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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VOT7

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 **09/26/2018** (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	__ 6. Scope of Services Limit
___ 3. 24 Hour RN	__ 7. Medical Director
___ 4. 7-Day RN (Rural SNF)	__ 8. Patient Room Size
___ 5. Life Safety Code	__ 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 Fischer, Unit Supervisor — 10/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 10/01/2018 (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
09/13/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 1, 2018

MS Certification Number (CCN): 245127

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

Dear Administrator:

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 September 3, 2018 the above facility is certified for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all skilled nursing facility beds located in rooms .

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 1, 2018

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

RE: Project Number S5127028

Dear Administrator:

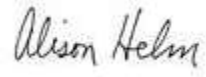
On August 24, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on August 9, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 26, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 9, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 3, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 9, 2018, effective September 3, 2018 and therefore remedies outlined in our letter to you dated August 24, 2018, 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,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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: VOT7

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

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(L1) **245127**
2.STATE VENDOR OR MEDICAID NO.
(L2) **190247401**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/09/2018** (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) :

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

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date:
Austin Fry, HFE NE II — 09/06/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 09/11/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 24, 2018

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

RE: Project Number S5127028

Dear Ms. Kucera:

On August 9, 2018, 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 electronically attached CMS-2567 whereby corrections are required.

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Brenda Fischer, 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.fischer@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 September 18, 2018, 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 November 9, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 9, 2019 (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

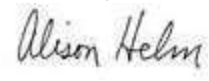
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	08/09/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with the Centers for Medicare and Medicaid (CMS) Appendix Z, Emergency Preparedness Requirements, was conducted on 8/6/18 to 8/9/18, during a recertification survey. The facility is in compliance with the Appendix Z, Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/6/18 to 8/9/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		9/3/18

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

Electronically Signed | 08/31/2018

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 _____	08/09/2018

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 550	Continued From page 1 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified	F 550	F550 (R27, R1, R29) with the Potential to affect all residents with RESIDENT	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	08/09/2018

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 550	Continued From page 2 dining experience for 3 of 3 residents (R27, R1, R29) with cognitive impairment and who were not served until staff were available to assist causing them to sit and watch others eat. Findings include: R27's quarterly Minimum Data Set (MDS) dated 6/11/18, identified R27 had severe cognitive impairment and was totally dependent on staff for eating. R1's quarterly MDS dated 4/22/18, identified R1 had severe cognitive impairment and required extensive assistance with eating. R29's quarterly MDS dated 6/12/18, identified R29 had moderate cognitive impairment and required supervision with eating. On 8/7/18, at 12:09 p.m. the afternoon meal service was observed in the main dining room. There were tables of residents' already eating who had been served their entree along the back of the room, closest to the serving kitchenette. On the opposite side of the room, R27 and R1 were seated next to each other in their wheelchairs and away from the tables; positioned to face the tables of residents' eating. R1 was looking around the room on several instances at the various tables watching other residents' eating. At 12:13 p.m. R29 was assisted into the dining room and seated next to R1 and R27, now forming a line with their wheelchairs placed adjacent to each other and approximately 15 feet away from the table(s) which the remaining resident population continued to eat at. There was no music or television on. At 12:26 p.m. (17 minutes since observation began) R27, R1, and R29 continued to be seated in their wheelchairs, in a line away from the	F 550	RIGHTS RELATED TO DINING DIGNITY • DON sent an e-mail to the nursing staff on 8/7/18 to be observant of residents in the dining room awaiting feeding assistance and related resident dignity concerns. (DON was alerted to this concern by a state surveyor). • The Interdisciplinary Team (representing nursing, social work, dietary and activities) reviewed the protocol of residents entering the dining room and the procedure for those residents needing feeding assistance on 8/10/18. The procedure was changed in which residents needing feeding assistance will not be brought into the dining room until a staff member can assist the resident. Options while waiting for feeding assistance including common areas (bird aviary, TV, music, etc.) are available. • The Long Term Care Dining Room Protocol was revised by the Nutrition Services Manager to include this new process on 8/29/18. • Nursing staff was educated regarding a review of Resident Rights (including dignity) and reinforcement of the new protocol revisions at staff meetings on 8/30/18 and 8/31/18. • Audits of residents needing assistance and the revised protocol to include observation of resident dignity in the dining areas will be completed weekly x4, and then monthly x3 by the DON or designee starting on 9/10/18. • The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings.	

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	245127	A. BUILDING _____ B. WING _____	08/09/2018

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

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F 550	Continued From page 3 tables. R1 and R29 continued to watch other residents eat, often visibly turning their heads' and looking around the room at different tables. At this time, registered nurse (RN)-D was passing medications from a mobile cart in the same area and observed the residents' lined up in their wheelchairs and watching others' eat. RN-D stated R27, R1 and R29 "all need assistance to eat" so they have to wait until staff are available to assist them. RN-D explained she was "not sure" why they were left to just sit there versus being assisted to a table and offered a beverage at least. Further, RN-D stated the assisted residents having to wait happens "quite often," and having more people to help feed residents would be nice so the assisted residents don't have to "sit here and smell the food and wait." R27, R1 and R29 were brought to the table and served their meal at 12:35 p.m. (26 minutes after observation began). On 8/9/18, at 7:51 a.m. licensed practical nurse (LPN)-A stated she observes assisted residents' having to wait to be served several times a week, however, staff usually try to keep them occupied with music or something while they wait. LPN-A explained in the past, staff used to not bring assisted residents down to the dining room until staff were able to assist them so as to avoid "the whole line them up like a herd thing." Further, LPN-A stated she felt assisted residents shouldn't be left "sitting here watching other people eat." When interviewed on 8/9/18, at 8:57 a.m. the director of nursing (DON) stated the dining room service had been worked on for "many aspects" since the last health survey (exited 7/2017). DON explained she still observed assisted residents having to wait for meal service a "couple times a	F 550	Responsible Parties: DON, Nutrition Manager, or Designee	

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F 550	Continued From page 4 week," and felt the issue partially stemmed from activities being completed and the residents being left there versus assisted back to their rooms. Further, DON stated residents should not be lined up to wait for meal service adding, "It's a dignity issue." A provided LTC - Dine with Assist Policy dated 6/2017, identified a purpose of helping residents' with cognitive or physical impairment to receive needed assistance and listed a procedure which included: Identifying residents who need assistance and assigning them to the "Dine with Assist" program, and, "Dietary staff will not prepare Resident's meal until [nursing assistant] or other staff who is trained to assist is available." The policy lacked any direction or guidance on ensuring assisted residents' are served timely, nor how to ensure they are not placed in a situation having to watch others eat for extended periods before being served.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		9/3/18

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F 609	Continued From page 5 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State agency (SA) was notified within 2 hours of allegations of physical abuse, following three separate resident to resident altercations initiated by R36 for 3 of 3 male residents (R9, R16, R23) whom resided on the locked memory care unit with R36. Findings include: R35's quarterly Minimum Data Set (MDS) dated 6/18/18, identified R35 had severe cognitive impairment and did not identify any behavior problems. R35 needed limited assistance for walking with a diagnosis of dementia. R35's progress note(s) identified the following: - 6/4/18, at 5:35 p.m. R35 became agitated with an unidentified male resident at the evening meal. R35 went over to a male resident and "got in his face" and said "I want to leave and if your not coming with me give me your damn keys." R35 slapped the unidentified male residents arm	F 609	F609 (R9, R16, R23) with the Potential to affect all residents with REPORTING OF ALLEGED VIOLATIONS • DON sent an e-mail on 8/10/18 to the Social Work and Nursing staff that Vulnerable Adult reports will be immediately reported to the State Agency (SA) regarding resident to resident altercations. The follow up investigation will continue to be completed per the Vulnerable Adult policy/procedures. The DON provided clarification on the regulation requiring coverage of “willful” acts. • The DON and Social Worker reviewed/revised the Vulnerable Adult Abuse/Neglect Policy and Procedures. The policy and procedures address the investigation (doing a root cause analysis which may include staff or family interviews, review of clinical records that would note behaviors during the time of the incident and an assessment of	

