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	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mille Lacs Health System	200 North Elm Street Onamia, MN 56359

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to ensure an injury of unknown origin was reported immediately and/or within 2 hours, to the State Agency (SA) and administrator for 1 of 1 residents (R1). Findings include: R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included stroke, aphasia, dementia, and hemiplegia. Further, MDS indicated R1 had severely impaired cognition and exhibited physical, verbal, and other behavioral symptoms. Review of facility report to the SA, submitted at 11:48 a.m. on 11/24/24, by director of nursing (DON) indicated R1 had unexplained bruising to left arm. Nursing assistant (NA)-A reported R1 had bruising to left forearm, left posterior hand, and some purple coloring on the inside of left fingers, and the bruising was tender to the touch to licensed practical nurse (LPN)-A in the morning after a.m. cares on 11/23/24. LPN-A reported to registered nurse (RN)-A around 2:00 p.m. on 11/23/24, and RN-A filed a MAARC (Minnesota Adult Abuse Reporting Center) report for injury of unknown source. Further, report indicated the administrator was notified at 9:46 a.m. on 11/24/24, by DON. On 11/27/24 at 10:21 a.m., LPN-A stated staff were expected to notify the floor nurse if a new bruise had been identified and the nurse would complete a skin assessment and document the findings in the resident's record as well as notify the charge nurse or care coordinator immediately. LPN-A stated she was notified by NA-A on 11/23/24 in the morning of R1's new bruising to her left arm and LPN-A then reported to RN-A. On 11/27/24 at 10:48 a.m., NA-A stated staff were expected to report to the nurse when a new skin impairment had been identified and attempt to determine if the skin concern is explainable or unexplainable. Further, NA-A stated on 11/23/24, she was assisting R1 with morning cares when NA-A noted new bruising on her left forearm which was raised, on her left hand and under her fingers. NA-A stated the bruising appeared to be fresh and R1 was unable to communicate what had happened and previous shift did not report any incidents that had occurred. NA-A stated she reported the bruising to LPN-A immediately. On 11/27/24 at 12:36 p.m., interview was attempted with RN-A but was unsuccessful. (continued on next page)

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.

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

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	11/27/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 2:01 p.m., DON stated once an injury of unknown was discovered the staff were expected to report the injury to the charge nurse and if the injury was reportable then notify the DON and administrator immediately. DON stated reporting an injury of unknown to the SA depended on the severity of the injury if the injury was severe immediately or no later than 2 hours and if the injury was not severe then 24 hours or less. Further, DON stated R1's bruising was discovered by NA-A who reported to LPN-A; however, LPN-A did not report the bruising to the charge nurse RN-A until 2:00 p.m. on 11/23/24. RN-A then submitted a MAARC report on 11/23/24 at 2:23 p.m. and printed the report and put it on DON's desk. DON stated she was made aware of R1's bruising on 11/24/24, in the morning and she called the administrator at that time. DON confirmed reeducation had not been provided to LPN-A or RN-A regarding reporting injuries of unknown to the SA, DON and administrator timely following this incident. Review of facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property/Vulnerable Adult Policy , undated, indicated an injury should be classified as an injury of unknown source when both of the following conditions are met: the source of the injury was not observed by any person or the source of the injury could not be explained by the protected adult; and the injury was suspicious because of the extent of the injury or the location of the injury (the injury was located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Further, policy indicated abuse allegations (abuse, neglect, exploitation, or mistreatment including injuries of known source and misappropriation of protected adult property) are reported per Federal and State law. The facility would ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation if made, if the events involves abuse or result in serious bodily injury, or not later than 24 hours if the events do not involve abuse and do not result in serious bodily injury, to the administrator, the director/manager or their designee, and to the department designated Common Entry Point (CEP).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to ensure a thorough investigation was completed for an injury of unknown to ensure abuse had not occurred for 1 of 1 residents (R1) reviewed. Findings include: R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included stroke, aphasia (language disorder that makes it difficult to understand, speak, read, or write), dementia, and hemiplegia. Further, MDS indicated R1 had severely impaired cognition and exhibited physical, verbal, and other behavioral symptoms. Review of facility report number 358743 to the SA, submitted at 11:48 a.m. on 11/24/24, by director of nursing (DON) indicated R1 had unexplained bruising to left arm. Nursing assistant (NA)-A reported R1 had bruising to left forearm, left posterior hand, and some purple coloring on the inside of left fingers, and the bruising was tender to the touch to licensed practical nurse (LPN)-A in the morning after a.m. cares on 11/23/24. Further, report indicated DON attempted to interview R1 however R1 could not speak due to aphasia other than single unclear words and sounds. R1 did not appear fearful or scared. DON asked if someone had hurt her, but she could not clearly answer. DON wrote down yes and no and asked resident to point, but R1 did not follow direction. On 11/27/24 at 2:01 p.m., DON stated she was completing the investigation related to R1's bruising. DON stated she had interviewed R1 in attempt to figure out the cause of the bruising however R1 did not respond appropriately to questions asked. DON stated she interviewed staff but that was it for interviews and DON confirmed she did not interview any other residents on R1's unit. DON stated she reviewed R1's behavior charting which revealed R1 had minimal behaviors and R1 was taking medications that would cause her to bruise easily. When asked how she ruled out abuse, DON stated she was not sure, but typically she would interview other residents but there were no other residents with any injuries that had been reported. Review of facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property/Vulnerable Adult Policy, undated, indicated investigations of injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse and injuries include but are not limited to, bruising of the inner thigh, chest, face, and breast, bruises of an unusual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable to trauma. Further, the policy indicated when an incident or suspected incident of abuse was reported, the administrator or designee would investigate the incident and the investigation would include: interview the protected adult, and 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, and obtain statements from the roommate or other residents located in the same area of the protected adult. In addition, procedures must be in place to provide the protected adult with a safe, protected environment during the investigation and staff were directed to examine, assess and interview the protected adult and others potentially affected immediately to determine any injury and identify any immediate clinic interventions necessary.

