I

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 **08/30/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fisher, Unit Supervisor — 09/07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Ceritification Specialist — 09/11/2017 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/08/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245127 September 7, 2017

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

Dear Ms. Kucera:

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

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

Effective August 11, 2017 the above facility is recommended for:

57 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 7, 2017

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

RE: Project Number S5127027

Dear Ms. Kucera:

On August 4, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 20, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On August 30, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 21, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 20, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 11, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 20, 2017, effective August 11, 2017 and therefore remedies outlined in our letter to you dated August 4, 2017, 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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 7, 2017

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

Re: Reinspection Results - Project Number S5127027

Dear Ms. Kucera:

On August 30, 2017 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 July 20, 2017, with orders received by you on August 3, 2017. At this time these correction orders were found corrected.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SW9I

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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 **07/20/2017** (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)

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10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE — Date :
Michell Koch, HFE-NE II — 08/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Certification Specialist — 09/07/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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3. Both of the Above :
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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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 4, 2017

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

RE: Project Number S5127027

Dear Ms. Kucera:

On July 20, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) has been electronically delivered.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fisher, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fisher@state.mn.us
Phone: (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 August 28, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 20, 2017 (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 20, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	C 07/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/17/17 through 7/20/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Mille Lacs Health System was found to not be in compliance with the regulations of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing	F 156		8/11/17

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

Electronically Signed | 08/10/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	C 07/20/2017

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 156	Continued From page 1	F 156		

(including Braille) in a format and a language he or she understands, including:

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	C 07/20/2017

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 156	Continued From page 2 information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation,	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	C 07/20/2017

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F 156	Continued From page 3	F 156		

misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must 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.

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F 156	Continued From page 4 (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) 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. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) 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 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 5 this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the	F 156		

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F 156	Continued From page 6 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) were provided in a timely manner upon termination of covered services for 2 of 3 residents (R64, R53) reviewed for liability notices. Findings include: R64's Notice of Medicare Non-Coverage (NOMNC) form Center Medicare/Medicaid Services (CMS) 10123 dated 6/29/17, identified R64's Medicare A covered services ended on 7/3/17 and had the rights to appeal this decision. The form was signed by R64's representative on 6/29/17. R64's SNFABN dated 6/15/17, identified directions of, "It is not Medicare's opinion, but our opinion, that Medicare will not pay for the items or services described below ... Medicare only pays for covered items and services when Medicare rules are met ...," further adding, "Right now, in your case, Medicare probably will not pay for," and provided spacing in which staff handwrote, "Haircuts/incidentals." The form was signed by R64 herself on her day of admission, 6/15/17, 17 days before Medicare services ended. The remainder of the form, including areas identifying if R64 elected to receive any non-covered services, other insurances, and estimated cost(s) were all left blank. R64's Admin Census/Rates listing dated 7/18/17, identified R64 was admitted on 6/15/17, with a	F 156	F156 (R64 AND R53) with the Potential to affect all residents with NOTIFICATION OF MEDICARE OR MEDICAL ASSISTANCE COVERAGE AND NOTICE OF NON-COVERAGE OR CHANGES IN COVERAGE RELATED TO PAYMENT FOR SERVICES. " A review of the Medicare Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) guidelines as directed by CMS was completed by the DON, Social Worker, and Billing Staff. " The Interdisciplinary Team (IDT) implemented a calendar to track skilled services during bi-weekly team meetings that include therapy staff. This calendar will ensure tracking of skilled coverage dates and timeliness notification to residents/representatives. This calendar tracking was initiated on 8/4/17. " A revised facility policy on issuance of SNFABN was completed on 8/8/17. " The Social Worker and Billing Staff were educated on the SNFABN policies, procedures,and forms on 8/8/17. " Admission documents including the admission agreement were reviewed by the Social Worker to ensure consistency with the CMS SNFABN guidelines and completed on 8/8/17. " A review of current Medicare Skilled residents admission and financial documents regarding SNFABN was completed by the Social Worker and Billing Coordinator. Residents or resident	

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F 156	Continued From page 7 payer source listed as, "Medicare A," until 7/3/17, when the payer source changed to, "Private Pay." The listing identified R64 had one day of private pay responsibility for over $300.00, and then discharged from the facility. R64's medical record was reviewed and lacked any evidence R64 had been provided a SNFABN when her Medicare A coverage ended and before she became private pay in the facility. R64 received the SNFABN upon admission. R53's NOMNC, CMS 10133 form dated 2/27/17, identified R53's Medicare A covered services were ending on 3/1/17, and had the rights to appeal this determination. The form was signed her R53's representative on 2/27/17. R53's Admin Census/Rates listing dated 7/18/17, identified R53 had been covered under Medicare A until 2/28/17, when her payer source switched to Medicaid, even though the facility identified R53's Medicare coverage would end on 3/1/17, and remained in the facility for care and services. R53's medical record was reviewed and lacked any evidence R53 had been provided a SNFABN when her Medicare A coverage ended on 2/28/17, which should have been completed two days prior to discharge from Medicare. During interview on 7/18/17, at 2:39 p.m. facility biller (B)-A stated R64 admitted under Medicare A coverage for therapy while in the SNF. B-A stated R64's Medicare A coverage ended on 7/3/17, and R64 became private pay adding she did receive a bill for one day of care in the SNF and paid it. B-A stated R53 admitted under	F 156	representatives were notified if the incorrect SNFABN had been signed. (This was found to be the case for 2 of 3 current residents receiving skilled/Medicare services). The notification to these residents/resident representatives will be completed by 8/11/17. No billing claims or adjustments were needed. " Audits of all residents SNFABN will be completed to determine that residents/resident representatives receive the SNFABN according to policy will be completed weekly x4, and then monthly x3 by the DON or designee starting on 8/21/17. " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: DON, Social Worker, and Billing Staff	

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F 156	Continued From page 8 Medicare A coverage for therapy while in the SNF as well, however, switched to Medicaid after completion of her coverage services. B-A stated the facility process was to provide all residents who come to the facility on Medicare the SNFABN's upon admission to the facility, and not when their covered Medicare A services were ending. B-A reviewed R64 and R53's medical record(s) and stated R64 did not receive any additional SNFABNs upon termination of her covered services, and staff were unable to locate any evidence R53 received a SNFABN at all, including upon admission. B-A stated, after reviewing these forms and the regulation guidance with the surveyor, all notices of Medicare non-coverage should be given timely and as required. A facility policy on notices of Medicare non-coverage and SNFABNs was requested, but none was provided.	F 156		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at	F 164		8/4/17

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F 164	Continued From page 9 §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was provided for 1 of 3 residents (R2) in the sample who required staff assistance with activities of daily living. Findings include: R2's 14-day Minimum Data Set (MDS) dated 4/27/17, identified R2 had intact cognition and	F 164	F164 (R2) with the Potential to affect all residents regarding PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS. " A mandatory educational module covering resident privacy and other resident rights was assigned to all facility staff on 8/4/17. " An additional review regarding resident privacy expectations will be done	

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F 164	Continued From page 10 required extensive assistance with locomotion and transfers. During observation on 07/19/17 at 7:03 a.m., R2 was in his room in bed. R2's window blinds was open and the facility courtyard was visible outside his window. Nursing assistant (NA)-F entered R2's room, and began to set up for morning cares. NA-F filled a water basin, then assisted R2 to wash his face and hands, and had not closed the window blinds to provide full visual privacy. At 7:14 a.m., NA-F finished his grooming care, was going to have R2 stand up to provide perineal care while he was unclothed from the waist down. Before NA-F assisted R2 to stand, the surveyor intervened and questioned NA-F about the open window blinds to the facility courtyard. NA-F lowered the blinds, but was unable to cover the entire window because of pictures sitting on the window sill. The blind was lowered to approximately one foot from the window sill. NA-F assisted R2 to complete his morning routine and cares. When interviewed on 7/19/17 at 7:19 a.m., NA-F stated she would normally lower the window blind all the way, but the pictures were in the way. The pictures should have been moved to lower the window blind all the way to the sill. NA-F stated it was important to provide R2 with privacy during cares. During interview on 7/20/17 at 11:45 a.m. with the director of nursing (DON) and registered nurse (RN)-A, the DON stated all blinds and privacy curtains should be closed prior to initiating cares. RN-A stated "this is important" to provide privacy and respect for residents.	F 164	by the DON at mandatory staff meetings on 8/22/17 and 8/23/17. (This review will include closure of window blinds during ADL care, pulling of resident room divider curtains for double rooms, knocking on doors prior to entering, etc.) " Resident Bill of Rights (including privacy) will be reviewed by the DON at mandatory staff meetings on 8/22/17 and 8/23/17. " Random audits on resident privacy (to include direct observation and resident/family interviews will be completed weekly X4, then monthly X3 by the DON or designee starting on 9/4/17. " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: DON or Designee	

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F 241	Continued From page 11	F 241		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 4 of 6 residents (R37, R10, R6, and R50) in the memory care unit who needed assistance to eat; and 4 of 4 residents (R21, R22, R42, and R47) observed in the main dining room. Also, the facility failed to provide a dignified transfer experience for 1 of 1 residents (R30) who needed assistance with transfers, and failed to knock or ask permission before entering resident rooms for two residents (R2 and R43) during five observations of care provision. Findings include: DIGNIFIED MEAL SERVICE R37's annual Minimum Data Set (MDS) dated 5/4/17, indicated R37 was severely, cognitively impaired and required extensive assistance and the physical assistance of one staff to eat. A facility document, "Details on Nursing Care Plan" dated 6/9/17, indicated staff were "to assist resident with eating and encourage resident to participate." R10's quarterly MDS dated 2/20/17, indicated R10 was severely, cognitively impaired, and	F 241	F241 Dignity and Respect of Individuality DIGNIFIED MEAL SERVICE (R37, R10, R6, R50, R21, R22, R42, R47) with the Potential to affect all residents regarding DIGNIFIED DINING EXPERIENCES. " Feeding Assistance care plans and food tickets were reviewed for accuracy by the RN Care Coordinators and Dietary staff. This will be completed on 8/11/17. " The DON and Nutrition Services Manager met to review dining room processes for both Memory Care and the main dining room. Staff interviews were conducted to gain ideas on improving dining room procedures. These interviews concluded that in the main dining room staff roles and the current system of resident seating and taking meal preferences needed changing. " The Nutrition Services Manager developed a Long Term Care Dining Room Protocol on 8/9/17 to outline changes to meal service for both the main dining room and Memory Care units. These changes include seating of residents, how meal choices are obtained	8/11/17