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F 609	Continued From page 6 twice. Staff intervened and R35 walked away yelling "I will hit him if I want to and I won't stop until I want to." R35 then walked over to another unidentified male resident and "did the same behavior to that resident" and staff intervened. Family was called to come sit with R35. No injuries were observed to the two unidentified male residents. There was no indication the administrator or SA were notified of the alleged physical abuse. - 7/20/18, at 8:57 p.m. R35 was trying to feed an unidentified male resident and tried to get the unidentified male resident to stand up, and then pulled his hair trying to get him to go with. There was no indication the administrator or SA were notified of the alleged physical abuse. - 7/31/18, at 2:43 p.m. R35 did not let an unidentified male finish his dinner. R35 hit him and told him "let's go home," and also spit in his face. There was no indication the administrator or SA were notified of the alleged physical abuse. During interview on 8/8/18, at 9:49 a.m. licensed practical nurse (LPN)-B stated when there are resident to resident altercations, staff intervene. The incident was documented in the progress notes and the care coordinator was e-mailed, unless there was major injury, then the director of nursing (DON) was notified immediately. LPN-B stated R35 would get angry at the male residents in the unit at times if they did not get up and "take her [R35] home." R9's quarterly MDS dated 5/4/18, identified R9 had severe cognitive impairment and needed extensive assistance with activities of daily living (ADL).	F 609	environmental factors). During the investigation, other residents' protection will be secured. These measures to protect other residents include separating residents to (another room or unit), separation of residents in common areas (example is the dining room), or 1:1 staff observation for immediate interventions. • The "Guide to Reporting Potential or Actual Vulnerable Adult Situations" was updated including removing the flow chart from 2013. New resources on reporting of Vulnerable Adults were added to the guide materials. • Staff education regarding this change/clarification of "willful" acts, reporting, and follow investigations in resident to resident altercations was completed at the staff meetings on 8/30/18 and 8/31/18. • Audits of reporting vulnerable adult reporting weekly x4, and then monthly x3 beginning 9/10/18 will include these components: o Behavior documentation and observations of resident to resident altercations o Audits of all vulnerable adult reports including an evaluation of the policy requirements being met (notices to the Administrator, SA, timelines of reporting, and actions to protect residents.) •The findings of these audits will be reported at weekly Behavior Management Team meetings and Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: Social Worker,	

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F 609	Continued From page 7 R16's quarterly MDS dated 5/14/18, identified R16 had severe cognitive impairment and needed limited supervision to walk. R23's quarterly MDS dated 5/27/18, identified R23 had severe cognitive impairment and required extensive assistance with ADL's. During interview on 8/9/18, at 9:22 a.m. the care coordinator registered nurse (RN)-B stated all resident to resident altercations were reviewed. R35 had dementia and likely did not know what she was doing; however R35 did hit and spit at the male residents in the unit. The facility utilized an internal incident report and it was then forwarded to the the DON and licensed social worker (LSW). Further, the male residents on the memory care unit were not injured, so a report was not filed with the SA. The administrator was notified by email, including all team members when there was an incident. The DON and LSW were interviewed on 8/9/18, at 9:48 a.m. regarding R35's physical altercations with male residents on the memory care unit. The DON and LSW stated the facility practice was to internally investigate resident to resident altercations unless there was an injury to a resident. The DON stated they were confused by the updated regulation on when to report resident to resident potential abuse when the residents had dementia and were utilizing a flow chart from 2013 to determine when to report resident to resident altercations. The facility provided a undated memory care resident list that identified 3 male residents (R9, R16, R23) whom resided on the unit when the	F 609	DON	

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F 609	Continued From page 8 incidents occurred. The facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property/ Vulnerable Adult policy dated 4/18, identified physical abuse included hitting, slapping, pinching and kicking. The facility "will ensure that all alleged violations involving abuse, and serious bodily injury would be reported to the administrator, the director/manager or designee and to the SA immediately but no later than 2 hours.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure allegations of resident to resident physical abuse were	F 610	F610 (R9, R16, R23) with the Potential to affect all residents with INVESTIGATE/PREVENT/CORRECT	9/3/18

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F 610	Continued From page 9 thoroughly investigated, and protection provided for 3 of 3 male residents (R9, R16, R23) who resided on the locked memory care unit and were involved in resident to resident physical altercations by R35. Findings include: R35's quarterly Minimum Data Set (MDS) dated 6/18/18, identified R35 had severe cognitive impairment and did not identify any behavior problems. R35 needed limited assistance for walking and had diagnosis of dementia. R35's progress note(s) identified the following: - 6/4/18, at 5:35 p.m. R35 became agitated with an unidentified male resident at the supper table. R35 went over to the male resident and "got in his face" and said "I want to leave and if your not coming with me give me your damn keys." R35 the slapped the male residents arm twice. Staff intervened. R35 walked away yelling "I will hit him if I want to and I won't stop until I want to." R35 then walked over to another unidentified male resident and "did the same behavior to that resident" and staff had to intervene. Family was called to come sit with R35. No injuries were observed to the two unidentified male residents. - 7/20/18, at 8:57 p.m. R35 was trying to feed an unidentified male resident and trying to get male resident to get up and then pulled his hair trying to get him to go with. - 7/31/18, at 2:43 p.m. R35 did not let an unidentified male finish his dinner. She hit him and told him "let's go home." She also spit in his face.	F 610	ALLEGED VILOTAION • DON sent an e-mail on 8/10/18 to the Social Work and Nursing staff that Vulnerable Adult reports will be immediately reported to the State Agency (SA) regarding resident to resident altercations. The follow up investigation will continue to be completed per the Vulnerable Adult policy/procedures. The DON provided clarification on the regulation requiring coverage of "willful" acts. • The IDT reviewed the previous resident to resident reports regarding R35 at the weekly Behavior Management team meeting on 8/9/18. Interventions initiated on 8/9/18 included new target behaviors monitoring form for assessment by the Behavior Management Team (BMT). • Following the BMT meeting on 8/16/18, (and new target behavior monitoring) interventions were clarified to staff including: 1. Staff to observe for behavioral issues or changes in behavior. 2. Staff to monitor resident behaviors toward other male resident's as d/t resident dementia she may think male residents are husband/father or other family members 3. Staff to remove/redirect for safety of other residents including male residents. 4. Staff should be mindful of seating arrangement during meal time's r/t placing resident near other males in attempt to avoid potential resident to resident altercations 5. This was communicated to all staff on 8/16/18 via e-mail.	

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F 610	Continued From page 10 R35's care plan dated 6/29/18, did not identify R35 had a history of resident to resident altercations towards male residents on the unit nor did the plan identify interventions to protect male residents. R9's quarterly MDS dated 5/4/18, identified R9 had severe cognitive impairment and needed extensive assistance with activities of daily living (ADL). R16's quarterly MDS dated 5/14/18, identified R16 had severe cognitive impairment and needed limited supervision to walk. R23's quarterly MDS dated 5/27/18, identified R23 had severe cognitive impairment and required extensive assistance with ADL's. During observation on 8/7/18, at 5:01 p.m. R35 was seated in a stationary chair at the dining room table with R5 seated next to her in a wheelchair. R5, a male resident, was looking around and was calm. R35 was pleasant with the residents and staff around her. During interview on 8/7/18, at 5:19 p.m. nursing assistant (NA)-G stated she was not aware of any resident to resident altercations or any particular resident whom hits other residents. On 8/7/18, at 5:26 p.m. NA-E stated R35 walked independently and was "bossy." At times she gets upset and hits and spits with male residents when they don't get up and come with her. Staff do there best to separate the residents or distract them. NA-E was unaware of any specific interventions to prevent R35's aggression	F 610	6. Resident remains on BMT for monitoring • R35's Care plan was updated in Point Click Care to reflect interventions and instruction consistent with target behavior monitoring in the Vulnerable Adult and Behavior sections. • The DON and Social Worker reviewed/revised the Vulnerable Adult Abuse/Neglect Policy and Procedures. The policy and procedures address the investigation (doing a root cause analysis which may include staff or family interviews, review of clinical records that would note behaviors during the time of the incident and an assessment of environmental factors). • Upon identification of suspected abuse and/or neglect, staff must provide for immediate safety of the resident. Means of providing protection may include, but are not limited to: a. Moving resident to another room b. Remove the aggressor from the situation. c. Provide 1:1 monitoring as necessary d. A multi-disciplinary team will address a plan of care to prevent future behavioral problems. This team will be comprised of the DON, Charge Nurse, Social Services, Family Members, Physician and resident as appropriate. • An initial evaluation shall begin immediately to determine if maltreatment occurred. If initial evaluation determines a reportable incident a thorough investigation will include: interviewing the individual suspected of maltreatment, witnesses, staff and residents as	

