STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milaca Elim Meadows Health Care Center	730 Second Street Southeast Milaca, MN 56353

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the hood vent over the flat top cooking surface and deep [NAME] was free of grease buildup in the secondary kitchen of the dining room. In addition, the facility failed to ensure the grates on a cooling fan were free of debris in the secondary kitchen of the dining room. This had the potential to affect all residents, staff and visitors who had food prepared in the secondary kitchen. During initial tour of main and secondary kitchens in the facility on 12/15/25 at 12:15 p.m., the secondary kitchen observed was a metal hood vent located over the float cook top and deep fryer. There was yellow substance noted in drips along the length of the hood-vent running approximately five inches down the angle of the metal hood. In the top of the hood there were three lightbulbs covered with glass bulb covers. On the bulb covers was a coating of yellow substance with a drip that hung from the far-left bulb. When observed on 12/16/25 at 12:56 p.m., the yellow substance remained on the hood vent and the lightbulb covers in the secondary kitchen. During observation and interview on 12/16/25 at 2:42 p.m., observed a white, stand-up, oscillating fan about three feet tall in the secondary kitchen, the grates of the fan contained a brown/yellow substance with black and brown dust particles clung to the substance. The cook stated the white fan was a cooling fan to help the kitchen staff cool down when the kitchen got hot. The cook uncertain about the cleaning schedule for the cooling fan. The cook stated the kitchen staff removed the vent covers and cleaned them every night, but they could and should have been cleaning off the metal hood. Maintenance would have cleaned the bulb covers. The cook stated the cleaning of the hood and bulb covers were important to ensure there was no grease that dropped onto food while it was being cooked. Facility policy Food and Nutrition Services reviewed 1/10/25, indicated all counter, shelves and equipment shall be kept clean and maintained in good repair.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess safety with self-administration of medication for 1 of 2 residents (R&) who self-administered medication after set up. R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 had intact cognition. Diagnoses included displaced femur fracture, chronic kidney disease, congestive heart failure and dementia. On 12/16/2025 at 4:07 p.m., R7 was seated in a recliner in her room watching television. The RN-A walked into the room, placed a paper cup containing medications onto the table next to R7 then walked out of the room. The paper cup contained two medications, one oval shaped brown colored and one round pink colored pill. R7 stated the nurses always just bring them to and I take them when I am ready to. When interviewed on 12/16/2025 at 4:20 p.m., registered nurse (RN)-A stated a resident could self-administer medications if there was an order and a self-administer medication assessment (SAM) was completed, the unit coordinator (UC) completed the SAM for residents. RN-A displayed R7's electronic medication administration record (EMAR) on the computer screen. On the screen was noted medication administration - self-administration OK after set up. A review of R7's electronic medical record (EMR) indicated R7 had an order dated 9/9/25, OK to self admin meds after set up. However, there was no SAM completed until 11/4/25, which indicated R7 did not want to self-administer medications. When interviewed on 12/16/2025 at 4:22 p.m., UC stated when a resident wanted to self-administer medication an assessment needed to be completed with an observation to indicate the resident was safe to self-administer their medication and there needed to be a provider order that allowed for self-administration. When asked if R7 was able to self-administer medication, UC logged out of the EMR, stated R7 was alert and oriented, and did not have an order nor an assessment to self-administer. When asked about observation of the nurse leaving medications in R7's room to self-administer Regarding the observation of RN-A leaving medications in R7's room for R7 to self-administer, UC stated that was not the right thing to do, UC then went back into EMR, located order for the OK to self-administer, UC identified order was obtained on 9/9/25, and an assessment with observation was not completed until 11/4/25. UC confirmed the assessment indicated R7 did not want to self-administer medications. UC stated seeing the order for self-administration was missed when the assessment was completed on 11/4/25, UC will need to complete a new assessment with observation. When interviewed on 12/18/2025 at 10:55 a.m., director of nursing (DON) stated was not aware if there was a time frame for the SAM to be completed when there was an order for OK to self-administer. DON stated roughly a couple of days between would be appropriate, would not want it to go over a week or a month before the SAM was done. The facility policy Self-Administration of Medications dated 10/20/25, indicated Self-Administration of medication assessment will be completed