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F 241	Continued From page 12 required extensive assistance and the physical assistance of one staff to eat. The "Details on Nursing Care Plan" undated, indicated staff were to assist R10 with eating, and "level of assist varies with how well R10 stays on task each day. Staff assists with tray set up." R6's quarterly MDS dated 6/4/17, indicated R6 was severely cognitively impaired, and required total staff assistance with eating and all activities of daily living. During observation on 7/18/17 at 8:21 a.m. of the meal service in the memory care unit, nursing assistant (NA)-D and trained medication assistant (TMA)-A began delivering meals from the kitchen service window to seven residents seated at the large table for breakfast. At 8:27 a.m., NA-D placed R10's serving of pureed scrambled eggs, bread, a bowl of hot oatmeal and a single serving container of yogurt in front of her and tied her clothing protector, and left. R10 stared at the food and made no effort to eat, nor was encouraged to begin eating. TMA-A and NA-D intermittently left R37's table and returned with other residents' breakfasts. At 8:40 a.m. NA-D served R37 a scrambled egg-filled croissant sandwich, bowl of oatmeal, along with beverages. The remaining residents at the table had already received their meals, had clothing protectors placed and began consuming their meals. Meanwhile, at 8:40 a.m., TMA-A administered eye drops to R6, cleaned his hands, sat down and began to assist R6 with breakfast. TMA-A then started talking with NA-D about the storm that went through town last evening, but did not engage in conversation with R6. After conversing with TMA-A for two minutes, NA-D walked away	F 241	and roles/responsibilities of staff (NAR, Dietary, and Activities staff). This protocol will be implemented on 8/28/17 following staff and resident education. " The Nutritional Services Manager developed a training document to educate staff on the changes to meal service that will be used in nursing staff meetings (8/22/17 and 8/23/17). " RN Coordinators performed observations of the Memory Care unit dining processes. (These were completed on 8/6/17 and 8/10/17). Findings of these observations included the need for clarifying toileting on rounds prior to meals to avoid interruptions and reviewing feeding assistance guidelines with staff. " A self-learning packet was developed for staff working in the Memory Care unit which describes expectations of feeding assistance in the Memory Care unit including toileting rounds prior to meals, engaging residents in eating and conversation, and how to seek additional staff assistance when needed. These packets will be distributed on 8/11/17. " The DON will reinforce education for NAR, Activity, and Nursing staff on feeding assistance guidelines for Memory Care and the new Long Term Care Dining Room Protocol at the mandatory staff meetings on 8/22/17 and 8/23/17. " Residents and resident representatives will be educated about the changes to the main dining room verbally, during "Fridays on the Patio" (those not present will receive individual notification), and in the monthly facility newsletter that	

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

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F 241	Continued From page 13 from the table to get something from the kitchen service window, temporarily leaving both R10 and R37 unassisted. During NA-D's absence, neither R10 nor R37 made any attempt to eat or feed themselves independently. At 8:46 a.m. NA-D returned from the kitchen area, then stood in front and between R37 and R10, and coaxed R37 to eat. NA-D held the juice cup and R37 drank a sip, then held the croissant sandwich and R37 took a bite. NA-D, was standing at the end of the table between R37 and R10, turned toward R10, scooped a biteful on a spoon and began to feed R10 breakfast. NA-D alternately fed and held beverages for R37 and R10, standing as she provided help. Between 8:48 a.m. and the end of the breakfast meal at 9:15 a.m. (more than 25 minutes), NA-D provided assistance to R10 and R37 at the breakfast meal, while standing up between them for the entire meal. When interviewed on 7/18/17 at 9:49 a.m., nursing assistant (NA)-D stated she fed R10 and R37 breakfast while standing up. She normally does not stand up "to help with another feeder," but the residents today were seated "farther apart." "I should have had them closer," NA-D stated. R50's quarterly MDS dated 5/28/17, indicated R50 was severely, cognitively impaired, and required extensive assistance and the physical assistance of one staff to eat. The "Details on Nursing Care Plan" indicated R50 fed self "part of meal- will usually drink liquids on own. Staff to set up meal tray and keep resident on task to complete meal and assist if needed with eating." During observation on 7/19/17 at 12:27 p.m., the	F 241	is mailed to all resident families and resident representatives. " The Resident Food Committee will be used to provide feedback regarding resident satisfaction with the new dining room changes at their monthly meetings. (Meeting is scheduled for 8/29/17). " Random audits on meal service for both the Memory Care Unit and main dining room to assess for resident dining experiences (to include direct observation and resident/family interviews) will be completed weekly X4, then monthly X3 by the DON, Nutrition Services Manager, or designee starting on 9/4/17. " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: DON, Nutrition Services Manager, or Designee DIGNITY WITH TRANSFER R30 with the potential to affect all residents with dignified transfers " The Social Worker completed an investigation of comments made by R30 to the state survey staff and finalized a plan with the DON per the facility Vulnerable Adult policy. Interviews with staff (based on staff schedules and timelines of the resident□s comments), suggested one NAR needed further training on providing dignity during transfers. That NAR was removed from the floor and completed re-education (prior to being re-assigned to resident care) on Vulnerable Adults including communication with residents during	

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F 241	Continued From page 14 noon lunch began in the memory care unit, and seven residents, including R50 and R37, were seated around the table and started to be served their meals. At 12:39 p.m. NA-E delivered R50 meal plate in front of him, and NA-E announced to R50 it was time to eat. At 12:42 p.m. a meal was delivered to R37, who was seated across the table from R50. R37 reached for a clothing protector from the table, even though R37 was already wearing one, and began reaching for her plate. NA-E stood up and wheeled R37 to the same side of table by R50, and positioned both R37's and R50's plates so NA-E could sit between and assist them at the same time. At 12:45 p.m. R50 began to take bites of food on her own after encouragement by NA-E, who also begin feeding R50 spoonfuls of his meal. R50 was initially resistive and blocked NA-E's hand which held the spoon, but was able to consume three bites of food and a sip of drink. NA-E fed R50 three bites and was interrupted when R16 announced she needed to use the bathroom. At 12:50 p.m., NA-E stood up, stopped feeding R50 and placed her spoon on the table. NA-E then turned her attention to R16, who she told she would take to the bathroom. NA-E left the table, located a transfer belt, and took R16 to the bathroom in her room, and left R50 and R37 unattended. Even though another staff member, licensed practical nurse (LPN)-A was seated a the table assisting other residents, R37 stopped eating, and R50 grasped the spoon on the table, and was holding it in front of himself but made no attempt to eat. R37 and R50 did not eat or drink in the absence of NA-E. After toileting R16, NA-E returned to the table at 12:58 (8 minutes later) and resumed to assist R50, and encouraged R37 to eat her meal.	F 241	ADL's/transfers. The facility Vulnerable Adult policy and procedures were followed. " A mandatory educational module covering resident rights including dignity during resident care was assigned to all facility staff on 8/4/17. " A review regarding resident dignity expectations will be done by the DON at mandatory staff meetings on 8/22/17 and 8/23/17. (This will include dignity during transfers and communication while performing ADL□s). " Random audits to ensure dignity during transfers by direct observation and resident/family interviews) will be completed weekly X4, then monthly X3 by the DON, or designee starting on 9/4/17. " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: DON or Designee KNOCKING BEFORE ENTERING (RESIDENT PRIVACY) R2, R43 with the potential to affect all residents related to privacy (resident room entering) " A mandatory educational module covering resident rights including privacy was assigned to all facility staff on 8/4/17. " A review regarding resident privacy (knocking on doors) expectations will be done by the DON at mandatory staff meetings on 8/22/17 and 8/23/17. " Random audits on privacy for knocking on resident doors (by direct observation and resident/family	

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F 241	Continued From page 15 When interviewed on 7/19/17 at 1:58 p.m. NA-E stated she had to leave R50 and R37 at the table, unassisted, and help out another resident to toilet. NA-E stated meal interruptions occurred 2-3 times a week on the memory unit, and there were times when there should be "an additional person" to help out to "eliminate disruption of meals." NA-E stated R10 and R37 deserve undivided attention and they also deserve their meals served and eaten warm. There needs to be more than one of me, NA-E stated. When interviewed on 7/19/17 at 2:06 p.m. licensed practical nurse (LPN)-A acknowledged R10's and R37's noon meals were interrupted, and stated once all residents were seated and the food was out, everyone should sit down to eat at the same time. LPN-A stated there was a "float" staff in the building, but usually that staff helped out more in other parts of the building. LPN-A stated it would be good to have extra staff to help out when a resident needs to toilet during the meal, but we have to try and manage it. LPN-A stated this is maybe "something we need to look at." LPN-A also stated residents should not be assisted and fed standing up, and doing so makes the resident feel like "you don't have time to sit down and feed me." LPN-A stated she would have asked staff to sit down when assisting residents. During interview on 7/20/17 at 9:01 a.m. the director of nursing (DON) stated feeding residents while standing next to them "is not what we would expect" and was "not how we train" staff to provide feeding assistance. The DON stated she was working to reallocate staff to address times on the units when additional help	F 241	interviews) will be completed weekly X4, then monthly X3 by the DON or designee starting on 9/4/17. " The findings of these audits will be reported at Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: DON or Designee	

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F 241	Continued From page 16	F 241		

may be needed, and added staff have to learn to be assertive and call for "the float" if they feel it is getting too chaotic or too distracting. The DON stated meal time were for interaction and conversation, and expected to "minimize interruption" such as having to stop feeding one resident to toilet another.