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F 610	Continued From page 11 towards male residents on the unit. During observation on 8/8/18, at 8:52 a.m. R35 was seated at the dining room table in a stationary chair with R9 in a wheelchair seated across the table from her. R16, a male resident, was seated two chairs down from R35 at the same dining room table in a stationary chair. R16 was relaxed while seated at the table. There were no verbal or physical altercations by R35. During interview on 8/8/18, at 9:49 a.m. licensed practical nurse (LPN)-B stated they intervene with any resident to resident altercations and document the incident in the progress notes. The care coordinator was then e-mailed, unless there was major injury, then the director of nursing (DON) was notified immediately. LPN-B stated R35 would get angry at male residents at times if they did not get up and "take her home." During interview on 8/9/18, at 9:22 a.m. the care coordinator registered nurse (RN)-B stated all resident to resident altercations were reviewed and investigated. R35 had dementia and likely did not know what she was doing; however R35 did hit and spit at the male residents on the unit. The facility utilized an internal incident report for investigations and then forwarded to the DON and licensed social worker (LSW). They had not identified any specific interventions to reduce R35's aggression towards male residents. The DON and LSW were interviewed on 8/9/18, at 9:48 a.m. regarding R35's physical altercations with male residents on the memory care unit. The DON and LSW stated the facility practice was to internally investigate resident to resident altercations and their behaviors were reviewed at	F 610	appropriate. The completed investigation should be sent electronically to the Minnesota Department of Health within 5 working days. • The "Guide to Reporting Potential or Actual Vulnerable Adult Situations" was updated including removing the flow chart from 2013. New resources on reporting of Vulnerable Adults were added to the guide materials. • Staff education regarding this change/clarification of reporting "willful" acts in resident to resident altercations and subsequent investigation was completed at the staff meetings on 8/30/18 and 8/31/18. • Audits of reporting vulnerable adult reporting weekly x4, and then monthly x3 beginning 9/10/18 will include these components: o Behavior documentation and observations of resident to resident altercations o Audits of all vulnerable adult reports including an evaluation of the policy requirements being met (notices to the Administrator, SA, timelines of reporting, and actions to protect residents) . • The findings of these audits will be shared and discussed with the IDT team at weekly Behavior Management Team meetings and at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: Social Worker, DON	

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F 610	Continued From page 12	F 610		

the behavioral meeting as well.

The facility provided a undated memory care resident list that identified 3 male residents (R9, R16, R23) whom resided on the unit when the incidents occurred.

The LSW provided a MLHS Vulnerable Adult Incident Referral Form regarding the incident on 6/4/18 at 5:35 p.m. and identified R35 became agitated with an unidentified male resident at the supper table. R35 went over to the male resident and "got in his face" and said "I want to leave and if your not coming with me give me your damn keys." R35 slapped the male residents arm twice and staff intervened. R35 walked away yelling "I will hit him if I want to and I won't stop until I want to." R35 then walked over to another unidentified male resident and "did the same behavior to that resident" and staff intervened. Family was called to come sit with R35. No injuries were observed to the two unidentified male residents.

The incident report identified the two male residents were R16 and R23. Both R16 and R23's families were updated about the incident. The report identified R35 had a urinary tract infection at the time and was receiving treatment so no abuse was suspected. Action taken to protect residents from further harm was left blank. The concern was resolved by interventions already implemented by staff, no further interventions or investigations was included. The investigation did not include talking with residents, staff, observing residents interactions or were interventions identified to protect male resident from R35.

The LSW was unable to provide a MLHS

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F 610	Continued From page 13 Vulnerable Adult Incident Referral Forms for the incidents on 7/20/18 and 7/21/18. The DON stated a comprehensive investigation should include an assessment of the environment, staff , resident and family interviews along with observations. That information was important to identify appropriate interventions to implement and protect other residents. The facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property/ Vulnerable Adult policy dated 4/18, identified investigations of suspected abuse the facility would begin an investigation immediately. A root cause investigation and analysis would be completed and would include: - Who was involved. - Interview the protected adult, for non verbal, cognitively impaired or those who refuse to be interviewed, the interviewer should; observe the protected adult, complete an evaluation of protected adult behavior, affect and response to interaction, and document findings. -Protected adult's roommate statement if applicable. -Involved staff and witness statements of events. - A description of the protected adult's behavior and environment at the time of the incident. - Injuries present including a protected adult assessment - Observations of protected adult and staff behaviors during investigation - Environmental considerations.	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		9/3/18

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F 689	Continued From page 14 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free from accident hazards for 1 of 2 residents (R30) who used a four-wheeled walker as a transportation device, contrary to the manufacture's recommendations. In addition the facility failed to comprehensively assess resident falls to ensure appropriate interventions were implemented to reduce the risk of falls for 2 of 3 residents (R 43, R13) reviewed for falls. Findings include: UNSAFE USE OF RESIDENT WALKER: R30's quarterly Minimum Data Set (MDS) dated 6/13/18, indicated she was independent to walk in the hallway, and was moderately cognitively impaired. A Fall Risk Assessment dated 6/7/18, indicated R30 had no history of falls, used an assistive device for mobility, and was a moderate risk for falls. An Occupational Therapy lift chair assessment dated 6/22/18, indicated R30 demonstrated ability to safely operate her four-wheeled walker. During observation on 8/8/18, at 8:10 a.m. R30 was seated in a Drive brand, four-wheeled walker (4 WW) and was observed being pushed backwards by registered nurse (RN)-B. Grasping	F 689	F689 (R30) with the Potential to affect all residents with FREE OF ACCIENT HAZARDS/SUPERVISION/DEVICES UNSAFE USE OF RESIDENT WALKER " DON sent an e-mail to the nursing staff on 8/10/18 notifying all staff that equipment such as walkers must be used according to manufactures intended use. DON explained to staff that equipment such as a front wheeled walker cannot be used to transport residents and safety concerns were addressed. (DON was alerted to this concern by one of the state surveyors). " A policy was developed (Resident Safety) to outline resident assessment of equipment, following of manufacturer intended use, identification of resident safety risks and education for equipment and other environmental safety concerns. " Staff was re-educated regarding resident safety concerns such as pushing a resident in a front wheeled walker and the new policy at staff meetings on 8/30/18 and 8/31/18. " Audits of safe resident equipment use such a front wheeled walkers (using observation of staff and equipment rounding reports) will be completed	

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F 689	Continued From page 15 the frame of R30's 4 WW, RN-B pushed R30 backwards from the north hallway just outside the dining room, then into the dining room, past the serving area, then to R30's spot at the first table in the dining room. When interviewed on 8/18/18, at 8:22 a.m., R30 stated she got a ride in her 4 WW when "my back and hips hurt." R30 stated she sometimes got a ride "halfway to the scale" and then into the dining room. During interview on 8/8/18, at 2:43 p.m. nursing assistant (NA)-D stated "most days" R30 has to get a daily weight and the scale was located on the north side, which was quite a ways from R30's room. NA-D stated occasionally R30 would walk to the scale on her own, maybe taking a break, but that "most days" R30 "gets a ride to the scale." When interviewed on 8/8/18, at 2:51 p.m. RN-B stated she pushed R30 into the dining room, backward and while seated in the dining area "as [R30] had requested." RN-B stated R30 needed to go to the scale and get a daily weight, but was not aware if staff were transporting her using the 4 WW. RN-B stated pushing R30 in the walker was not what she would normally do and "that is not my practice." During interview on 8/9/18, at 9:56 a.m. the rehab manager (RM) stated a "seated" four-wheeled walker was not to be used to transport a resident. The RM stated it was "ok" to sit on the seat of the walker to rest, but that walkers "were not built" to hold and carry weight. A Drive (brand name) Rollator (trademark	F 689	weekly x4, and then monthly x3 by the DON or designee starting on 9/10/18. " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: DON, or Designee FALLS (R43, R13) with the Potential for affect all residents regarding FALLS " Immediate actions were taken for R43 related to fall prevention. Interventions included dycem in w/c and between mattress and bed frame, ordering of a full non slip mat for the mattress/bed frame, and a bed rail assessment. OT was also consulted for w/c seating and bed mobility. These actions were communicated to staff on 8/9/18. A RCA for R43 was completed by the Falls Committee on 8/28/18. " Immediate actions were taken for R13 related to fall prevention which included every 15 minute checks. DON met with OT that had previously evaluated R43□s falls on 8/21/18. This OT reviewed R13□s fall history including the RCA and made suggestion for visual cues. Special tape to mark the resident□s chair, doorway, and bed were ordered. An updated RCA was completed by the Falls Committee on 8/28/18. Additional interventions include roll back brakes to w/c, continued safety checks, offering resident to lie down in room when sleeping on couch in common area, limit resident having a roommate (decreasing	