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 2 of 5 residents (R7, R16) reviewed whose Medicare A coverage ended and then remained in the facility. R7's Centers for Medicare and Medicaid Services (CMS)-10123 signed as received on 8/27/25, identified a last covered day (LCD) of 8/29/25, when R7's Medicare coverage would end. R7's undated Census Records listing identified R7's payer source changed from Medicare Part A to Private Pay, and remained in the facility. R7 signed a SNFABN on 8/29/25, however, there was no estimated cost per day provided in the notification. R16's CMS-10123 signed as received on 10/7/25, identified a last covered day (LCD) of 10/10/25, when R16's Medicare coverage would end. R16's undated Census Records listing identified R16's payer source changed from Medicare Part A to Medicaid, and remained in the facility. R16's medical record was reviewed and lacked any evidence a SNFABN had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. When interviewed on 12/18/25, at 9:20 a.m. admission coordinator (AC) stated missed putting the estimated cost for R7 on the SNFABN, AC did not realize that information was not entered. R7 is private pay. AC stated for R16 the CMS-10123 had been provided but the SNFABN was not yet due until Saturday (10/11/25) however, AC did not notice the SNFABN had not been provided to R16 until surveyors had requested the copy for review. AC stated R16 was private pay while awaiting Medicaid decision. AC stated it was important to provide the SNFABN with estimated cost per day so the resident/resident representative would be aware of what their potential financial responsibility would be. Facility policy regarding beneficiary notifications was requested, however, none was provided.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the completed quarterly Minimum Data Set (MDS) was accurately coded to reflect hospice services for 1 of 2 residents (R15) reviewed for MDS accuracy. Findings include:The CMS Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.20.1, dated 10/2025, identified each section of the MDS along with various instructions how to code and/or complete them. The section labeled, Section O: Special Treatments, Procedures, and Programs, listed directions to record any special treatments or programs the resident received during the specified time period (i.e., assessment reference date; ARD). This included, Hemodialysis . and Hospice Care, , The manual outlined, Code peritoneal or renal dialysis which occurs at the nursing home or at another facility. Additionally, the directions also indicated Code residents identified as being in a hospice program . where any array of services is provided for the palliation and management of terminal illness .A review of R10's admission face sheet, dated 12/18/25, identified R10 had the diagnosis of chronic kidney disease, stage three, typically treated with medications, diet and exercise. R10's face sheet identified R10 was enrolled with hospice services. R10's diagnoses listing included chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs). R10's care plan, last reviewed/revised 12/15/25, indicated R10 was enrolled in a hospice program with the admitting diagnosis of COPD. A review of the facility Matrix completed by the facility indicated R10 was enrolled in hospice. A review of the Minimum Data Set (MDS) dated [DATE], section O, was marked to indicate R10 was receiving dialysis. The MDS did not indicate R10 received hospice services.During interview on 12/18/2025 at 1:36 p.m., the MDS Coordinator identified dialysis had been marked in error and indicated she should have marked hospice instead. The facility policy, last reviewed 3/10/25, identified the Long-Term Care Facility RAI process will be used to complete a comprehensive of a resident's needs, strengths, goals, life history and preferences. Assessments are to be completed per the guidelines of the RAI Manual, in compliance with Centers for Medicare and Medicaid Services (CMS) and any state regulations.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a mobility device was in good repair for 1 of 2 residents (R49), reviewed for accidents.R49's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R49 had severe cognitive impairment and was independent with ambulation and transfers with use of a cane.R49's care plan dated 08/28/2025, indicated R49 ambulated independently, used a cane/staff. R49's care plan further indicated R49 was high risk for falls.Progress note dated 11/20/25 at 6:19 p.m., indicated R49 was more confused than baseline. R49 had very unsteady gait and the walking stick resident used had been broken and temporarily mended for weeks. Have reported to daughter he needed a new one with the level of weight he applied on it being unsteady and she stated it is fine.On 12/15/25 at 10:29 a.m., R49 was observed seated in recliner in his room with a walking stick about five feet in length rested against his chest. About halfway up the length of the walking stick there was clear packaging like tape wrapped around the stick. Spouse stated the walking stick had broken and was taped together. Follow up observations on 12/16/25 at 4:04 p.m., taped walking stick was leaning against R49's recliner. On 12/17/25 at 7:19 a.m., taped walking stick was leaning against nightstand next to the bed where R49 was sleeping. On 12/17/25 at 10:42 a.m., and at 1:30 p.m., R49 was seated in recliner in the room with the taped walking stick rested against his chest. When interviewed on 12/17/25 at 2:01 p.m., nursing assistant (NA)-A stated