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NAME OF PROVIDER OR SUPPLIER: Mille Lacs Health System		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 North Elm Street Onamia, MN 56359	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview and document review, the facility failed to ensure bruising was monitored for changes until resolved for 1 of 3 residents (R1) reviewed. Findings include: R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included stroke, aphasia (language disorder that makes it difficult to understand, speak, read, or write), dementia, and hemiplegia. Further, MDS indicated R1 had severely impaired cognition and exhibited physical, verbal, and other behavioral symptoms. R1's Progress Notes revealed: -On 11/23/24 at 2:35 p.m., large amount of bruising was reported by nursing assistant. R1 was unable to state what happened. -On 11/24/24 at 11:48 a.m., resident had a 7-centimeter (cm) x 7 cm bruise to proximal and posterior left forearm, bruise was purple in the center with green around the edges, bruise was slightly raised and tender to the touch. Bruise 2 cm x 1.8 cm to distal posterior forearm dark purple in color. 3 cm x 4 cm bruise to posterior (back) of left hand by the thumb and index finger and going up onto the posterior middle finger, bruise was purple in color. 1 cm x 1 cm purple bruise to posterior left and near the ring finger. There was a slight purple coloring to the inside of fingers 2-5. R1's progress notes lacked any additional monitoring of the bruise. R1's care plan revised on 6/16/22, indicated R1 had the potential for alteration in skin integrity related to impaired mobility with right sided hemiparesis, and incontinence of bowel and bladder. Further, R1's care plan directed staff to inspect skin daily with cares. However, care plan lacked evidence of notification for staff to monitor for bruising on R1's arm and appropriate interventions. R1's treatment administration record for November 2024, printed 11/27/24, lacked evidence of monitoring for R1's bruising until resolved. On 11/27/24 at 10:21 a.m., licensed practical nurse (LPN)-A stated if bruising was identified, the floor nurse would enter a treatment order into the resident's record to monitor at least daily, for changes until resolved. LPN-A stated she was made are of R1's bruising by a nursing assistant on 11/23/24, and LPN-A confirmed she did not put in an order to monitor the bruising. On 11/27/24 at 12:27 p.m., registered nurse (RN)-A stated if a new skin impairment had been identified staff would document in the resident's record but was unaware of facility procedure for additional monitoring. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 1:25 p.m. RN-B stated when a bruise was identified staff would be expected to measure the bruising and the bruising was extensive staff would enter a treatment order into the resident's record to monitor the bruising daily for changes until the bruise was resolved. RN-B stated she observed R1's bruising on 11/25/24, and the bruising appeared to be healing and R1 had no pain. RN-B confirmed there was not an order in R1's treatment record for staff to monitor her bruising but staff should be assessing the bruise, but they are not. RN-B stated monitoring the bruise would be important to ensure the bruising does not worsen and there are no complications. On 11/27/24 at 2:01 p.m., director of nursing stated when a new skin impairment was identified the licensed nurse should implement an order to monitor every shift or twice a day for changes until resolved. DON confirmed R1's record lacked evidence of a treatment order for licensed nursing staff to monitor. DON stated she was at fault for the error of the missed treatment. DON stated monitoring the bruise for any changes or worsening would be important. Review of facility policy titled Treatment and Prevention of Skin Breakdown and Ulcers, undated, indicated nurse aides (NA) would inspect the skin every shift with cares for signs and symptoms of breakdown, and report issues to the team leader. Further, policy indicated a licensed nurse weekly skin assessment was to be performed by the licensed nurse on shower day or other designated day and the care plan was to be evaluated and revised based on response, outcomes, and needs of the resident.