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F 689	Continued From page 16 four-wheeled walker) product use-guide document dated 2012, indicated a important safety notice: "Do not have anyone push you while you are seated on the Rollator. This is a walking aid only and is not to be used as a transportation device." When interviewed on 8/9/18, at 10:55 a.m. the director of nursing (DON) stated using the walker like a wheel chair, when residents were pushed backwards, was both a safety and dignity concern. The DON stated a few months ago she sent out a reminder to staff addressing this very issue. The DON stated using the walker for transport was not a safe practice "and it should not be done." A facility policy regarding safe use of four-wheeled walkers was requested, but none was provided. FALLS R 43's annual Minimum Data Set dated 7/10/18, identified R 43 had severe cognitive impairment and required extensive assistance with bed mobility and transfers. R 43 had two or more falls without injury since the previous quarterly MDS dated 4/10/18. and a diagnosis of dementia. R 43's fall Care Area Assessment (CAA) dated 7/23/18, identified R 43 was at risk for falls related to difficulty maintaining a sitting position and impaired balance during transitions. R 43 had an unsteady gait and walked with staff assistance and a walker. R 43 was prescribed diuretics which increased her risk for falls. Clinical	F 689	anxiety that a roommate has caused this resident in the past), and a new rehab referral with family being encouraged to assist resident to participate with the rehab assessment. A Maintenance Nursing exercise program may be established if resident cooperates with rehab assessment. " DON began auditing Fall Scene Investigation Reports starting on 8/21/18 for completeness including Fall Huddles, medication reviews, and, fall root cause if known. Nursing staff was notified that Fall Scene Investigation Reports will be reviewed by the DON on the following business day for completeness and that insufficient reports will be returned to the nursing staff submitting the reports. This was communicated via e-mail on 8/21/18. " The Falls Committee met to review the Fall Prevention Program on 8/28/18. Changes to the program included identifying triggers for initial and follow up RCA□s: (2) two falls in one week or (3) three falls in one month, triggers to Rehab for (2) falls in a week or (3) three falls in a month, involvement of additional Rehab members for RCA□s, and fall risk assessments for all new admissions to determine baseline fall risks when entering the facility. " The Falls Policy was revised to include initial and follow up RCA triggers, rehab referral triggers, and fall risk assessments for new admissions. " Nursing, Activities, and Social Work staff were educated on the revised fall policies and strategies at the staff meetings on 8/30/18 and 8/31/18.	

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F 689	Continued From page 17 indicators and diagnoses included cognitive impairments, incontinence and visual impairments. R 43's falls usually result from self transfer and was currently on an ambulation and toileting program. R 43 used a mobility monitor when in chair and a pad alarm and motion sensor when in bed. During observation on 8/7/18, at 5:07 p.m. R 43 was seated in a rock-n-go wheelchair in the day area. R 43 was not attempting to self transfer and had a mobility alarm on the back of her wheelchair with a string attached to her upper left shoulder. R 43's record identified the following falls: R 43's progress note on 3/25/18, at 7:00 a.m. identified R 43 was found on the floor seated next to her wheelchair. The nursing assistant identified R 43 had taken her shirt off, and the alarm was attached to the shirt, so the alarm did not sound. R 43 also had one of her socks off. Resident was leaning forward which may have caused the fall. No injuries were identified. The facility Fall Scene Investigation Report(s) identified on 3/25/18, no time identified, R 43 slipped out of her wheelchair. R 43 has one barefoot and one gripper sock on. Last time toileted was not identified. R 43 had a mobility monitor that was not sounding as R 43 removed her shirt. The fall team notes identified R 43 was restless and staff felt she removed her mobility alarm as it was not attached so it did not sound. The alarm was not changed alarm at the time due to no further episodes of removing alarm. No new interventions to prevent further falls were identified.	F 689	" The Falls Committee will be recommending to the QAPI Committee (on 9/13/18) that Fall prevention be started as a priority PIP project " Audits of falls including Falls Scene Investigation Reports (summary), Initial and follow up RCA□s per new policy revision, and referrals to Rehab per new policy will be completed weekly x4, and then monthly x3 by the DON or designee starting on 9/10/18. " 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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The progress note for 6/27/18, at 1:37 a.m. identified R 43 was having a "behavior" in her room attempting to sit on the edge of her bed. R 43 was assisted up into her wheelchair and brought to the nursing station. R 43 wanted to watch TV and was brought to the other side of the room to watch TV. R 43 was found on the floor next to her. R 43's motion alarm was attached to her nightgown and not alarming. There was no injury.

The facility Fall Scene Investigation Report(s) identified on 6/27/18, R 43 lost her balance and fell out of her wheelchair in the day area. R 43 had a mobility monitor attached to her nightgown and it was not sounding. R 43 had bare feet and was last toileted at 12:30 a.m. The fall huddle and fall recreation area's were blank. The fall team meeting notes section was blank. R 43's alarm was replaced without any further interventions to try and prevent further falls.

The progress note on 6/30/18, at 12:42 a.m. identified R 43 was found on the floor at the foot of her bed. Resident was seated in wheelchair and was attempting to self transfer to her bed. R 43 was wearing gripper socks and the motion alarm was not sounding and not clipped to the resident. No injuries were identified. No new interventions to prevent falls were identified.

The facility Fall Scene Investigation Report(s) identified on 6/30/18, R 43 lost her balance and fell attempted to self transfer from her wheelchair to her bed. R 43 had on gripper socks and R 43's mobility alarm was not attached and not sounding. Last time toileted was not identified. The fall huddle and fall recreation area's were

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blank. The fall team meeting notes section was blank. No new fall interventions were identified.

The facility Fall Scene Investigation Report(s) identified on 8/3/18, no time identified, R 43 fell from her wheelchair. R 43's mobility alarm did not sound as R 43 had unclipped it. R 43 had removed the alarm multiple times prior to the fall. R 43 was last toileted at 10:30 a.m. and had on shoes. The fall huddle and fall recreation area's were blank. The fall team meeting notes section was blank. No new fall interventions were identified.

R 43's care plan dated 7/25/18, identified R 43 was at risk for falls related to a history of falls, dementia, impaired mobility with gait imbalance, incontinence and impaired vision. Interventions included: bed pad alarm on when in bed, mobility monitor on when in wheelchair, motion sensor on when in bed, raised side mattress on bed and keep frequently used items within reach. New interventions to reduce the risk of falls had not been updated since 9/14/17, even though R 43's had four falls since then.

During interview on 8/7/18, at 5:11 p.m. nursing assistant (NA)-G stated R 43's fall interventions were the mobility alarm on her chair, a pressure and motion alarm while in bed. R 43 stated when R 43 became agitated she frequently tried to self transfer.

During interview on 8/7/18, at 6:59 p.m. NA-E stated when R 43 became agitated she became restless and attempts to self transfer and has fallen. She tries to distract R 43 with food when she became restless. Her current fall interventions were a motion monitor while in her

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chair and a pressure and motion alarm while in bed. R 43 frequently sat herself up on the edge of the bed.