R49 had ambulated independently with the walking stick frequently, more recently has been utilizing a wheelchair or she encourages him to use a walker. NA-A stated R49's balance was not that great, she did not trust the walking stick stability but was unsure of where the tape had come from. When interviewed on 12/17/25, at 2:30 p.m. licensed practical nurse (LPN)-B stated R49 had walked out of the dining room using the walking stick after breakfast this morning. LPN-B stated R49 had always used the walking stick since he admitted but since recent decline in status the last several weeks has been utilizing a wheelchair most of the time. Observation at 12/18/25 at 9:45 a.m., R49 was seated in dining room in wheelchair with walking stick resting against his chest. When NA approached and assisted R49 from the dining room utilizing the wheelchair, it was noted the tape had been removed from the walking stick. When interviewed at that time, R49's spouse stated someone from the facility had glued the walking stick. Walking stick was observed to have a U-shaped crack approximately five inches long approximately halfway up the walking stick with gluelike substance observed in the crack area. When interviewed on 12/18/25 at 11:22 a.m., Maintenance (Maint)- B stated the walking stick had a split that went along the grain of the wood, but was not fully split apart. Maint-B stated was able to apply some pressure to separate the wood to get the heavy-duty glue into the crack, used a activating agent to set the glue which hardened instantly. Maint -B stated the walking stick would probably break elsewhere before the repair area would break again, would take a lot of pressure to break the walking stick. When interviewed on 12/18/25 at 10:50 a.m., director of nursing (DON) stated was not aware the walking stick was broken, the walking stick was R49's personal property. DON was made aware of the walking stick condition the prior evening (12/17/25) and in the morning had retrieved the walking stick and provided a cane to R49. DON stated had removed the tape, saw the break, then got maintenance who used heavy duty glue to repair the break. DON stated if the repair had not held, would have spoken with the family regarding the walking stick being a fall risk. Facility Safety policy reviewed 7/1/25, indicated assistive devices will be adjusted to meet the residents physical condition, reviewed for appropriate fit and working order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed during observations of personal cares completed with 1 of 2 residents (R5) observed during personal cares. Findings include: R5's Resident Face Sheet, printed 12/18/25, diagnoses included urinary retention with indwelling catheter and pressure ulcer of sacral region (tailbone). Review of R5's physician's orders included catheter care.R5's care plan, last reviewed on 11/26/25, identified R5 required an indwelling urinary catheter related to numerous and ongoing ischemic (an area with decreased blood flow) injuries and pressure wounds. The care plan identified R5 required enhanced barrier precautions (EBP) (use of gown and gloves during high-contact care activities) related to chronic wounds and indwelling catheter. The care plan directed staff to wear gown and gloves for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing personal hygiene, changing briefs or assisting with toileting, and catheter care.The undated nursing assisting care sheet identified R5 was on EBP.During interview on 12/15/25 at 4:52 p.m., R5 acknowledged she had a pressure ulcer, however, stated she was unsure when it started. During observation of morning cares and interview following on 12/17/25 at 7:58 a.m., as nursing assistant (NA)-D assisted R5. Prior to entering R5's room, NA-D was observed properly donning (putting on) both gown and gloves, after performing hand hygiene. Upon entering room, NA-D explained to R5 that she was going to provide assist with personal cares. NA-D obtained a basin with warm water and washcloths to perform cares. NA-D placed supplies at bedside. After assisting R5 to wash face and upper body, NA-D assisted R5 to remove hospital gown and into a sweatshirt. R5t had an incontinence brief in place. NA-D proceeded to loosen tabs, lower brief and performed frontal peri care. NA-D was wearing gloves and gown throughout cares. While cleansing with washcloth, a clean fold was used to maintain cleanliness with washing. Once soiled on all folds, the washcloth was set aside with soiled linen and a fresh washcloth was used. The catheter was cleansed downward from the meatus (opening into the urinary tract). NA-D was then joined by NA-E, who had donned gown and gloves prior to entering room, to assist with completion of peri care. R5 was positioned on her side, facing NA-E. NA-D proceeded to perform peri care and cleansing of stool for R5. Once peri care was completed, and brief was placed into position, R5 was assisted by NA-D and NA-E to place sling by rolling resident from side to side. Once sling was in place, R5 was again in a back lying position. The tabs to the incontinent brief were secured. NA-D removed soiled gloves and disposed of them. NA-D did not perform hand hygiene or replace gloves. NA-E proceeded to wear gloves, however, had not had direct contact aside from maintaining side lying position. R5 sling was then attached to the mechanical lift. Once mechanical lift was in place, NA-D