When interviewed on 7/20/17 at 11:27 a.m. registered nurse (RN)-A stated residents needed to be toileted on the last rounds before meals, and staff needed to arrange residents, who needed help to eat, so they can be easily assisted. RN-A further stated her expectations would be that residents, and the staff who assist them, could all sit down, be at eye level with the residents, and not be interrupted by other needs during the meal service.

R21's annual MDS assessment of 4/17/17, identified the resident was cognitively intact and independent with eating.

R22's quarterly MDS assessment of 6/12/17, identified the resident was cognitively intact and was independent with eating.

R42's quarterly assessment of 6/30/17 identified some cognitive impairment and independent with eating.

R47's quarterly MDS of 6/30/17 identified some cognitive impairment and was independent with eating.

During observation in the main dining room on 7/19/17 at 12:12 p.m., R21, R47, and R42 were all seated at the same table awaiting the noon

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F 241	Continued From page 17	F 241		

meal. Dietary aide (DA)-C brought R21 her food at 12:12 p.m. At 12:21 p.m. (9 minutes later) R47 was served her meal. While R21 and R47 ate their food, R42 still had not yet received the noon meal. At 12:24 p.m., R22 arrived at the table as the fourth resident. A minute later, R42 stated "We ordered it [noon meal], but we haven't yet received it." R21 offered R42 and R22 taco chips to "tide them over" until their meals came. At 12:34 p.m., R22 was served their meal and was the last resident seated at the table. Meanwhile, R42 continued without any food, had a scowled expression on her face, and made comments about not having received her noon meal yet. At 12:38 p.m., R42, was still wafting for her meal as other residents (R21, R22, R47) at her table ate their meal. R42 began slapping her hands on the table making loud noises and harshly speaking, "Bring me something!" A unidentified visitor approached DA-D about R42's noon meal. At 12:41 p.m., 29 minutes later R42 was served her noon meal. R42 began to eat quickly, bite after bite, without pause to socialize. At the table, R42 commented the wait for the meal was long and this was "the usual" pattern of service.

During interview on 7/19/17 at 12:53 p.m., dietary aide (DA)-C and DA-D stated meals were served first come, first served, however if there are concerns addressed with foods not being served in a timely fashion, they (the serving staff) "will try to get their food out too." DA-C stated this was how they managed serving tables, and added some residents will come in and complain they don't have their food yet, "We will try to get their food out too." DA-D reviewed the delayed service to R42 and stated whomever took the order only put the "number symbol on the slip" and staff had to follow up with resident to determine what she

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F 241	Continued From page 18	F 241		

wanted for breakfast, causing a delay. DA-D stated he was unaware of the length of time it took to serve residents (R21, R22, R42, R47) at the one table to finally get served.

When interviewed on 7/19/17, at 1:05 p.m., R42 stated the wait for meals happens frequently. R42 stated, "I got so tired of waiting." R42 acknowledged although she ate some of her meal, she left before finishing her meal "because I had to sit there and wait." R42 stated she got so tired of waiting, and "everyone was eating." R42 stated this delay in meal service happened at least weekly.

During interview on 7/19/17 at 1:11 p.m. R22 and family member (FM)-A discussed the service pattern at meals. FM-A commented everyone was brought up differently. FM-A and R22 stated it was confusing as to how residents were to proceed in the dining room. FM-A stated were brought up that people didn't eat until everyone was served. Some get their meals "right away, and others wait and wait." FM-A stated that R42 had waited quite a while and was getting agitated. R22 stated when they come in, they let the aide know what they want for their meal. R22 stated if served the meal first, "I don't feel like I should eat it."

During interview on 7/19/17 at 1:24 p.m. R22 stated there frequently was confusion with services and it was not uncommon to have a delay. R22 stated when other residents don't have their food, "I am almost done."

DIGNITY WITH TRANSFER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 19 R30's quarterly Minimum Data Set (MDS) dated 5/3/17, indicated she was cognitively intact and needed extensive assist of one with transfers. R30's care plan dated 8/15/16, indicated she had dementia, Parkinson's and needs assist with bed mobility transfers and ambulation. R30's care plan dated 8/15/16, indicated she had alteration in mobility related to cerebral vascular accident, dementia and Parkinson's. The care plan further indicated she needed limited to extensive assist with transfers. During interview 7/17/17, at 6:31 p.m. R30 stated that on the night shift a few months ago a girl was making me stand up. R30 stated she would say stand up and that, "I can't lift you, I can't lift you." She was rude, she was unsure of her name but the unidentified nursing assistant was orientating someone and though she was showing off to them. During observation 7/19/17, at 7:33 a.m. nursing assistant (NA)-B was assisting R30 to transfer her from bed to her wheelchair. NA-B placed a belt around R30's waist and while she was sitting up in bed stated "1,2,3 were gonna get you up" she attempted this twice, then left the room and returned with a EZ-stand (a mechanical standing aide device) and transferred R30 into her wheelchair. R30's Progress Note dated 7/3/17, at 10:02 p.m. indicated "when nar's [nursing assistants] assisted resident to bed this evening, she almost fell, refusing to stand, NAR's lifted her into bed, resident stated multiple times," 'You are just throwing me around.' 'Now you are just throwing me around.' Will continue to monitor assistance need for transfer and ambulation."	F 241		

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F 241	Continued From page 20 During interview 7/20/17, at 9:35 a.m. R30 stated sometimes they transfer me with a belt and sometimes with the stand, "it depends, sometimes I can't stand." R30 referred to the progress note 7/3/17, at 10:02 p.m., and stated that incident did not make me feel good. R30 stated she told (NA-B) I am 91 years old and "when you get to my age is this the way you would want someone to treat you?" R30 stated she didn't feel (NA-B) treated her with respect but since that incident she has been good to me. During interview 7/20/17, at 10:19 a.m. licensed social worker (LSW) stated the incident was a dignity issue and the aides need to under stand the dignity issue and feels sometimes they need to realize they are working with the elderly and treat them with respect. KNOCK BEFORE ENTERING R2's 14-day Minimum Data Set (MDS) dated 4/27/17, identified R2 had intact cognition and required extensive assistance with locomotion and transfers. R43's significant change MDS dated 6/14/17, identified R43 had intact cognition and required extensive assistance with transfers. During observation and interview on 7/18/17, at 9:26 a.m. R2 and R43 were seated in their shared room with the door closed visiting with the surveyor. Nursing assistant (NA)-C opened the door to the room without any audible knocking or other announcement of presence and proceeded to enter the room without permission. R43	F 241		

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F 241	Continued From page 21	F 241		

abruptly held up his opened right hand to NA-A when she entered, causing her to stop. NA-C then looked at the surveyor seated on the opposite side of the room, backed out of the room and closed the door.

When interviewed immediately following, R2 stated he did not have any concerns with NA-C opening the door without knocking or announcing her presence as he had been in the Navy prior and privacy was not typically afforded to people there.

When interviewed on 7/18/17, at 9:58 a.m. R43 stated staff have opened the door without knocking before and he did not like it adding, "I don't think that's right to just zap into somebody's room like that."

During interview on 7/18/17, at 10:01 a.m. NA-C stated she had worked at the facility for several months. NA-C stated she, "should of knocked on the door first," before entering R43 and R2's room, however, it had been, "a crazy morning," and she, "didn't even think about it." Further, NA-C stated it was important to knock before entering a resident room, "for the residents dignity."

When interviewed on 7/18/17, at 11:29 a.m. registered nurse (RN)-B stated staff were expected to knock on resident doors prior to entering to provide privacy as, "this is their [residents] home," adding, "so often [staff] forget that." Further, RN-B stated she would be, "reinforcing that [need to knock on doors before entering]," with the staff.

A facility policy, Rights and Responsibilities of

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F 241	Continued From page 22 Patients/Residents, revised 6/17, under the "Quality of Life" section indicated: 1. Dignity. The facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality.	F 241		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was implemented for 1 of 3 residents (R24) reviewed who was dependent on staff for toileting and repositioning. Findings include: R24's quarterly Minimum Data Set (MDS) dated 5/9/17, indicated he had severe cognitive impairment and needed extensive assist of two physical assist with bed mobility and transfers. The MDS further indicated he was at risk for pressure ulcers and was always incontinent of urine and occasionally incontinent of bowel. R24's care plan dated 7/14/16, indicated he had potential for alteration in skin integrity related to incontinence , impaired mobility and history of	F 282	F282 (R24) with the Potential to affect all residents regarding SERVICES BY QUALIFIED PERSONS/PER CARE PLAN. " The policy/procedure related to comprehensive care plans was reviewed by the DON. " A listing of all residents requiring toileting, and/or turning or re-positioning schedules was reviewed by the RN Care Coordinators and completed on 8/5/17. " Staff was informed via e-mail on the need for following care plan and NAR assignment sheets related to toileting and positioning on 8/4/17. " A documentation record for all residents having care plan instructions for toileting, turning, or re-positioning schedules was implemented on 8/6/17.	8/6/17