During interview on 8/8/18, at 9:31 a.m. NA-F stated R 43's fall interventions were were a motion monitor while in her chair and a pressure and motion alarm while in bed. The staff were to place the motion monitor on R 43 and clip it out of her reach as she frequently removed the alarm. R 43 stated the alarms alerted the staff to R 43 when she was trying to transfer her self. When a resident has a fall the staff alert the nurse.

On 8/8/18, at 9:47 a.m. licensed practical nurse (LPN)-B stated following a fall residents were assessed for injury and complete a fall scene investigation. After completion of the form it was forwarded to the director of nursing (DON). The facility care coordinators determine new interventions and update the care plans. Further, alarms were not preventing falls as the residents move so fast it was hard to get to them prior to falling.

On 8/9/18, at 9:31 a.m. care coordinator registered nurse (RN)-B stated R 43 attempted to self transfer from her wheelchair and her bed. R 43 had alarms on her wheelchair and in bed . R 43 stated the alarms did not prevent falls, but altered staff to resident movement. New interventions were supposed to be implemented at the time of the fall and then were reviewed the next business day during the morning team meeting. R 43 had not been referred to physical or occupational therapy for fall prevention. She was not sure why new interventions were not implemented following R 43's falls and felt it just slipped "through the cracks."

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On 8/9/18, at 10:11 a.m. DON stated each fall was reviewed. A root cause analysis are only conducted when there is a fall trend identified. There had not been a root cause analysis of R 43's falls. Upon review of R 43's fall scene investigation forms, the DON stated a comprehensive assessment of the fall could not be completed with incomplete fall information. There could have been interventions implemented for R 43 to attempt to reduce falls. Further, alarm use was discussed at a recent fall meeting and as a team decided to look into a performance improvement project on falls and reduce alarms in the facility.

R13's quarterly MDS 5/16/18 identified R13 had moderate cognitive impairment, requires assistance with activities of daily living, frequently incontinent of bladder and had diagnosis of dementia. The MDS did not identify any visual deficit, however, but R13's Admission Record, printed 8/9/18, indicated R13 had a serious retinal detachment (retina separates from eye causing vision loss) and unspecified glaucoma (high pressure of eye causing optic nerve damage).

The fall CAA dated 2/24/18, identified resident has dementia with impaired cognition, wandering and has poor vision. He had two falls since previous assessment, and was unable to remember what occurred and was incontinent of bowel and bladder. R13 received medication, Lasix (water pill, causing increased urination). The fall assessment score was 16 (high risk) for fall but no no referrals were indicated.

R13's Fall Risk Assessment on 2/9/18 and on 5/12/18, both indicated R13's fall risk score was

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16, high risk for falls. The assessment indicated R13 had a history of multiple falls, poor memory, impaired vision, frequently incontinent, and used assistive device. The two assessments identified the same risk factors but there was no analysis of the data to determine what interventions should be implemented to decrease R13's risk for falls, even though R13 had multiple falls.

R13's care plan updated on 5/24/18 indicated R13 had alteration in mobility related to dementia, poor vision, and COPD (Chronic obstructive pulmonary disease-a chronic inflammatory lung disease) and needed assistance with bed mobility and transfers. Staff were directed to provide supervision with mobility and a walker. The care plan identified R13 had difficulty maneuvering about the facility related to impaired vision, mobility, and dementia, placing R13 at increased risk for falls. The care plan interventions directed staff to encourage resident to use his walker, assure proper foot wear was worn at all times, have night light in room, and have commonly used articles within reach at all times.

During observation on 8/7/18, at approximately 3:40 p.m. R13 was observed sitting in his wheelchair, with a gauze dressing in place over his right eye and his left hand wrapped in kerlix. R13 was at an appointment with his family and fell in the parking lot and was waiting transportation to the clinic for an evaluation.

On 8/7/18, at 7:22 p.m. R13 was observed in bed, resting on his side with a dressing in place over his right eye and a gauze dressing wrapped around his left hand.

R13's progress noted 8/7/18 identified he was

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seen in clinic and had two inner sutures and four outer sutures to a cut next to his eye. The skin tear on his left hand been covered with Bacitracin and dressing and neuro checks were initiated.

On 8/8/18, at 4:00 p.m. R13 was observed walking hunched over, hanging on to his recliner. He walked to the nightstand and stood there hanging onto the stand. RN-A was notified, placed a transfer belt, and assisted R13 to ambulate with his walker.

On 8/9/18, at 9:54 a.m. R13 was observed seated in the day room near the nurses station with the television playing a game show in the background. NA-G asked R13 if he needed anything. NA-G stated R13 was now on every 15 minutes checks.

R13 progress notes identified the following falls:

On 6/26/18, at 6:30 p.m. R13 had been at an activity with the use of a walker. R13 was found on the floor in the activity room :"Laying on the floor, wearing shoes". The report indicated R13 stood up and the went to sit down, and went to the side of the chair, landing on the floor.

On 6/26/18, at 8:00 p.m. R13 was observed in the television room and had gotten up from chair, began walking, and attempted to sit on side table. R13 was redirected by staff. R13 was calling for help and was found in the nurses station, sitting on the the floor with his back to the station wall and walker in front of him.

On 7/13/18, at 3:00 p,m, resident was in common area on his hands and knees. Resident stated that he knelt down to the ground to put a rope

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under the boat. No injuries.

On 7/15/18, was found sitting on the floor by the beauty shop. Resident had been on the sofa when last seen. R13 stated he was trying to lay down.

On 7/25/18, at 10:15 p.m. was in the common TV area at 10:15 p.m. where he had been watching TV. Upon getting up with his walker, fell to his left side.

On 8/7/18, R13 had gone with family for eye appt. Family went to seek jacket while R13 stood in parking lot and R13 was observed to be on the ground upon family members return. R13 was seen in clinic and received 6 sutures total.

The facility Fall Scene Investigation Reports (FSI) dated 8/7/18, identified a the fall occurred on 8/7/18, during a leave of absence, but there was no know contributing factors identified. A fall huddle was not completed nor was a root cause completed for this fall, these area were left blank. Also, there was no indication the facility completed an FSI for the 6/26, 7/13 fallen x2 that day or for the 7/25/18 fall.

During interview on 8/9/18, at 10:39 a.m. RN-D stated R13's falls occurred during transfers between bed to chair, and needed close supervision when walking. They added 15 minute checks on 8/8/18 to increase their visualization. Physical therapy, tried to evaluate R13 but determined he was not a candidate for therapy related to his cognition and refusals, and was last seen in therapy on 4/21/18. RN-D reviewed the PT discharge summary dated 4/24/18 that identified R13 was not independent with

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F 689	Continued From page 25 ambulation, but needed a contact-guard to minimal assist for pathfinding. RN-D stated she was not aware of these recommendations from therapy. RN-D also stated R13 was incontinent and was voiding outside of the bathroom/urinals and they attempt to toilet him every two hours. RN-D reviewed the last bowel and bladder assessment was completed on 2/23/17, over one year ago. On 8/9/18, at 11:15 a.m. the director of nursing (DON) stated a root cause analysis were completed for R13's falls at the end of June and interventions reviewed. A subsequent root cause analysis has not been completed with recent falls. R13's decreased vision places him at risk, but is able to distinguish shapes. The DON stated a post fall huddle is important to complete immediately after the fall to determine potential reason for the fall and to identify any changes that should be made. Although R13 has had multiple falls without injuries, the facility has not comprehensively assessed R13 falls to determine appropriate interventions related to his limited vision, voiding in inappropriate places and needing ambulation assistance for pathfinding even though this was identified by therapy in April 2018. The facility Falls Policy dated 11/17, identified falls were reviewed by the interdisciplinary team Monday through Friday and the reports were sent to the medical director for review weekly. A Fall Scene Investigation Report, was completed on each fall event.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		9/3/18

