Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 11, 2024

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

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

Dear Administrator:

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

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

Feel free to contact me if you have questions.

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

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Electronically delivered
April 11, 2024

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

Re: Reinspection Results
Event ID: NOS712

Dear Administrator:

On April 3, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility to determine correction of orders found on the survey completed on February 8, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 21, 2024

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

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

Dear Administrator:

On January 23, 2024, we informed you that we may impose enforcement remedies.

On February 8, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 10, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 10, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 10, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 10, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mille Lacs Health System will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 10, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care

deficiencies (those preceded by a "F" and/or an "E"tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 July 10, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services

determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	C 02/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/6/24 through 2/8/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51279424C (MN1000363) with a deficiency cited at F689. The following complaint was reviewed H51279603C (MN100016) with no deficiency issued. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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.	F 689		3/28/24

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

Electronically Signed — 02/29/2024

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

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure process's were followed for safe lift transfers for 1 of 6 residents (R1) reviewed for safety with mechanical stand transfers. Findings include: R1's significant change Minimum Data Set (MDS) dated 11/24/23, identified R1 had intact cognition, and was dependant on staff for transfers. R1 had a height of 60" and weighed 198 pounds (lbs) diagnoses included stroke, hemiparesis or hemiplegia, and seizure disorder, R1's care plan dated 11/5/23, directed staff to transfer R1 with EZ-stand (sit to stand lift). R1's undated, Care Sheet directed staff to transfer R1 with EZ-stand and large sling. A Facility Reported Incident (FRI) dated 1/29/24, identified R1 had a fall during a transfer to the bathroom. R1 was being transferred from the EZ-stand when the left side of the sling slipped off. R1 was lowered from the EZ-stand and assisted to the floor. It was a witnessed fall and no injuries. The facility investigation dated 1/29/24, indicated R1 had hemiplegia and hemiparesis following cerebral infarction affecting right dominate side. Nursing assistant (NA)-A felt the sling may have been too large for the resident, as they were using an XL sling and it was switched out for a large size. On 2/6/24 at 1:05 p.m., NA-A was obsered transferring R1 from R1's wheelchair using the EZ-stand. NA-A was working the day R1 had slid	F 689	The corrective action will be accomplished for the resident affected by the deficient process by ensuring the incorrect XL size harness will not be used for that resident by removing it from use. No other resident's use the XL harness at this time. The correct harness size has been added to the resident's care plan and NAR worksheet. An EZ Way representative has visualized the machine and made adjustments to the safety tabs. The DON and Administrative Assistant will identify other residents with the potential to be affected by the same deficient process by conducting an audit on all residents who transfer with this type of equipment or similar and use a sling or a harness. The audit will be conducted to determine the current sling or harness being used, the resident's current weight, and the recommended size of sling or harness per manufacturer recommendations. The DON and Administrative Assistant will complete a second audit on all EZ Way Stand Aids to ensure that the safety tabs are placed correctly based on the recommendation of the EZ Way representative and replace as needed. To ensure that the deficient process will not recur, the sling or harness sizes will be added to the residents care plan and NAR worksheet based on manufacturer recommendations or nursing recommendations. If not using manufacturer recommendations for sizing, a reason will be documented in the care	

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

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F 689	Continued From page 2 to the floor when the left side of the strap came undone from the EZ- stand. NA-A was using the XL sling and thought it was too big fro R1 as R1's left arm was raised in the air. During interview on 2/6/24 at 2:16 p.m., NA-B stated she transferred R1 with the EZ-stand with the large sling, but sometimes was unable to find the large sling and would have to use the XL sling, which was too big for R1. During interview on 2/6/24, at 1:34 p.m., NA-C stated he worked with R1 and they used a EZ-stand and was working the day R1 slipped from sling during a the lift transfer. NA-C stated R1 had a XL sling that was too large for her and felt that was why she slid out. During interview on 2/7/24 at 10:03 a.m., physical therapy assistant (PT)-A stated R1 used to use a stand aide, and now was using a EZ-stand, and suspected the reason R1 slid out from her sling was due to her not providing enough upper and lower assistance. During interview on 2/7/24, at 11:28 a.m. director of nursing (DON) stated R1 was transfered with a XL sling, after the incident R1's sling was switched to a large sling. "It sounds like from what I gathered the loop came off on the left side and maybe was not connected properly." The staff had training on using the EZ-stand and are having company come out to the facility and do refresher training on the lifts/stands on February 19th this year. On 2/7/24 at 3:35 p.m., NA-D while orientating NA-E stated she was told to use the large sling with R1 since she started in September 2023,	F 689	plan. The DON will update the current policy and procedure with these new changes. Weekly audits will completed x6 weeks to ensure staff compliance with the sizing specified within the resident's care plan as well as placement of the safety tabs on the all EZ Stands. Education was provided immediately after incident via verbal communication and in writing with all staff on safe use of the EZ Stand. The staff understanding was documented. EZ Way provided an in-service on February 19, 2024 for all staff able to attend and discussed the harness sizing, appropriate use of the harness and sling, and inspecting the machine and accessories prior to use.	