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F 282	Continued From page 23 redness to his left heel. R24's toileting care plan directed staff to toilet every two hours during the day and check and change at night. R24's nursing assistant worksheet undated directed staff to turn and reposition every two hours and toilet every two hours and if resistive to toileting so may check and change. During continuous observation on 7/19/17, from 7:45 a.m. to 10:10 a.m. (2 hours and 25 minutes) R24 was observed sitting in his Broda chair (tilt and recline positioning chair), without being repositioned or toileted. At 7:45 a.m. R24 was sitting in his Broda chair, and remained sitting in his chair in his room until 7:55 a.m. At 8:00 a.m. R24 was in the dining room drinking a cup of coffee in his Broda chair and remained in the dining room eating his breakfast until 9:12 a.m.. At 9:14 a.m. R24 was wheeled from the dinning room to the day room to watch television and remained there until 10:09 a.m. At 10:09 a.m. he was wheeled to his room and transferred to the toilet. At 10:10 a.m. nursing assistant (NA)-B removed R24's incontinent product which was moderately wet with urine. From 7:45 a.m. to 10:10 a.m. staff made no attempts to assist R24 to toilet or reposition during this time. During interview 7/19/17, at 10:00 a.m. NA-A stated according to the nursing assistant worksheet R24 should be turned and positioned every two hours. NA-A stated she checked and changed R24 at 7:45 a.m., and then he was brought to breakfast. During interview 7/19/17, at 2:45 p.m. director of nursing (DON) stated R24 can be aggressive and at times can be resistive but would expect the staff to follow the care plan and what that states	F 282	These documentation records will be submitted to the DON for review. " Mandatory staff meetings will be held on 8/22/17 and 8/23/17 to reinforce the importance of following the toileting, turning or re-positioning schedules of residents. " Random audits on following the prescribed care plans for toileting, turning, or re-positioning schedules will be will be completed weekly X4, then monthly X3 by the DON or designee starting on 9/4/17. These audits will include review of the new toileting, turning or re-positioning document forms and direct observations of residents. " The findings of these audits will be reported at Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: DON, or Designee	

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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 282	Continued From page 24 is what they should be doing. Facility policy, Care Plan Procedure revised 3/17/17, indicated "Following the initial and comprehensive assessment, an individualized care plan will be developed for each resident. The facility develops the 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."	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely assistance with toileting for 1 of 3 residents (R24) who was incontinent of urine and dependent on staff for activities of daily living. Findings include: R24's quarterly Minimum Data Set (MDS) dated 5/9/17, indicated he had severe cognitive impairment and needed extensive assist of two physical assist with bed mobility and transfers. The MDS further indicated he was always incontinent of urine. R24's Care Area Assessment (CAA) dated 2/21/17, indicated he had bladder incontinence, and was on a check and change toileting schedule.	F 312	F312 (R24) with the Potential to affect all residents regarding ADL CARE PROVIDED FOR DEPENDENT RESIDENTS " The policy/procedure related to comprehensive care plans was reviewed by the DON. " A listing of all residents requiring toileting, and/or turning or re-positioning schedules was reviewed by the RN Care Coordinators on 8/5/17. " Staff was informed via e-mail on the need for following care plan and NAR assignment sheets related to toileting, turning and re-positioning on 8/4/17. " A documentation record for all residents having care plan instructions for	8/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	C 07/20/2017

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F 312	Continued From page 25 R24's care plan dated 7/14/16, indicated to toilet every two hours during the day and check and change at night. R24's nursing assistant worksheet undated directed staff to toilet the resident every two hours but was resistive to toileting so may check and change. During continuous observation on 7/19/17, from 7:45 a.m. to 10:10 a.m. (2 hours and 25 minutes) R24 was observed sitting in his Broda chair (tilt and recline positioning chair), without being toileted. At 7:45 a.m. R24 was sitting in his Broda chair, and remained sitting in his chair in his room until 7:55 a.m. At 8:00 a.m. R24 was in the dining room drinking a cup of coffee in his Broda chair and remained in the dining room eating his breakfast until 9:12 a.m.. At 9:14 a.m. R24 was wheeled from the dinning room to the day room to watch television and remained there until 10:09 a.m. At 10:09 a.m. he was wheeled to his room and transferred to the toilet. At 10:10 a.m. nursing assistant (NA)-B removed R24's incontinent product which was moderately wet with urine. From 7:45 a.m. to 10:10 a.m. staff made no attempts to assist R24 to toilet during this time. During interview 7/19/17, at 10:00 a.m. NA-A stated according to the nursing assistant worksheet R24 should be toileted every two hours. The resident was last checked and changed at 7:45 a.m. and brought to breakfast. During interview 7/19/17, at 2:45 p.m. director of nursing (DON) stated R24 can be aggressive and at times can be resistive but would expect the staff to provide timely incontinence care.	F 312	toileting, turning, or re-positioning was implemented on 8/6/17. These documentation records will be submitted to the DON for review. " Mandatory staff meetings will be held on 8/22/17 and 8/23/17 to reinforce the importance of following the toileting, turning or re-positioning schedules of residents. " Random audits on following the prescribed care plans for toileting, turning, or re-positioning schedules will be will be completed weekly X4, then monthly X3 by the DON or designee starting on 9/4/17. These audits will include review of the new toileting, turning or re-positioning document forms and direct observations of residents. " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: DON, or Designee	

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F 312	Continued From page 26 Facility policy, Care Plan Procedure revised 3/17/17, indicated, to develop the comprehensive care plan for each resident to meet a resident's medical, nursing, mental and psychosocial needs based on their assessment.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 3 residents (R24) reviewed in the sample identified at risk for pressure ulcers. Findings include: R24's quarterly Minimum Data Set (MDS) dated 5/9/17, indicated he had severe cognitive impairment and needed extensive assist of two physical assist with bed mobility and transfers.	F 314	F314 (R24) with the Potential to affect all residents regarding TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES " The policy/procedure related to comprehensive care plans was reviewed by the DON. " A listing of all residents requiring toileting, and/or turning or re-positioning schedules to maintain skin integrity and prevention of pressure ulcers was	8/6/17

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F 314	Continued From page 27 The MDS further indicated he was at risk for pressure ulcers and was always incontinent of urine and occasionally incontinent of bowel. R24's Care Area Assessment (CAA) dated 2/21/17, indicated he had no current skin condition, risk for pressure ulcer and needed a special mattress and required regular schedule of turning. The CAA further indicated he had dementia and had bowel and bladder incontinence and transfers with a lift. R24's care plan dated 7/14/16, indicated he had potential for alteration in skin integrity related to incontinence , impaired mobility and history of redness to his left heel, with interventions of: air mattress, cushion in wheelchair, float heels follow toileting and mobility care plan. R24's toileting care plan indicated to toilet every two hours during the day and check and change at night. R24's nursing assistant worksheet undated directed staff to turn and reposition every two hours and toilet every two hours and was resistive to toileting so may check and change. During continuous observation on 7/19/17, from 7:45 a.m. to 10:10 a.m. (2 hours and 25 minutes) R24 was observed sitting in his Broda chair (tilt and recline positioning chair), without being repositioned or toileted. At 7:45 a.m. R24 was sitting in his Broda chair, and remained sitting in his chair in his room until 7:55 a.m. At 8:00 a.m. R24 was in the dining room drinking a cup of coffee in his Broda chair and remained in the dining room eating his breakfast until 9:12 a.m.. At 9:14 a.m. R24 was wheeled from the dinning room to the day room to watch television and remained there until 10:09 a.m. At 10:09 a.m. he was wheeled to his room and transferred to the toilet. At 10::10 a.m. nursing assistant (NA)-B	F 314	reviewed and completed by the RN Care Coordinators on 8/5/17. " Staff was informed via e-mail on the need for following care plan and NAR assignment sheets related to toileting and/or turning re-positioning schedules on 8/4/17. " A documentation record for all residents having care plan instructions for toileting, turning, or re-positioning was implemented on 8/6/17. These documentation records will be submitted to the DON for review. " Mandatory staff meetings will be held on 8/22/17 and 8/23/17 to reinforce the importance of following the toileting, turning or re-positioning schedules of residents. " Random audits on following the prescribed care plans for toileting, turning, or re-positioning schedules will be will be completed weekly X4, then monthly X3 by the DON or designee starting on 9/4/17. These audits will include review of the new toileting, turning or re-positioning document forms and direct observations of residents. " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: DON, or Designee	

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F 314	Continued From page 28 removed R24's incontinent product that was moderately wet of urine and placed a new one on. Between 7:45 a.m. to 10:10 a.m. (2 hours and 25 minutes) staff made no attempts to assist R24 to reposition or check for incontinence. During interview 7/19/17, at 10:00 a.m. NA-A stated according to the nursing assistant worksheet R24 should be turned and positioned every two hours, and was last checked and changed at 7:45 a.m. and then brought to breakfast. When interviewed on 7/19/17, at 2:45 p.m., the director of nursing (DON) stated R24 can be aggressive and at times can be resistive but would expect the staff to provide timely repositiong and incontinence care. Facility policy, Care Plan Procedure revised 3/17/17, indicated, to develop the comprehensive care plan for each resident to meet a resident's medical, nursing, mental and psychosocial needs based on their assessment.	F 314		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by:	F 364		8/10/17

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F 364	Continued From page 29 Based on observation, interview and document review, the facility failed to ensure a system was in place to monitor food palatability and temperature for 4 of 39 residents (R42, R28, R21, and R18) who complained of cold food served in the main dinning room. Findings include: R42's quarterly Minimum Data Set (MDS) dated 4/30/17, indicated she was moderately cognitive intact. R42's Diet Type Report dated 6/20/17, indicated she received a regular diet. R28's quarterly MDS dated 6/15/17, indicated she was severely cognitively impaired. R28's Diet Type Report dated 6/20/17, indicated she received a regular diet. R21's annual MDS dated 4/17/17, indicated she was cognitively intact. R21's Diet Type Report dated 6/20/17, indicated she received a regular diet. R18's quarterly MDS dated 5/6/17, indicated she was cognitively intact. R18's Diet Type Report dated 6/20/17, indicated she received a regular diet. During observation of the evening meal service on 7/17/17 in the afternoon a facility menu was posted to the entrance of the dinning room that identified beef stroganoff, buttered noodles, seasoned beets with bread and butter and the alternative listed was barbeque blue cheese pork sandwich, strawberry spinach salad and honey dew melon were being served that evening. During observation on 7/17/17, at 4:31 p.m. the	F 364	F364 R42, R28, R21, R18 with the potential to affect all residents regarding NUTRITIVE VALUE/APPEARANCE, PALATABLE/PREFERRED TEMPERATURES. " The Nutrition Services Manager completed an on-line webinar on CMS Regulations for Long Term Care Nutrition on 8/2/17. " The Nutrition Services Manager contacted consulting dietitians for guidance in developing a Long Term Care Dining Room Protocol that includes meeting residents needs for palatable food. " The DON and Nutrition Services Manager met to review dining room processes for both Memory Care and the main dining room. Staff interviews were conducted to gain ideas on improving dining room procedures. These interviews concluded that in the main dining room staff roles and the current system of resident seating and taking meal preferences needed changing. " Dietary staff meetings were held on 8/8/17 and 8/9/17 to outline palatable food goals for residents. " The Nutrition Services Manager developed a Long Term Care Dining Room Protocol to outline changes to meal service for both the main dining room and Memory Care units. These changes include the seating of residents, how meal choices are obtained and roles/responsibilities of staff (NAR, Dietary, and Activities staff). This protocol was developed on 8/9/17 and will be implemented on 8/28/17 following staff	