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F 697	Continued From page 26 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote comfort and reduce pain for 1 of 2 residents (R41) reviewed who had ongoing complaints of leg and knee pain. Findings include: R41's annual Minimum Data Set (MDS) dated 7/8/18, identified R41 had severe cognitive impairment and required extensive assistance to complete activities of daily living (ADLs). Further, R41 was on a scheduled pain regimen, had not received any as-needed (PRN) pain medications , and rated her pain a 3 out of 10 (10 being the worst). R41's Pain Assessment completed 7/7/18, identified R41 had mild pain on a constant, steady basis in her right knee. This pain was evident through non-verbal sounds, vocal complaints and protective body movements; impacting R41 with interfered sleep, physical activity and reduced quality of life. R41's pain was identified as ongoing for longer than six months, and was worse with moving and walking. R41's current pain management regimen listed PRN BioFreeze and Tylenol 1000 milligrams (mg) every 4 hours as-needed. R41 was recorded as understanding	F 697	F697 (R41) with the Potential to affect all residents in regards to PAIN MANAGEMENT " A pain assessment and pain monitoring plan was implemented on 8/8/18 for R4. Scheduled BioFreeze and pain monitoring was added. " The RN Care Coordinators reviewed all current residents for PRN pain medication use (frequency of 3 or more PRN med medications in one week). This review was completed on 8/29/18. Three of 48 current residents were identified. These three residents had a pain assessment completed and were placed on pain monitoring. " The Pain Management policy was reviewed and revised. The addition of adding a pain assessment (based on PRN use of 3 or greater PRN medications in one week for the same pain issue) and pain monitoring if indicated was added to the assessment cycle. " Nursing staff was re-educated on the pain management policy at 8/30/18 and 8/31/18 staff meetings. " Audits of pain management effectiveness (including documentation of response to pain interventions), pain assessments/monitoring for residents with	

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F 697	Continued From page 27 the 0 - 10 pain scale, and was to report unrelieved pain. Further, R41 did not want to have narcotic pain medication. R41's Pain Care Area Assessment (CAA) dated 7/12/18, identified R41 had actual problems with pain and described, "Resident stated she has [right] knee pain." The pain' effect was listed as affecting her sleep and causing limited day-to-day activities, with dictation listed, "She was started on scheduled Tylenol [sic]." A section labeled, "Care Plan Considerations," listed objectives to provide improvement in R41's pain and avoid complications. This went on to describe R41 as having dementia and osteoarthritis. R41's physician was contacted at R41 was started on scheduled Tylenol twice a day, along with as-needed BioFreeze (a topical pain reliever gel). No further referrals were identified. On 8/6/18, at 12:56 p.m. R41 was observed seated in a standard wheelchair in the unit commons area. R41 was interviewed and expressed she was having "quite a bit of pain" in her leg, describing the pain as a "burning" sensation. This pain had been going on for "awhile" and R41 stated she was not sure what staff were doing, or giving her, to help reduce the pain. Further, R41 explained the pain had not impacted her sleeping or daily activities, however, she wished to have less pain, if possible. R41's pain care plan revised 10/19/17, identified R41 had a potential for alteration in comfort and listed a goal of reporting pain of a 3 or less (on the 0 - 10 scale) after interventions were provided. These interventions included administering medications as ordered, monitoring for pain, and updating the physician with any	F 697	3 or more PRN medications in one week for the same concern will be completed weekly x4, and then monthly x3 by the DON or designee starting on 9/10/18 " 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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increased reports of pain.

When interviewed on 8/6/18, at 1:52 p.m. R41's appointed guardian (FM)-A stated R41 had been complaining of her knee and leg pain "more than usual" lately when she visited. R41's physician had seen her for it, and increased her Tylenol (a mild pain relieving medication) recently though she thought. FM-A explained she felt R41's pain to be "an arthritic type thing" which had been an ongoing issue.

R41's Order Summary Report signed by the physician on 7/25/18, identified R41 had orders for the following pain medications:

- Apply BioFreeze twice daily as-needed (PRN) to achy areas (started 6/6/18),

- Tylenol 1000 milligrams (mg) orally twice daily for pain, and,

- Tylenol 1000 mg orally every four hours PRN for pain. Both Tylenol orders were started 7/8/18.

On 8/7/18, at 6:42 p.m. R41 was observed for evening cares from nursing assistant (NA)-A and NA-B. She was assisted to stand and transfer using a mechanical standing lift. R41 voiced no complaints of pain, nor demonstrated any physical signs or symptoms of pain during the transfer.

NA-A and NA-B were interviewed immediately following the observed cares. R41 had complained about knee pain in the past, however, felt it had been the same as it always was versus being new or worse. NA-A stated R41 "really doesn't" complain about any pain during cares,

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and added R41 would be someone who could report to staff if she was experiencing pain.

On 8/8/18, at 10:25 a.m. NA-C was interviewed. R41 did have complaints of right leg pain throughout the day and would report to staff it was "sore" while rubbing her right leg up and down. R41 received BioFreeze to her knees every night, however she still had complaints of pain which were "fairly new" within the past month or so. NA-C expressed she had not seen any declines or impacts on R41 as a result of the pain.

R41's nursing progress notes dated 7/1/18, to 8/8/18, identified on 7/9/18, R41 was provided a single dose of as-needed Tylenol for right leg and knee pain. There were no other entries recorded in the progress note(s) to demonstrate R41 had been provided any additional pain medication doses despite them being ordered by the physician on 7/8/18.

Furthermore, R41's medical record lacked any evidence R41 had been comprehensively re-assessed for pain to determine if the scheduled Tylenol was effective; or if the current interventions were effective and adequate for R41's pain management program.

When interviewed on 8/8/18, at 11:30 a.m. registered nurse manager (RN)-A stated she followed up with R41 towards the "end of July" when doing a skin assessment, and R41 denied pain at that time. However, RN-A had not conducted any comprehensive assessment of R41 to ensure the scheduled Tylenol was effective or adequate; despite R41 continuing to verbalize pain to the staff. RN-A stated she had

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F 697	Continued From page 30 not heard of R41's ongoing complaints of pain, and staff should report those things to her if they are seeing or hearing them. Further, RN-A stated it was important to ensure residents are assessed for pain "to make sure their comfortable." A facility Pain Management policy dated 9/2017, identified residents had a right to treatment which includes appropriate assessment and management of pain. The plan directed a collaborative interdisciplinary approach to pain management which included all members of the health care team, and provided a procedure which included, "Based on patient self-report and evaluation/assessment findings, a process of individualized treatment modification will be initiated and documented. The patient will be included in this process."	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions	F 700		9/3/18

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F 700	Continued From page 31 are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents with attached bed rails were comprehensively assessed to determine if the device was appropriate, and prevented possible entrapment for 1 of 1 resident (R43) whom had large gaps between the mattress and bed rail. Findings include: R43's annual Minimum Data Set dated 7/10/18, identified R43 had severe cognitive impairment and required extensive assistance with bed mobility and transfers. R43 had two or more falls without injury since the previous quarterly MDS dated 4/10/18, and had diagnosis of dementia. During observation on 8/6/18, at 11:41 a.m. R43's bed had a 1/4 bed rail affixed to the left side of the bed in a upright position. R43's mattress was not secure and easily slid to the the right of the bed which created a gap, approximately 1 foot between the mattress and bed rail exposing the metal bed frame. Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 5/10/06, identified the following bed rail zones: Zone 1 - Within the rail, with no more than a 4 and 3/4 inches (in) gap. Zone 2 - Under the rail, between the rail supports	F 700	F700 (R43) with the Potential to affect all residents in regards to BED RAILS • The RN Care Coordinator completed a bed rail assessment for R 43 on 8/9/18. The mattress was secured using a full length mat. (RN Care Coordinator discussed the risks/benefits of the bed rail with R43's Resident Representative on 8/29/18.) • The RN Care Coordinators, Facilities Manager and DON met to review the current bed rail policy on 8/14/18. Policy revisions were discussed as well as plans for current resident bed rail assessments and form revision. • The RN Care Coordinators completed a bed rail assessment for all current residents. These were completed by 8/17/18. • The bed rail policy was revised and now includes a bed rail assessment each time a mattress is changed out. Bed rails will be evaluated on admission, when a mattress is changed,annually and quarterly for any resident using a physically protective device. • Education on bed rail safety was presented to the nursing staff on 8/30/18 and 8/31/18. • Audits of bed rail assessments and interventions (bed rail use, mattress changes, admissions) will be completed	