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F 689	Continued From page 3 but did not feel it was safe and prefers to use the XL sling. NA-D stated the large sling was too small for R1. NA-D and NA-E were observed to transfer R1 from her chair into the bathroom on to the toilet with the XL sling and not the L sling as care planned.There were no observed concerns with the transfer. During interview on 2/7/24, at 4:45 p.m. the DON stated immediately after the incident occurred with R1 sliding out of her sling she had changed the nursing assistance care sheets to make sure they use the large sling instead of the XL sling. During interview on 2/8/24 at 11:58 a.m. the DON stated she informed NA-D she needed to use the large sling and not the XL sling. The DON stated NA-D was not happy since she felt the XL sling was safer. An EZ Way Harness (sling) sizing chart indicated the large sling to be used on 190-320 lbs, the XL sling to be used on 280-450 lbs., and The size/weight designations are merely estimates that have basic guidelines.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 21, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: NOS711

Dear Administrator:

The above facility was surveyed on February 6, 2024 through February 8, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	02/08/2024

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/6/24 through 2/8/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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	00374	A. BUILDING: _____ B. WING _____	02/08/2024

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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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed H51279424C (MN100363) with a licensing order MN Rule 4658.0520 Subp. 1 (0830). The following complaint was reviewed H51279603C (MN100016) with no licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	02/08/2024

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure process's were followed for safe lift transfers for 1 of 6 residents (R1) reviewed for safety with mechanical stand transfers. Findings include: R1's significant change Minimum Data Set (MDS) dated 11/24/23, identified R1 had intact cognition,	2 830	Corrected	3/28/24

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2 830	Continued From page 3 and was dependant on staff for transfers. R1 had a height of 60" and weighed 198 pounds (lbs) diagnoses included stroke, hemiparesis or hemiplegia, and seizure disorder, R1's care plan dated 11/5/23, directed staff to transfer R1 with EZ-stand (sit to stand lift). R1's undated, Care Sheet directed staff to transfer R1 with EZ-stand and large sling. A Facility Reported Incident (FRI) dated 1/29/24, identified R1 had a fall during a transfer to the bathroom. R1 was being transferred from the EZ-stand when the left side of the sling slipped off. R1 was lowered from the EZ-stand and assisted to the floor. It was a witnessed fall and no injuries. The facility investigation dated 1/29/24, indicated R1 had hemiplegia and hemiparesis following cerebral infarction affecting right dominate side. Nursing assistant (NA)-A felt the sling may have been too large for the resident, as they were using an XL sling and it was switched out for a large size. On 2/6/24 at 1:05 p.m., NA-A was obsered transferring R1 from R1's wheelchair using the EZ-stand. NA-A was working the day R1 had slid to the floor when the left side of the strap came undone from the EZ- stand. NA-A was using the XL sling and thought it was too big fro R1 as R1's left arm was raised in the air. During interview on 2/6/24 at 2:16 p.m., NA-B stated she transferred R1 with the EZ-stand with the large sling, but sometimes was unable to find the large sling and would have to use the XL sling, which was too big for R1. During interview on 2/6/24, at 1:34 p.m., NA-C	2 830		

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2 830	Continued From page 4 stated he worked with R1 and they used a EZ-stand and was working the day R1 slipped from sling during a the lift transfer. NA-C stated R1 had a XL sling that was too large for her and felt that was why she slid out. During interview on 2/7/24 at 10:03 a.m., physical therapy assistant (PT)-A stated R1 used to use a stand aide, and now was using a EZ-stand, and suspected the reason R1 slid out from her sling was due to her not providing enough upper and lower assistance. During interview on 2/7/24, at 11:28 a.m. director of nursing (DON) stated R1 was transfered with a XL sling, after the incident R1's sling was switched to a large sling. "It sounds like from what I gathered the loop came off on the left side and maybe was not connected properly." The staff had training on using the EZ-stand and are having company come out to the facility and do refresher training on the lifts/stands on February 19th this year. On 2/7/24 at 3:35 p.m., NA-D while orientating NA-E stated she was told to use the large sling with R1 since she started in September 2023, but did not feel it was safe and prefers to use the XL sling. NA-D stated the large sling was too small for R1. NA-D and NA-E were observed to transfer R1 from her chair into the bathroom on to the toilet with the XL sling and not the L sling as care planned.There were no observed concerns with the transfer. During interview on 2/7/24, at 4:45 p.m. the DON stated immediately after the incident occurred with R1 sliding out of her sling she had changed the nursing assistance care sheets to make sure they use the large sling instead of the XL sling.	2 830		

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2 830	Continued From page 5 During interview on 2/8/24 at 11:58 a.m. the DON stated she informed NA-D she needed to use the large sling and not the XL sling. The DON stated NA-D was not happy since she felt the XL sling was safer. An EZ Way Harness (sling) sizing chart indicated the large sling to be used on 190-320 lbs, the XL sling to be used on 280-450 lbs., and The size/weight designations are merely estimates that have basic guidelines. SUGGESTED METHOD OF CORRECTION: The DON or designee could update facility policies and procedures on sizing lift slings for residents, ensure care plans are updated and educate staff on the using the correct lift sling. The DON or designeed could complete audits to ensure staff are using the appropriate lift slings. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		