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F 364	Continued From page 30 food arrived in a closed plastic cart in the main dinning room. Dietary Aide (DA)-A removed the food and assisted DA-B by placing food in the metal steam table pans. The food was left uncovered in the steam table and DA-B took the temperature of the meal. The temperature of the noodles were 130 degrees Fahrenheit (F). DA-B stated they would send the noodles back to the kitchen to get hotter. At 4:53 p.m. DA-B began serving the meal. The meal was served from 4:53 p.m. until 5:48 p.m. a total of 54 minutes. During the entire meal service the food was in the steam table but was uncovered. During interview's on 7/17/17, at 5:10 p.m. R42 stated " the noodles aren't hot" but the rest of the meal was good and warm. At 5:12 p.m. R28 stated "its cold" the stroganoff and noodles are cold and "its lousy". At 5:14 p.m. R21 stated "the beef is warm but the noodles are almost cold". During a resident interview on 7/18/17, at 9:15 a.m., R18 stated the meals are often served cold, which frequently occurred at the noon and evening meals. The vegetables were cold when served and the casseroles are not very warm when served. R18 stated they addressed this concern at the Resident Council meeting in June, but it continues to be a problem. When DA-B finished serving a sample tray was requested by the surveyor at 5:48 p.m. The noodles tasted lukewarm and hard. DA-A also tasted the food and stated "the noodles could be a little warmer". Review of the Production Record from the kitchen, dated 7/17/17, indicated the noodles temperature was 144 degrees F for the evening	F 364	and resident education. Resident education will be done by presentation at "Fridays on the Patio", individual resident education and newsletter communication to resident families/resident representative. " The Nutritional Services Manager developed a training document on 8/9/17 to educate staff on the changes to meal service that will be used in nursing staff meetings (8/22/17 and 8/23/17). " Mandatory staff meetings will be held with the NAR, Activity, and Nursing staff on 8/22/17 and 8/23/17 to review the guidelines related to palatable meal service. " The Resident Food Committee will be used to provide feedback regarding resident satisfaction with the palatability of food at their monthly meetings. " Random audits regarding food palatability (using interviews with residents during care conferences and including resident representatives) will be done weekly X4, then monthly X3 by the facility dietitians. " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: Nutrition Services Manager or designees, DON	

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F 364	Continued From page 31 meal. Review of the Tray Line Temperature log taken in the dinning room identified the noodles temperature were 162 deg. F, prior to service. Review of the facility Food Committee Minutes for the last six months indicated on 1/31/17, a meeting was held and the residents responded over the Fall/Winter menus "food is sometimes cold, especially vegetables which can be cold and mushy". During interview 7/19/17, at 1:51 p.m. dietary manager (DM) stated they take temperatures of the food in the kitchen before they go down to the dinning room and the temperatures are taken again in the dinning room. The DM stated if foods were not hot enough, they are sent back to the kitchen. The DM further stated the facility has a food committee that meets monthly. The DM stated she has had complaints of cold food in January. Review of the facility food temperature identified Holding Temperature Audit's were completed on 2/3/17 and 2/7/17. The audits indicated the food temperatures were with in range but no additional audits were completed. A facility policy regarding palatability of food was requested, but was not received.	F 364		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 371		8/9/17

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F 371	Continued From page 32 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to serve food in a sanitary manner in 1 of 2 dinning rooms (main dinning room) which had the potential to affect 39 residents who were served from the main dining room. Findings include: During observation of meal service in the main dining room 7/17/17, at 4:53 p.m. dietary aide (DA)-A had gloves on, went into the refrigerator with the same gloves, removed a container of orange juice and proceed to bring R22's plate with her. DA-A continued with the same gloves and removed milk from a tray and placed it in a bin with ice. DA-A then wiped the tip of her nose with her left gloved hand and then took R28's plate and touched the lip of the plate which had	F 371	F371 R22, R28 with the potential to affect all residents regarding FOOD PROCUREMENT, STOREAGE/PREPARATION/SERVICE " The Nutrition Services Sanitation Procedure was reviewed by the facility Infection Control Coordinator and Nutrition Services Manager. " Staff training materials on hand washing and glove use was reviewed. Reinforcement on hand washing and glove use for Dietary staff was completed at staff meetings on 8/8/17 and 8/9/17. " Random audits by direct observation of glove use for the dietary staff will be done weekly X4, then monthly X3 beginning 9/4/17. " The findings of these audits will be	

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	245127	A. BUILDING _____ B. WING _____	C 07/20/2017

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F 371	Continued From page 33 food on it with her left soiled glove, and served R28. At 5:03 p.m. DA-A, proceeded with the same soiled gloves, and took a banana, cut in half, peeled it, placed it on a plate and handed the plate to DA-B who proceeded to add other foods to the plate. DA-A did not remove her soiled gloves or washed her hands after touching her nose. At 5:20 p.m., DA-B wiped the lid of her eye with her right gloved hand and proceeded to serve seven resident meals, touching each of the plates and placed bread on the plates with the same soiled gloves. DA-B did not remove her soiled gloves or wash her hands after wiping the lid of her eye. During interview 7/19/17, at 1:51 p.m. with dietary manager (DM) stated that if the staff touched their face during meal service, she would expect staff to change gloves before serving residents their food. A facility policy Nutrition Services Sanitation Procedures revised 7/16, indicated "In order to safeguard the health of the residents, patients, and staff, Nutrition Services will maintain guidelines in infection control". The policy further stated hand washing is done frequently and correctly by all Dietary staff. A additional policy dated 10/30/14, Nutrition services Department Training indicted to wash hands after touching clothing, hair, face or anything on your person.	F 371	reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: Nutrition Services Manager or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2017**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Mille Lacs Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/10/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2017**

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
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Inspected as one building: 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.	K 000		

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	245127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2017**

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K 000	Continued From page 2 The facility has a licensed capacity of 57 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 133 SS=D	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.1.3.3. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 10 of 49 residents, as well as an undetermined number of staff, and visitors.	K 133	On 7/21/17 The chief engineer (KV) completed fire caulking the two conduits between Long Term Care and Physical Therapy thus making this smoke barrier compliant as witnessed by Facility Manager	7/21/17

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K 133	Continued From page 3 Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 07/19/2017, observations revealed that the fire rated wall separating the main care center from the attached physical therapy addition has two sections of conduit piping running through the separation that had penetrations around the piping. This deficient condition was verified by a Maintenance Supervisor.	K 133		
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 4 smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 10 of 47 residents as well as an	K 372	On 7/26/17 a new larger flange was installed around smoke compartment number 8 HVAC making compartment 8 smoke and fire proof and compliant per codes as witnessed by Facility Manager	7/26/17

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K 372	Continued From page 4 undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 07/19/2017, observations revealed that the Smoke Compartment 8 smoke barrier located by resident room 23 has a 1 inch square opening outside of the flange connection of the HVAC duct work that is passing through the smoke barrier wall. This deficient condition was verified by a Maintenance Supervisor.	K 372		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 3, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5127027

Dear Ms. Kucera:

The above facility was surveyed on July 17, 2017 through July 20, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fisher, Unit Supervisor at (320) 223-7338 or brenda.fisher@state.mn.us .

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	C 07/20/2017

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/17/17 through 7/20/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: F282 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan	2 565	Corrected	8/6/17

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2 565	Continued From page 2 of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 3 residents (R24) reviewed in the sample identified at risk for pressure ulcers. Findings include: R24's quarterly Minimum Data Set (MDS) dated 5/9/17, indicated he had severe cognitive impairment and needed extensive assist of two physical assist with bed mobility and transfers.	2 900	Corrected	8/6/17

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2 900	Continued From page 3 The MDS further indicated he was at risk for pressure ulcers and was always incontinent of urine and occasionally incontinent of bowel. R24's Care Area Assessment (CAA) dated 2/21/17, indicated he had no current skin condition, risk for pressure ulcer and needed a special mattress and required regular schedule of turning. The CAA further indicated he had dementia and had bowel and bladder incontinence and transfers with a lift. R24's care plan dated 7/14/16, indicated he had potential for alteration in skin integrity related to incontinence , impaired mobility and history of redness to his left heel, with interventions of: air mattress, cushion in wheelchair, float heels follow toileting and mobility care plan. R24's toileting care plan indicated to toilet every two hours during the day and check and change at night. R24's nursing assistant worksheet undated directed staff to turn and reposition every two hours and toilet every two hours and was resistive to toileting so may check and change. During continuous observation on 7/19/17, from 7:45 a.m. to 10:10 a.m. (2 hours and 25 minutes) R24 was observed sitting in his Broda chair (tilt and recline positioning chair), without being repositioned or toileted. At 7:45 a.m. R24 was sitting in his Broda chair, and remained sitting in his chair in his room until 7:55 a.m. At 8:00 a.m. R24 was in the dining room drinking a cup of coffee in his Broda chair and remained in the dining room eating his breakfast until 9:12 a.m.. At 9:14 a.m. R24 was wheeled from the dinning room to the day room to watch television and remained there until 10:09 a.m. At 10:09 a.m. he was wheeled to his room and transferred to the toilet. At 10::10 a.m. nursing assistant (NA)-B removed R24's incontinent product that was	2 900		