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F 700	Continued From page 32 or next to a single rail support ,with no more than a 4 and 3/4 in gap. Zone 3 - Between the rail and the mattress, ,with no more than a 4 and 3/4 in gap. Zone 4 - Under the rail at the ends of the rail, ,with no more than a 4 and 3/4 in gap. R43's Side Rail Protocol dated 7/7/15, identified R43 was unable to utilize side rails for a bed accessory or mobility, and side rails would remain down. R43's Side Rail/ U-Bar Entrapment assessment dated 7/7/15 identified Zone 1, Zone 2, Zone 3 and Zone 4 of the side rail had gaps less than 4 and 3/4 inch. R43's Physical Protective Device Assessment dated 7/6/18, did not identify the use of any bed rails. There was no indication the facility identify risk versus benefits for the use of the bed rail had been discussed with the resident or resident representative. R43's care plan dated 7/25/18, identified R43 was at risk for falls related to a history of falls, dementia and impaired mobility with gait imbalance. R43 was identified to require limited to extensive assistance with bed mobility; however R43 was able to move on her own. The care plan did not identify the use of a side rail. During interview on 8/7/18, at 6:59 p.m. nursing assistant (NA)-E stated R43 did attempt to transfer from bed at times and frequently sat herself up on the edge of her bed. NA-E stated the left side rail was up when R43 was in bed and	F 700	weekly x4, and then monthly x3 by the DON or designee starting on 9/10/18. • The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: Facility Manager, DON or Designee	

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she grabbed on to it for assistance with transfers.

During interview on 8/8/18, at 9:31 a.m. NA-F stated R43 had the side rail on her bed for as long as she could remember . The side rail was in the raised position when R43 was in bed and R43 had made attempts to transfer from her bed.

On 8/9/18, at 8:17 a.m. the maintenance manager (MM)-A lightly pushed on the left side of R43's mattress and it slid over to the right and stopped when the mattress came in contact with a chair to the right side of R43's bed. MM-A measured the gab between the mattress and left bed rail at 10 inches. MM-A stated there should not be a gap that large, the mattress should fit tight. MM-A stated the maintenance department does not routinely assess for the function and fit of the bed rails for resident. They only look at bed rails when the nursing department contacted them.

During interview on 8/9/18, at 9:31 a.m. registered nurse (RN)-B stated R43's had poor balance while standing and was able to sit up on her own at times on the edge of her bed. RN-B stated R43 was not assessed for the use of a bed rail, and should not be used. We had red tape on the rail that identified not to use, but she was unsure what happened. The facility practice was to assess for the use of bed rails, obtain a physician order, measure for gaps and provide risk versus benefits for the use of bed rails to the resident and/or the resident representative.

During interview on 8/9/18, at 10:11 a.m. the director if nursing stated there should not be large gabs between the mattress and side rails and is a potential for injury. The facility zipped tied the bed

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F 700	Continued From page 34 rail down and placed a non skid pad under the mattress until the resident could be re-assessed for bed rail use. The facility policy LTC- Resident Assessment dated 9/17, identified a Physical Protective Device Assessment was to be completed on admission, annually and quarterly on any resident using a physically protective device including a bed rail.	F 700		
F 811 SS=E	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.	F 811		9/3/18

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F 811	Continued From page 35 (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents who had difficulty swallowing and/or were on a specialized diet received assistance from a paid feeding assistant (PFA) to eat for 3 of 3 residents (R29, R18, R27) whom were at risk for complicated feeding issues and were on the Dine with Assist program provided by the PFA's. This had the potenial to affect 14 resident listed on the Dine with Assist program. Findings include: During the entrance conference on 8/6/18, at 10:45 a.m. with the administrator and director of nursing (DON). The DON explained the facility used PFA in the main dining room only, and could help "anybody." They were unable to provide a list of residents who utilized assistance from the PFA's. R29's quarterly Minimum Data Set (MDS) assessment dated 6/12/18 indicated R29 had moderate cognitive impairment, received supervision and oversight with set up assistance only for eating. R29 was identified as receiving a mechanically altered diet and had diagnoses of dementia and hemiplegia (paralysis of one side of the body). R29's care plan last reviewed 6/21/18 identified a potential for altered nutrition status due to	F 811	F811 (R29, R18, R27) with the Potential to affect all residents in regards to FEEDING ASSISTANTS/TRAINING/SUPERVISION " The DON immediately removed the employee identified by the State Survey Team from assisting with feeding residents on 8/9/18. (This employee is no longer an employee of the department). The remaining staff identified as Paid Feeding Assistants (PFA) had a review of their PFA education completion. All of the remaining PFA□s have completed the MN Dept. of Health training. " A repeat competency for PFA□s was completed by the DON or other RN designee. This competency included observation of skills based on the MN Dept. of Health Paid Feeding Assistant program and successful completion of the recommended MN Dept. of Health Paid Feeding Assistant Test. These will be completed by 9/3/18. " A Paid Feeding Assistant Program policy was developed " The Interdisciplinary Team met on 8/28/18. This group including nursing, dietary, rehab and speech representatives reviewed the feeding assistance processes and recommended the following actions: 1. The Nutrition Manager updated the	

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F 811	Continued From page 36 diagnosis of CVA (Cerebrovascular accident-medical diagnosis for a stroke) and participated in "Dine with Assist" program. R29 received honey thickened liquids, and a mechanically altered diet. Staff were to cut food and set up with a lidded cup with a straw and provide supervision with eating. There was no indication R29 had any swallowing, coughing or respiratory concerns identified but received honey thickened liquids. There was no indication the facility has assessed if R29 could be fed by a PFA. During observation on 8/6/18, at 12:15 p.m. R29 was seated at the dining room table accompanied by activities assistant (AA)-A. R29 had a cup of thickened liquids in front of him. R29 was coughing intermittently while drinking thickened liquids independently, and was able to clear his cough without interventions. On 8/8/18, at 2:53 p.m. AA-A stated she assisted R29 in the Dine with Assist program and was unaware of any special needs. AA-A stated R29 "Coughs a lot. " When he coughs, she covered his mouth with a clothing protector and asked if he was "OK". If the problem persisted, she would ask a nurse for assistance. AA-A stated she checks R29 meal after he is served and compares it to his food menu. On 8/8/18, at 3:03 p.m. AA-B stated she provided assistance in the dining room for R29, and encourages him to eat independently however he has received hands on assistance with eating. If residents were coughing in the dining room, staff would assist to cover their mouth if they were unable to do so. There was always a nurse present in the dining room.	F 811	Dine with Assist policy 2. The Speech Therapist will observe all residents in the dining rooms who are current on Dine with Assist. This will be completed by 9/3/18. 3. As of 8/28/18, the speech therapist will notify the nursing staff which residents are high risk and will not be assigned to receive feeding assistance from the PFA□s. " The Speech Therapist developed a communication tool to be used for resident diet recommendations. This new tool provides communication to staff on diet, liquids, safety precautions (including if a resident is appropriate for receiving feeding assistance from a Paid Feeding Assistant). This new tool was completed on 8/29/18. " Nursing and Activities Staff will be educated on the Paid Feeding Assistant policy changes at the 8/30/18 and 8/31/18 staff meetings. This education will include a reminder on where resident feeding information is kept in the dining rooms. " Audits of use of Paid Feeding Assistants (appropriate resident assignments) will be completed weekly x4, and then monthly x3 by the DON or designee starting on 9/10/18 " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: Nutrition Services Manager, Speech Therapist, DON or Designee	

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	245127	A. BUILDING _____ B. WING _____	08/09/2018

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

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F 811	Continued From page 37	F 811		

R27's quarterly MDS dated 6/11/18 identified R27 had significant cognitive impairment and received full assistance with eating. R27 had a mechanically altered diet with diagnosis of dementia.

R27's Nutritional Assessment of 6/8/18 indicated R27 exhibited swallowing difficulties. There was no indication the facility has assessed if R27 could be fed by a PFA.