placed catheter bag on0top of R5's brief for transfer into wheelchair. R5 was placed in wheelchair, and the lift was removed from the sling. R5 was covered with a lap robe. NA-D, while still not wearing gloves, proceeded to place a cover on the catheter bag, and attached the catheter bag to the frame under the wheelchair. R5 was provided assist to brush her hair and was provided with her glasses by NA-E. Once R5 was positioned into wheelchair and covered with a lap robe. NA-D proceeded to remove her protective gown and placed it with the linens and placed them in the hamper. NA-E was observed to remove and dispose of gloves, and removed gown. NA-E placed the gown in the soiled linen hamper. Upon exiting the room, hand hygiene was performed by both NA-D and NA-E using alcohol-based hand sanitizer. Following completion of morning cares, NA-D was interviewed. NA-D stated the gown and gloves were used due to R5 having the wound and catheter in place. NA-D stated staff were to wear both gown and gloves. NA-D stated the use of gown and gloves was to protect R5 from infections, as well as protecting staff. NA-D stated she did not think about the need to perform hand hygiene and replace gloves once peri care was complete and soiled gloves were removed. NA-D stated not using gloves was not sanitary. During interview on 12/17/25 at 1:41 p.m., with the Infection Control Nurse/Assistant Director of Nursing (ADON), the ADON stated her expectation was for hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	washing/hand hygiene to be performed routinely throughout provision of cares. ADON went on to state staff should wash hands with soap after three times of use of alcohol-based hand sanitizer. Upon review of the provision of care to residents with enhanced barrier precautions, ADON stated hand hygiene was to be performed prior to entering room, and prior to donning the gown. Once hand hygiene has been performed, staff were to don gown and gloves. Staff were then to gather supplies and prep items for use with cares. Throughout provision of cares, when staff had completed a dirty task, they were to remove soiled gloves, perform hand hygiene, and don fresh gloves and proceed with cares. This process should be repeated whenever gloves became soiled with cares. ADON stated prior to leaving the room, staff were expected to remove gloves and dispose of them. Staff should then remove gown and place the gown in the soiled linen. Once that is completed, staff were to perform hand hygiene upon exiting room and prior to performing cares for others. ADON reviewed the signage for enhanced barrier precautions and staff were to wear glove and a gown during High-Contact Resident Care Activities. ADON verified a urinary catheter was classified as a device for enhanced barrier precautions. During interview on 12/18/25 at 12:54 p.m., licensed practical nurse (LPN)-C, clinical coordinator, stated gloves must be used at all times while providing direct resident care, including transferring with lift, adjusting in chair, and placement of catheter bag. LPN-C stated if gloves become soiled with provision of care, they should be removed, disposed of, hand hygiene performed, and new gloves donned. A facility policy, last reviewed 7/2/25, identified it was the policy of Cassia that handwashing/alcohol-based hand sanitizer be regarded as the single most important means of preventing the spread of microorganisms/transmission of infection. The policy identified the purpose of hand washing was to prevent heal care associated infections and promote employee health and safety. The facility policy, Transmission based precautions, enhanced barrier precautions and empiric precautions, last reviewed/revised 9/29/25, identified the use of EBP were used for residents who met criteria, which included a chronic wound, regardless of MDRO status, as well as used with residents with an indwelling medical device (which included indwelling urinary catheter). The policy identified high contact care activities required gown and glove use. These activities included provision of hygiene, changing briefs or associated toileting, device care or use, and wound care. The policy indicates a sign will be place on the resident's door to provide guidance to those entering the room.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the Ombudsman of transfers and discharge for 1 of 3 residents (R61) reviewed for discharge and/or hospitalizationR61's admission minimum data set (MDS) dated [DATE], indicated R61 admitted on [DATE], and was cognitively intact. R61 had diagnoses of hypertension, atrial fibrillation, end stage renal disease, quadriplegia, and diabetes.R61's discharge MDS dated [DATE], indicated R61 discharged to home. Review of the October-November 2025 Ombudsman log identified residents who transferred to the hospital, however, the log failed to identify notification to the Ombudsman was completed for any residents who discharged from the facility. When interviewed on 12/18/25 at 9:14 a.m., social service director (SSD) stated she was trained to send Ombudsman notifications either monthly or each time a resident was sent to the hospital. SSD stated was not aware of the need to inform the Ombudsman's office of residents discharged from the facility. Facility policy Discharge Planning and Ombudsman Notification reviewed 4/28/25, indicated notice to the ombudsman is required for emergency transfers.