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2 900	Continued From page 4 moderately wet of urine and placed a new one on. Between 7:45 a.m. to 10:10 a.m. (2 hours and 25 minutes) staff made no attempts to assist R24 to reposition or check for incontinence. During interview 7/19/17, at 10:00 a.m. NA-A stated according to the nursing assistant worksheet R24 should be turned and positioned every two hours, and was last checked and changed at 7:45 a.m. and then brought to breakfast. When interviewed on 7/19/17, at 2:45 p.m., the director of nursing (DON) stated R24 can be aggressive and at times can be resistive but would expect the staff to provide timely repositiong and incontinence care. Facility policy, Care Plan Procedure revised 3/17/17, indicated, to develop the comprehensive care plan for each resident to meet a resident's medical, nursing, mental and psychosocial needs based on their assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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2 920	Continued From page 5	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely assistance with toileting for 1 of 3 residents (R24) who was incontinent of urine and dependent on staff for activities of daily living. Findings include: R24's quarterly Minimum Data Set (MDS) dated 5/9/17, indicated he had severe cognitive impairment and needed extensive assist of two physical assist with bed mobility and transfers. The MDS further indicated he was always incontinent of urine. R24's Care Area Assessment (CAA) dated 2/21/17, indicated he had bladder incontinence, and was on a check and change toileting schedule. R24's care plan dated 7/14/16, indicated to toilet every two hours during the day and check and change at night. R24's nursing assistant worksheet undated directed staff to toilet the resident every two hours but was resistive to toileting so may check and change. During continuous observation on 7/19/17, from 7:45 a.m. to 10:10 a.m. (2 hours and 25 minutes)	2 920	Corrected	8/6/17

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2 920	Continued From page 6 R24 was observed sitting in his Broda chair (tilt and recline positioning chair), without being toileted. At 7:45 a.m. R24 was sitting in his Broda chair, and remained sitting in his chair in his room until 7:55 a.m. At 8:00 a.m. R24 was in the dining room drinking a cup of coffee in his Broda chair and remained in the dining room eating his breakfast until 9:12 a.m.. At 9:14 a.m. R24 was wheeled from the dinning room to the day room to watch television and remained there until 10:09 a.m. At 10:09 a.m. he was wheeled to his room and transferred to the toilet. At 10:10 a.m. nursing assistant (NA)-B removed R24's incontinent product which was moderately wet with urine. From 7:45 a.m. to 10:10 a.m. staff made no attempts to assist R24 to toilet during this time. During interview 7/19/17, at 10:00 a.m. NA-A stated according to the nursing assistant worksheet R24 should be toileted every two hours. The resident was last checked and changed at 7:45 a.m. and brought to breakfast. During interview 7/19/17, at 2:45 p.m. director of nursing (DON) stated R24 can be aggressive and at times can be resistive but would expect the staff to provide timely incontinence care. Facility policy, Care Plan Procedure revised 3/17/17, indicated, to develop the comprehensive care plan for each resident to meet a resident's medical, nursing, mental and psychosocial needs based on their assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents who need assistance to complete their activities of daily living (ADLs) to assure they are receiving the assistance they require. The	2 920		

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2 920	Continued From page 7 director of nursing or designee, could conduct random audits of the delivery of care, to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system was in place to monitor food palatability for 4 of 39 residents (R42, R28, R21, and R18) who complained of cold food served in the main dinning room. Findings include: R42's quarterly Minimum Data Set (MDS) dated 4/30/17, indicated she was moderately cognitive intact. R42's Diet Type Report dated 6/20/17, indicated she received a regular diet. R28's quarterly MDS dated 6/15/17, indicated she was severely cognitively impaired. R28's Diet Type Report dated 6/20/17, indicated she received a regular diet. R21's annual MDS dated 4/17/17, indicated she was cognitively intact. R21's Diet Type Report dated 6/20/17, indicated she received a regular	2 960	Corrected	8/10/17

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2 960	Continued From page 8 diet. R18's quarterly MDS dated 5/6/17, indicated she was cognitively intact. R18's Diet Type Report dated 6/20/17, indicated she received a regular diet. During observation of the evening meal service on 7/17/17 in the afternoon a facility menu was posted to the entrance of the dinning room that identified beef stroganoff, buttered noodles, seasoned beets with bread and butter and the alternative listed was barbeque blue cheese pork sandwich, strawberry spinach salad and honey dew melon were being served that evening. During observation on 7/17/17, at 4:31 p.m. the food arrived in a closed plastic cart in the main dinning room. Dietary Aide (DA)-A removed the food and assisted DA-B by placing food in the metal steam table pans. The food was left uncovered in the steam table and DA-B took the temperature of the meal. The temperature of the noodles were 130 degrees Fahrenheit (F). DA-B stated they would send the noodles back to the kitchen to get hotter. At 4:53 p.m. DA-B began serving the meal. The meal was served from 4:53 p.m. until 5:48 p.m. a total of 54 minutes. During the entire meal service the food was in the steam table but was uncovered. During interview's on 7/17/17, at 5:10 p.m. R42 stated " the noodles aren't hot" but the rest of the meal was good and warm. At 5:12 p.m. R28 stated "its cold" the stroganoff and noodles are cold and "its lousy". At 5:14 p.m. R21 stated "the beef is warm but the noodles are almost cold". During a resident interview on 7/18/17, at 9:15 a.m., R18 stated the meals are often served cold,	2 960		

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	00374	A. BUILDING: _____ B. WING _____	C 07/20/2017

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2 960	Continued From page 9 which frequently occurred at the noon and evening meals. The vegetables were cold when served and the casseroles are not very warm when served. R18 stated they addressed this concern at the Resident Council meeting in June, but it continues to be a problem. When DA-B finished serving a sample tray was requested by the surveyor at 5:48 p.m. The noodles tasted lukewarm and hard. DA-A also tasted the food and stated "the noodles could be a little warmer". Review of the Production Record from the kitchen, dated 7/17/17, indicated the noodles temperature was 144 degrees F for the evening meal. Review of the Tray Line Temperature log taken in the dinning room identified the noodles temperature were 162 deg. F, prior to service. Review of the facility Food Committee Minutes for the last six months indicated on 1/31/17, a meeting was held and the residents responded over the Fall/Winter menus "food is sometimes cold, especially vegetables which can be cold and mushy". During interview 7/19/17, at 1:51 p.m. dietary manager (DM) stated they take temperatures of the food in the kitchen before they go down to the dinning room and the temperatures are taken again in the dinning room. The DM stated if foods were not hot enough, they are sent back to the kitchen. The DM further stated the facility has a food committee that meets monthly. The DM stated she has had complaints of cold food in January. Review of the facility food temperature identified Holding Temperature Audit's were completed on	2 960		

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2 960	Continued From page 10 2/3/17 and 2/7/17. The audits indicated the food temperatures were with in range but no additional audits were completed. A facility policy regarding palatability of food was requested, but was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review dining services as it relates to timely delivery and resident meals. The director of nursing or designee, could conduct random audits of resident dining meal times to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to serve food in a sanitary manner in 1 of 2 dinning rooms (main dinning room) which had the potential to affect 39 residents who were served from the main dining room. Findings include: During observation of meal service in the main dining room 7/17/17, at 4:53 p.m. dietary aide	21015	Corrected	8/9/17

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21015	Continued From page 11 (DA)-A had gloves on, went into the refrigerator with the same gloves, removed a container of orange juice and proceed to bring R22's plate with her. DA-A continued with the same gloves and removed milk from a tray and placed it in a bin with ice. DA-A then wiped the tip of her nose with her left gloved hand and then took R28's plate and touched the lip of the plate which had food on it with her left soiled glove, and served R28. At 5:03 p.m. DA-A, proceeded with the same soiled gloves, and took a banana, cut in half, peeled it, placed it on a plate and handed the plate to DA-B who proceeded to add other foods to the plate. DA-A did not remove her soiled gloves or washed her hands after touching her nose. At 5:20 p.m., DA-B wiped the lid of her eye with her right gloved hand and proceeded to serve seven resident meals, touching each of the plates and placed bread on the plates with the same soiled gloves. DA-B did not remove her soiled gloves or wash her hands after wiping the lid of her eye. During interview 7/19/17, at 1:51 p.m. with dietary manager (DM) stated that if the staff touched their face during meal service, she would expect staff to change gloves before serving residents their food. A facility policy Nutrition Services Sanitation Procedures revised 7/16, indicated "In order to safeguard the health of the residents, patients, and staff, Nutrition Services will maintain guidelines in infection control". The policy further stated hand washing is done frequently and correctly by all Dietary staff. A additional policy dated 10/30/14, Nutrition services Department Training indicted to wash hands after touching clothing, hair, face or anything on your person.	21015		

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21015	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review dining services as it relates to preparation, set-up and delivery of resident meals. The director of nursing or designee could conduct random audits of dietary services during resident dining times to ensure appropriate and hygienic techniques are consistently followed by dietary staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21800	MN St. Statute144.651 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 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	21800		8/11/17

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21800	Continued From page 13 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 ensure Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) were provided in a timely manner upon termination of covered services for 2 of 3 residents (R64, R53) reviewed for liability notices. Findings include: R64's Notice of Medicare Non-Coverage (NOMNC) form Center Medicare/Medicaid Services (CMS) 10123 dated 6/29/17, identified R64's Medicare A covered services ended on 7/3/17 and had the rights to appeal this decision. The form was signed by R64's representative on 6/29/17. R64's SNFABN dated 6/15/17, identified directions of, "It is not Medicare's opinion, but our opinion, that Medicare will not pay for the items or services described below ... Medicare only pays for covered items and services when Medicare rules are met ...," further adding, "Right now, in your case, Medicare probably will not pay for," and provided spacing in which staff handwrote, "Haircuts/incidentals." The form was signed by R64 herself on her day of admission, 6/15/17, 17 days before Medicare services ended. The remainder of the form, including areas identifying if R64 elected to receive any non-covered	21800	Corrected	