R27's care plan updated on 6/20/18 identified R27 had a potential for altered nutrition status related to dementia, had a mechanically altered diet, staff were directed to use lidded cups for fluids and R27 participated in the Dine and Assist program. The care plan identified an alteration with eating, and had chewing and swallowing difficulty. Staff were directed to provide total assistance with eating, check for pocketing (storing food in mouth) and provide oral cares after meals.

On 8/6/18, at 12:12 p.m. AA-B was observed assisting R27 with the noon meal. R27 had a nutritional supplement and a pureed diet. AA-B was assisting R27 to eat, offering small bites slowly.

R18's quarterly Minimum Data Set (MDS) assessment dated 5/18/18 indicated R18 had significant cognitive impairment, received limited assistance of one with eating and had diagnosis of dementia.

R18's care plan last reviewed on 6/6/18 indicated R18 had a potential for altered nutritional risk

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F 811	Continued From page 38	F 811		

related to the dementia. He needed variable assistance with eating, and participated in the Dine with Assist program. Staff were directed to sit at the table, monitor, and assist with meal set up, encourage resident to feed independently and provide assistance when needed. R18's ability varied from needing supervision to extensive assistance with eating.

There was no indication the facility has assessed if R18 could be fed by a PFA.

During observation on 8/6/18 12:12 p.m. AA-B was assisting R18 with a chicken salad sandwich, cold vegetable salad and regular liquids. AA-B provided set up assistance, verbal prompts and cuing for R18.

On 8/8/18, at 2:53 p.m. AA-A stated she assists any residents when needed. She was unaware of any limitations to what she could do, or whom she could feed. AA-A was unaware of a specific guideline for residents who participated in the Dine with Assist program.

During interview on 8/8/18, at 3:03 p.m. AA-B stated she had training as a PFA, and was able to feed anyone in the dining room, adding "Whoever needs help, we are there to assist." AA-B stated with dysphagia diets (diets used for residents with chewing and swallowing problems), it was important to go slow, offering small bites and making sure residents swallowed the food. AA-B was unaware of any resident listing for the Dine with Assist program.

On 8/9/18, at 12:28 p.m. the director of nursing (DON) stated trained PFA implemented the Dine and Assist program. Residents who participate in

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F 811	Continued From page 39 this program should be screened by the interdisciplinary team, which included nursing, dietary, and activity staff representatives. The residents care plan was updated to reflect this program and any special instructions would be outlined. The DON stated only residents screened by the IDT and found appropriate for assistance should be assisted by PFA's. Although the facility was aware residents had chewing, swallowing problems and altered diet needs. These residents were still being fed by PFA, even though they were at risk for complicated feeding problems. A facility listing titled Dine with Assist, was provided on 8/9/18 for the Dine and Assist program dated 7/27/18, which identified, R29, R18 and R27, and 14 additional resident were identified on this program. The list included resident name, details of need on the nursing and dietary care plan, and information provided on the residents information sheet including supervision to total assistance for eating. The listing did not include the residents diet order. A facility policy titled "Dine with Assist Policy" dated 6/2017, identified residents who needed assist will be assigned to the Dine with Assist program and would be provided with assistance by nursing assistants-registered (NAR) or other staff who are trained to assist (PFA'S). The policy indicated residents may be enrolled in the program if they had concerns with chewing or swallowing difficulties. It did not outline specifically which residents could not be provided assistance by PFA's related to medical concerns.	F 811		
F 948	Training for Feeding Assistants	F 948		9/3/18

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F 948 SS=E	Continued From page 40 CFR(s): 483.95(h) §483.95(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure an approved training program for paid feeding assistants (PFA) was provided for 1 of 2 activity assistants (AA)-A who completed job duties of a paid feeding assistant (PFA). This had the potential to affect 17 residents who utilized the Dine with Assist facility program administered by PFA's. Findings include: During the entrance conference on 8/6/18, at 10:45 a.m. with the administrator and director of nursing (DON). The DON explained the facility used PFA in the main dining room only, and could help "anybody." They were unable to provide a list of residents who utilized assistance from the PFA's. On 8/6/18, at 12:12 p.m. during the noon meal observation, activities assistants (AA's)-A was observed providing resident assistance and feeding residents during the meal. On 8/8/18, at 2:53 p.m. AA-A stated she was provided training for the (PFA) program. Registered nurse (RN)-C provided instruction and demonstrations on how to feed residents, and	F 948	F948 The Potential to affect all residents in regards to FEEDING ASSISTANTS/TRAINING/SUPERVISION " The DON immediately removed the employee identified by the State Survey Team from assisting with feeding residents on 8/9/18. (This employee is no longer employed in the department). The remaining staff identified as Paid Feeding Assistants (PFA) had a review of their PFA education completion. All of the remaining PFA□s have completed the MN Dept. of Health training. " A repeat competency for PFA□s was completed by the DON or other RN designee. This competency included observation of skills based on the MN Dept. of Health Paid Feeding Assistant program and successful completion of the recommended MN Dept. of Health Paid Feeding Assistant Test. These will be completed by 9/3/18. " A Paid Feeding Assistant Program policy was developed " The Interdisciplinary Team met on 8/28/18. This group including nursing, dietary, rehab and speech representatives reviewed the feeding assistance	

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F 948	Continued From page 41 she (AA-A) did a returned demonstration of feeding a resident. She did not receive or review any handouts, videos, or informational packets. At 3:26 p.m. AA-A stated she told she had been "certified" but had not received any certificate for the PFA. RN-C showed me for five minutes and "I got to feed." On 8/9/18, at 12:28 p.m. the director of nursing (DON) reviewed the program for instruction of PFA's which included the following components as required by the Minnesota Department of Health (MDH): *Feeding techniques *Assistance with feeding and hydration *Communication and interpersonal skills *Appropriate responses to resident behavior *Safety and emergency procedures, including the Heimlich maneuver *Infection control *Resident rights *Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. The DON stated, AA-A was provided training for her role of PFA by RN-C using the current curriculum from OnTrack Training online system, and not the State Approved training course as the other AA's completed. Review of the OnTrack Training online system syllabus identified the following areas: *Person Centered Care *Communication and interpersonal skills *Infectious disease *Standard precautions	F 948	processes and recommended the following actions: 1. The Nutrition Manager updated the Dine with Assist policy 2. The Speech Therapist will observe all residents in the dining rooms who are current on Dine with Assist. This will be completed by 9/3/18. 3. As of 8/28/18, the speech therapist will notify the nursing staff which residents are high risk and will not be assigned to receive feeding assistance from the PFA□s. 4. The Speech Therapist developed a communication tool to be used for resident diet recommendations. This new tool provides communication to staff on diet, liquids, safety precautions (including if a resident is appropriate for receiving feeding assistance from a Paid Feeding Assistant). This new tool was completed on 8/29/18. 5. Nursing and Activities Staff will be educated on the Paid Feeding Assistant policy changes at the 8/30/18 and 8/31/18 staff meetings. This education will include a reminder on where resident feeding information is kept in the dining rooms. " Audits of use of Paid Feeding Assistants (appropriate resident assignments) will be completed weekly x4, and then monthly x3 by the DON or designee starting on 9/10/18 " The findings of these audits will be reported at the Quality Assurance and Performance Improvement (QAPI) meetings. Responsible Parties: Nutrition Services Manager, Speech Therapist, DON or	

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F 948	Continued From page 42 *Pathogens and infection chain *Transmission based precautions *Nutritional and special diets *Alternative nutrition methods *Dining and meal assistance *Emergency response The OnTrack Training syllabus did not identify education regarding resident rights, feeding techniques, assistance with feeding and hydration, appropriate responses to resident behavior, or recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to nurse which are requried training for PFA. The facility was unable to provide the Nursing Assistant Performance Record used by the OnTrack Training course to demonstrate lab and clinical completion and proctored exam scores. A facility listing titled Dine with Assist, was provided on 8/9/18 for the Dine and Assist program dated 7/27/18, which identified, 17 residents were involved in the program and could be fed by a PFA. A facility policy for paid feeding assistants was requested and not received.	F 948	Designee	

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 9, 2018. At the time of this survey, Mille Lacs Health Center was found 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. 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. The facility has a licensed capacity of 57 beds and had a census of 47 at the time of the survey.	K 000		

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

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

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K 000	Continued From page 1 The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		