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21800	Continued From page 14 services, other insurances, and estimated cost(s) were all left blank. R64's Admin Census/Rates listing dated 7/18/17, identified R64 was admitted on 6/15/17, with a payer source listed as, "Medicare A," until 7/3/17, when the payer source changed to, "Private Pay." The listing identified R64 had one day of private pay responsibility for over $300.00, and then discharged from the facility. R64's medical record was reviewed and lacked any evidence R64 had been provided a SNFABN when her Medicare A coverage ended and before she became private pay in the facility. R64 received the SNFABN upon admission. R53's NOMNC, CMS 10133 form dated 2/27/17, identified R53's Medicare A covered services were ending on 3/1/17, and had the rights to appeal this determination. The form was signed her R53's representative on 2/27/17. R53's Admin Census/Rates listing dated 7/18/17, identified R53 had been covered under Medicare A until 2/28/17, when her payer source switched to Medicaid, even though the facility identified R53's Medicare coverage would end on 3/1/17, and remained in the facility for care and services. R53's medical record was reviewed and lacked any evidence R53 had been provided a SNFABN when her Medicare A coverage ended on 2/28/17, which should have been completed two days prior to discharge from Medicare. During interview on 7/18/17, at 2:39 p.m. facility biller (B)-A stated R64 admitted under Medicare A coverage for therapy while in the SNF. B-A	21800		

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21800	Continued From page 15 stated R64's Medicare A coverage ended on 7/3/17, and R64 became private pay adding she did receive a bill for one day of care in the SNF and paid it. B-A stated R53 admitted under Medicare A coverage for therapy while in the SNF as well, however, switched to Medicaid after completion of her coverage services. B-A stated the facility process was to provide all residents who come to the facility on Medicare the SNFABN's upon admission to the facility, and not when their covered Medicare A services were ending. B-A reviewed R64 and R53's medical record(s) and stated R64 did not receive any additional SNFABNs upon termination of her covered services, and staff were unable to locate any evidence R53 received a SNFABN at all, including upon admission. B-A stated, after reviewing these forms and the regulation guidance with the surveyor, all notices of Medicare non-coverage should be given timely and as required. A facility policy on notices of Medicare non-coverage and SNFABNs was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21800		

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21800	Continued From page 16 (21) Days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 4 of 6 residents (R37, R10, R6 and R50) in the memory care unit who needed assistance to eat; and 4 of 4 residents (R21, R22, R42, and R47) observed in the main dining room. Also, the facility failed to provide a dignified transfer experience for 1 of 1 residents (R30) who needed assistance with transfers, and failed to knock or ask permission before entering resident rooms for two residents (R2 and R43) during five observations of care provision. Findings include: DIGNIFIED MEAL SERVICE R37's annual Minimum Data Set (MDS) dated 5/4/17, indicated R37 was severely, cognitively impaired and required extensive assistance and the physical assistance of one staff to eat. A facility document, "Details on Nursing Care Plan" dated 6/9/17, indicated staff were "to assist resident with eating and encourage resident to participate."	21805	Corrected	8/11/17

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21805	Continued From page 17 R10's quarterly MDS dated 2/20/17, indicated R10 was severely, cognitively impaired, and required extensive assistance and the physical assistance of one staff to eat. The "Details on Nursing Care Plan" undated, indicated staff were to assist R10 with eating, and "level of assist varies with how well R10 stays on task each day. Staff assists with tray set up." R6's quarterly MDS dated 6/4/17, indicated R6 was severely cognitively impaired, and required total staff assistance with eating and all activities of daily living. During observation on 7/18/17 at 8:21 a.m. of the meal service in the memory care unit, nursing assistant (NA)-D and trained medication assistant (TMA)-A began delivering meals from the kitchen service window to seven residents seated at the large table for breakfast. At 8:27 a.m., NA-D placed R10's serving of pureed scrambled eggs, bread, a bowl of hot oatmeal and a single serving container of yogurt in front of her and tied her clothing protector, and left. R10 stared at the food and made no effort to eat, nor was encouraged to begin eating. TMA-A and NA-D intermittently left R37's table and returned with other residents' breakfasts. At 8:40 a.m. NA-D served R37 a scrambled egg-filled croissant sandwich, bowl of oatmeal, along with beverages. The remaining residents at the table had already received their meals, had clothing protectors placed and began consuming their meals. Meanwhile, at 8:40 a.m., TMA-A administered eye drops to R6, cleaned his hands, sat down and began to assist R6 with breakfast. TMA-A then started talking with NA-D about the storm that went through town last evening, and did not	21805		

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	00374	A. BUILDING: _____ B. WING _____	C 07/20/2017

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21805	Continued From page 18	21805		

engage conversation with R6. After conversing with TMA-A for two minutes, NA-D walked away from the table to get something from the kitchen service window, temporarily leaving both R10 and R37 unassisted. During NA-D's absence, neither R10 nor R37 made any attempt to eat or feed themselves independently. At 8:46 a.m. NA-D returned from the kitchen area, then stood in front and between R37 and R10, and coaxed R37 to eat. NA-D held the juice cup and R37 drank a sip, then held the croissant sandwich and R37 took a bite. NA-D, was standing at the end of the table between R37 and R10, turned toward R10, scooped a biteful on a spoon and began to feed R10 breakfast. NA-D alternately fed and held beverages for R37 and R10, standing as she provided help. Between 8:48 a.m. and the end of the breakfast meal at 9:15 a.m. (more than 25 minutes), NA-D provided assistance to R10 and R37 at the breakfast meal, while standing up between them for the entire meal.

When interviewed on 7/18/17 at 9:49 a.m., nursing assistant (NA)-D stated she fed R10 and R37 breakfast while standing up. She normally does not stand up "to help with another feeder," but the residents today were seated "farther apart." "I should have had them closer," NA-D stated.

R50's quarterly MDS dated 5/28/17, indicated R50 was severely, cognitively impaired, and required extensive assistance and the physical assistance of one staff to eat. The "Details on Nursing Care Plan" indicated R50 fed self "part of meal- will usually drink liquids on own. Staff to set up meal tray and keep resident on task to complete meal and assist if needed with eating."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	C 07/20/2017

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21805	Continued From page 19 During observation on 7/19/17 at 12:27 p.m., the noon lunch began in the memory care unit, and seven residents, including R50 and R37, were seated around the table and started to be served their meals. At 12:39 p.m. NA-E delivered R50 meal plate in front of him, and NA-E announced to R50 it was time to eat. At 12:42 p.m. a meal was delivered to R37, who was seated across the table from R50. R37 reached for a clothing protector from the table, even though R37 was already wearing one, and began reaching for her plate. NA-E stood up and wheeled R37 to the same side of table by R50, and positioned both R37's and R50's plates so NA-E could sit between and assist them at the same time. At 12:45 p.m. R50 began to take bites of food on her own after encouragement by NA-E, who also begin feeding R50 spoonfuls of his meal. R50 was initially resistive and blocked NA-E's hand which held the spoon, but was able to consume three bites of food and a sip of drink. NA-E fed R50 three bites and was interrupted when R16 announced she needed to use the bathroom. At 12:50 p.m., NA-E stood up, stopped feeding R50 and placed her spoon on the table. NA-E then turned her attention to R16, who she told she would take to the bathroom. NA-E left the table, located a transfer belt, and took R16 to the bathroom in her room, and left R50 and R37 unattended. Even though another staff member, licensed practical nurse (LPN)-A was seated a the table assisting other residents, R37 stopped eating, and R50 grasped the spoon on the table, and was holding it in front of himself but made no attempt to eat. R37 and R50 did not eat or drink in the absence of NA-E. After toileting R16, NA-E returned to the table at 12:58 (8 minutes later) and resumed to assist R50, and encouraged R37 to eat her meal.	21805		

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21805	Continued From page 20 When interviewed on 7/19/17 at 1:58 p.m. NA-E stated she had to leave R50 and R37 at the table, unassisted, and help out another resident to toilet. NA-E stated meal interruptions occurred 2-3 times a week on the memory unit, and there were times when there should be "an additional person" to help out to "eliminate disruption of meals." NA-E stated R10 and R37 deserve undivided attention and they also deserve their meals served and eaten warm. There needs to be more than one of me, NA-E stated. When interviewed on 7/19/17 at 2:06 p.m. licensed practical nurse (LPN)-A acknowledged R10's and R37's noon meals were interrupted, and stated once all residents were seated and the food was out, everyone should sit down to eat at the same time. LPN-A stated there was a "float" staff in the building, but usually that staff helped out more in other parts of the building. LPN-A stated it would be good to have extra staff to help out when a resident needs to toilet during the meal, but we have to try and manage it. LPN-A stated this is maybe "something we need to look at." LPN-A also stated residents should not be assisted and fed standing up, and doing so makes the resident feel like "you don't have time to sit down and feed me." LPN-A stated she would have asked staff to sit down when assisting residents. During interview on 7/20/17 at 9:01 a.m. the director of nursing (DON) stated feeding residents while standing next to them "is not what we would expect" and was "not how we train" staff to provide feeding assistance. The DON stated she was working to reallocate staff to address times on the units when additional help may be needed, and added staff have to learn to	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
21805	Continued From page 21	21805		

be assertive and call for "the float" if they feel it is getting too chaotic or too distracting. The DON stated meal time were for interaction and conversation, and expected to "minimize interruption" such as having to stop feeding one resident to toilet another.

When interviewed on 7/20/17 at 11:27 a.m. registered nurse (RN)-A stated residents needed to be toileted on the last rounds before meals, and staff needed to arrange residents, who needed help to eat, so they can be easily assisted. RN-A further stated her expectations would be that residents, and the staff who assist them, could all sit down, be at eye level with the residents, and not be interrupted by other needs during the meal service.

R21's annual MDS assessment of 4/17/17, identified the resident was cognitively intact and independent with eating.

R22's quarterly MDS assessment of 6/12/17, identified the resident was cognitively intact and was independent with eating.

R42's quarterly assessment of 6/30/17 identified some cognitive impairment and independent with eating.

R47's quarterly MDS of 6/30/17 identified some cognitive impairment and was independent with eating.

During observation in the main dining room on 7/19/17 at 12:12 p.m., R21, R47, and R42 were all seated at the same table awaiting the noon meal. Dietary aide (DA)-C brought R21 her food at 12:12 p.m. At 12:21 p.m. (9 minutes later) R47

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	C 07/20/2017

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21805	Continued From page 22	21805		

was served her meal. While R21 and R47 ate their food, R42 still had not yet received the noon meal. At 12:24 p.m., R22 arrived at the table as the fourth resident. A minute later, R42 stated "We ordered it [noon meal], but we haven't yet received it." R21 offered R42 and R22 taco chips to "tide them over" until their meals came. At 12:34 p.m., R22 was served their meal and was the last resident seated at the table. Meanwhile, R42 continued without any food, had a scowled expression on her face, and made comments about not having received her noon meal yet. At 12:38 p.m., R42, was still wafting for her meal as other residents (R21, R22, R47) at her table ate their meal. R42 began slapping her hands on the table making loud noises and harshly speaking, "Bring me something!" A unidentified visitor approached DA-D about R42's noon meal. At 12:41 p.m., 29 minutes later R42 was served her noon meal. R42 began to eat quickly, bite after bite, without pause to socialize. At the table, R42 commented the wait for the meal was long and this was "the usual" pattern of service.

During interview on 7/19/17 at 12:53 p.m., dietary aide (DA)-C and DA-D stated meals were served first come, first served, however if there are concerns addressed with foods not being served in a timely fashion, they (the serving staff) "will try to get their food out too." DA-C stated this was how they managed serving tables, and added some residents will come in and complain they don't have their food yet, "We will try to get their food out too." DA-D reviewed the delayed service to R42 and stated whomever took the order only put the "number symbol on the slip" and staff had to follow up with resident to determine what she wanted for breakfast, causing a delay. DA-D stated he was unaware of the length of time it took to serve residents (R21, R22, R42, R47) at

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	00374	A. BUILDING: _____ B. WING _____	C 07/20/2017

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21805	Continued From page 23 the one table to finally get served. When interviewed on 7/19/17, at 1:05 p.m., R42 stated the wait for meals happens frequently. R42 stated, "I got so tired of waiting." R42 acknowledged although she ate some of her meal, she left before finishing her meal "because I had to sit there and wait." R42 stated she got so tired of waiting, and "everyone was eating." R42 stated this delay in meal service happened at least weekly. During interview on 7/19/17 at 1:11 p.m. R22 and family member (FM)-A discussed the service pattern at meals. FM-A commented everyone was brought up differently. FM-A and R22 stated it was confusing as to how residents were to proceed in the dining room. FM-A stated were brought up that people didn't eat until everyone was served. Some get their meals "right away, and others wait and wait." FM-A stated that R42 had waited quite a while and was getting agitated. R22 stated when they come in, they let the aide know what they want for their meal. R22 stated if served the meal first, "I don't feel like I should eat it." During interview on 7/19/17 at 1:24 p.m. R22 stated there frequently was confusion with services and it was not uncommon to have a delay. R22 stated when other residents don't have their food, "I am almost done." DIGNITY WITH TRANSFER R30's quarterly Minimum Data Set (MDS) dated 5/3/17, indicated she was cognitively intact and needed extensive assist of one with transfers. R30's care plan dated 8/15/16, indicated she had dementia, Parkinson's and needs assist with bed	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	C 07/20/2017

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21805	Continued From page 24	21805		

mobility transfers and ambulation. R30's care plan dated 8/15/16, indicated she had alteration in mobility related to cerebral vascular accident, dementia and Parkinson's. The care plan further indicated she needed limited to extensive assist with transfers.

During interview 7/17/17, at 6:31 p.m. R30 stated that on the night shift a few months ago a girl was making me stand up. R30 stated she would say stand up and that, "I can't lift you, I can't lift you." She was rude, she was unsure of her name but the unidentified nursing assistant was orientating someone and though she was showing off to them.

During observation 7/19/17, at 7:33 a.m. nursing assistant (NA)-B was assisting R30 to transfer her from bed to her wheelchair. NA-B placed a belt around R30's waist and while she was sitting up in bed stated "1,2,3 were gonna get you up" she attempted this twice, then left the room and returned with a EZ-stand (a mechanical standing aide device) and transferred R30 into her wheelchair.

R30's Progress Note dated 7/3/17, at 10:02 p.m. indicated "when nar's [nursing assistants] assisted resident to bed this evening, she almost fell, refusing to stand, NAR's lifted her into bed, resident stated multiple times," 'You are just throwing me around.' 'Now you are just throwing me around.' Will continue to monitor assistance need for transfer and ambulation."

During interview 7/20/17, at 9:35 a.m. R30 stated sometimes they transfer me with a belt and sometimes with the stand, "it depends, sometimes I can't stand." R30 referred to the progress note 7/3/17, at 10:02 p.m., and stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	C 07/20/2017

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21805	Continued From page 25	21805		

that incident did not make me feel good. R30 stated she told (NA-B) I am 91 years old and "when you get to my age is this the way you would want someone to treat you?" R30 stated she didn't feel (NA-B) treated her with respect but since that incident she has been good to me.

During interview 7/20/17, at 10:19 a.m. licensed social worker (LSW) stated the incident was a dignity issue and the aides need to under stand the dignity issue and feels sometimes they need to realize they are working with the elderly and treat them with respect.

KNOCK BEFORE ENTERING

R2's 14-day Minimum Data Set (MDS) dated 4/27/17, identified R2 had intact cognition and required extensive assistance with locomotion and transfers.

R43's significant change MDS dated 6/14/17, identified R43 had intact cognition and required extensive assistance with transfers.

During observation and interview on 7/18/17, at 9:26 a.m. R2 and R43 were seated in their shared room with the door closed visiting with the surveyor. Nursing assistant (NA)-C opened the door to the room without any audible knocking or other announcement of presence and proceeded to enter the room without permission. R43 abruptly held up his opened right hand to NA-A when she entered, causing her to stop. NA-C then looked at the surveyor seated on the opposite side of the room, backed out of the room and closed the door.

When interviewed immediately following, R2 stated he did not have any concerns with NA-C

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21805	Continued From page 26	21805		

opening the door without knocking or announcing her presence as he had been in the Navy prior and privacy was not typically afforded to people there.

When interviewed on 7/18/17, at 9:58 a.m. R43 stated staff have opened the door without knocking before and he did not like it adding, "I don't think that's right to just zap into somebody's room like that."

During interview on 7/18/17, at 10:01 a.m. NA-C stated she had worked at the facility for several months. NA-C stated she, "should of knocked on the door first," before entering R43 and R2's room, however, it had been, "a crazy morning," and she, "didn't even think about it." Further, NA-C stated it was important to knock before entering a resident room, "for the residents dignity."

When interviewed on 7/18/17, at 11:29 a.m. registered nurse (RN)-B stated staff were expected to knock on resident doors prior to entering to provide privacy as, "this is their [residents] home," adding, "so often [staff] forget that." Further, RN-B stated she would be, "reinforcing that [need to knock on doors before entering]," with the staff.

A facility policy, Rights and Responsibilities of Patients/Residents, revised 6/17, under the "Quality of Life" section indicated: 1. Dignity. The facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality.

SUGGESTED METHOD OF CORRECTION:

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	00374	A. BUILDING: _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21805	Continued From page 27 The director of nursing, or designee, could review and revise policies and procedures related to dignity and provision of care; and provide staff education to reinforce the provision of dignified care. The director of nursing or designee could develop a tool and audit to ensure appropriate, timely and dignified resident care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was provided for 1 of 3 residents (R2) in the sample who required staff assistance with activities of daily living. Findings include: R2's 14-day Minimum Data Set (MDS) dated 4/27/17, identified R2 had intact cognition and required extensive assistance with locomotion	21855	Corrected	8/4/17

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21855	Continued From page 28 and transfers. During observation on 07/19/17 at 7:03 a.m., R2 was in his room in bed. R2's window blinds was open and the facility courtyard was visible outside his window. Nursing assistant (NA)-F entered R2's room, and began to set up for morning cares. NA-F filled a water basin, then assisted R2 to wash his face and hands, and had not closed the window blinds to provide full visual privacy. At 7:14 a.m., NA-F finished his grooming care, was going to have R2 stand up to provide perineal care while he was unclothed from the waist down. Before NA-F assisted R2 to stand, the surveyor intervened and questioned NA-F about the open window blinds to the facility courtyard. NA-F lowered the blinds, but was unable to cover the entire window because of pictures sitting on the window sill. The blind was lowered to approximately one foot from the window sill. NA-F assisted R2 to complete his morning routine and cares. When interviewed on 7/19/17 at 7:19 a.m., NA-F stated she would normally lower the window blind all the way, but the pictures were in the way. The pictures should have been moved to lower the window blind all the way to the sill. NA-F stated it was important to provide R2 with privacy during cares. During interview on 7/20/17 at 11:45 a.m. with the director of nursing (DON) and registered nurse (RN)-A, the DON stated all blinds and privacy curtains should be closed prior to initiating cares. RN-A stated "this is important" to provide privacy and respect for residents. SUGGESTED METHOD OF CORRECTION:	21855		

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21855	Continued From page 29 The director of nursing (DON) or designee could review and revise policies and procedures related to personal privacy, and ensure privacy for each individual resident is maintained, especially during provision of cares. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing and maintaining resident privacy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		