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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 38E2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00930

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245313**

2.STATE VENDOR OR MEDICAID NO.
(L2) **306920600**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW LANE REHABILITATION & HEALTHCARE CTR**
(L4) **2209 UTAH AVENUE**
(L5) **BENSON, MN** (L6) **56215**

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 **02/22/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (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)
12/31

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
19	37			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NE II 02/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Assurance Supervisor 05/08/2018 (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
05/01/1986
(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.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/05/2018
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5313

On January 11, 2018 a standard survey was completed at this facility. The most serious deficiency (F686) was cited at a S/S level of G. A "G" level deficiency (F309). The facility meets the "GG" criteria and the Department is imposing the Category 1 remedy of State monitoring, effective January 31, 2018. In addition, we recommended to the CMS RO the following enforcement remedy for imposition:

- CMP for deficiency cited at F686

On February 22, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and verified that all health code deficiencies had been corrected.
As a result of the revisit findings, the department is discontinuing the Category 1 remedy of State Monitoring as of February 12, 2018.

In addition, we recommended the following action to the CMS RO as it relates to the remedy outlined in our letter dated February 27, 2018.

- CMP for the deficiency cited at F686 be imposed. (42 CFR 4889.430 through 488.444)

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245313

February 27, 2018

Ms. Brooke Dillon, Administrator
Meadow Lane Rehabilitation & Healthcare Ctr
2209 Utah Avenue
Benson, MN 56215

Dear Ms. Dillon:

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 February 12, 2018 the above facility is recommended for:

62 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 62 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
February 27, 2018

Ms. Brooke Dillon, Administrator
Meadow Lane Rehabilitation & Healthcare Center
2209 Utah Avenue
Benson, MN 56215

RE: Project Number S5313028

Dear Ms. Dillon:

On January 26, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 31, 2018. (42 CFR 488.422)

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office, the following actions related to the imposed remedies in our letter dated January 26, 2018.

- Civil money penalty for the deficiency cited at F 686. (42 CFR 488.430 through 488.444)

This was based on the deficiency cited by this Department for a standard survey completed on January 11, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 22, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 11, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 12, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 11, 2018, as of February 12, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 12, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions

- Civil Money Penalty for deficiency sited at F 686 be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 38E2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00930

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245313**
2.STATE VENDOR OR MEDICAID NO.
(L2) **306920600**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW LANE REHABILITATION & HEALTHCARE CTR**
(L4) **2209 UTAH AVENUE**
(L5) **BENSON, MN** (L6) **56215**

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) **02/01/2017**

6. DATE OF SURVEY **01/11/2018** (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)
12/31

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
19	37			
(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

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NE II 02/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 03/05/2018 (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
05/01/1986
(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.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

January 26, 2018

Ms. Brooke Dillon, Administrator
Meadow Lane Rehabilitation & Healthcare Center
2209 Utah Avenue
Benson, MN 56215

RE: Project Numbers S5313028, H5313032 and H5313033

Dear Ms. Dillon:

On January 11, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the January 11, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5313032 and H5313033 that were found to be unsubstantiated.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 31, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil Money Penalty for the deficiency cited at F686. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

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 remedy be imposed:

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

Failure to submit an acceptable PoC 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 11, 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 July 11, 2018 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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
	245313	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE REHABILITATION & HEALTHCARE CTR	**2209 UTAH AVENUE BENSON, MN 56215**

(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 CMS Appendix Z Emergency Preparedness Requirements, was conducted 1/8/17, through 1/11/17, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 1/8/18 through 1/11/18, and complaint investigations were also completed at the time of the standard survey. At the time of the survey, an investigation of complaint H5313032 and H5313033 were completed and were found to be unsubstantiated. 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. 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.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be	F 578		2/12/18

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

Electronically Signed | 02/05/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE REHABILITATION & HEALTHCARE CTR	**2209 UTAH AVENUE BENSON, MN 56215**

(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 578	Continued From page 1 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident advanced directives were accurately documented in the residents paper and electronic records to reflect	F 578	It is the policy of Meadow Lane Rehabilitation and Healthcare Center that the facility ensures resident□s advanced directives are accurately documented in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE REHABILITATION & HEALTHCARE CTR	**2209 UTAH AVENUE BENSON, MN 56215**

(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 578	Continued From page 2 resident current wishes for 2 of 4 residents (R38, R18) reviewed for advanced directives. Findings Include: R38 R38's Significant Change Minimum Data Set (MDS) Assessment dated 12/14/17, indicated R38 had severe cognitive impairment with diagnoses of dementia, chronic obstructive pulmonary disease and hypertension. The MDS also indicated R38 was also receiving hospice services. Review of R38's current Order Summary Report dated and signed by physician 12/14/17, indicated R38 was a full code. Review of R38's current administration record(MAR) dated 1/18, under advance directive indicated R38 was a full code. R38'S Resuscitation Status, Advanced Directive Review located under the cover of R38's chart in a clear plastic sleeve dated 11/29/17, indicated R38 was DNR/DNI (do not resuscitate/do not intubate) (do not attempt resuscitation). Further review of R38's medical record under the hospice tab was R38's DNR/DNI Request form dated 11/30/17, indicated R38 was DNR/DNI meaning that if R38's heart stops beating or if she stops breathing, no medical procedure to restart breathing or heart functioning will be instituted or continued. R38 would be allowed to die naturally. Review of R38's current care plan, with print date1/9/18, indicated R38 had an advance directives as evidenced by DNR and R38 enrolled	F 578	their paper and electronic records to reflect their current wishes. Code status R38 and R18 were immediately updated on the paper form in their chart and on PCC so there were no discrepancies. All resident□s in facility could be potentially affected by not having accurate documentation of their wishes in their medical record. All resident□s electronic and paper charts were immediately reviewed to assure that there were no discrepancies. On 1-18-18 all nurses were educated on resident□s code status change, proper documentation to ensure residents□ current wishes. Nursing admission checklists were updated to include this information. Random audits will be conducted by SSC/Designee and forwarded to Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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F 578	Continued From page 3 in hospice. R38's clinical record had not been updated to reflect R38's current DNI/DNR wishes. R18 R18's quarterly MDS dated 11/22/17, indicated R18 had severe cognitive impairment with diagnoses of dementia, anxiety and depression. Review of R18's current care plan dated 1/9/18, indicated R18 had an advance directive as evidenced by full code. CPR would be performed as ordered. R18's Resuscitation Status, Advanced Directive Review located under the cover of R18's chart in a clear plastic sleeve reviewed on 6/21/17, indicated R18 was full code (do resuscitate). Review of R18's current Order Summary Report signed by physician 12/7/17, indicated R18 was a full code. Further review of R18's medical record under the hospice tab was R18's DNR/DNI Request form dated 1/5/18 indicated R18 was DNR/DNI status (meaning that if 18's heart stops beating or if she stops breathing, no medical procedure to restart breathing or heart functioning will be instituted or continued. R18 would be allowed to die naturally.) Review of R18's current MAR dated 1/18, under advance directive indicated R18 was a DNR/DNI per family request (enrolled in hospice). R18's clinical record did not accurately reflect R18's current wishes for advance directives.	F 578		

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F 578	Continued From page 4 On 1/9/18 at 4:41 p.m. licensed practical nurse (LPN)-C confirmed R18 and R38'code status was identified differently in various locations of the clinical record. LPN-C indicated her usual routine to verify a resident's current advance directives was to review the code status in the plastic sleeve in the front of each resident's chart. On 01/09/18, at 4:44 p.m. a group interview with the administrator and MDS coordinator (MDSC)-A was conducted. MDSC-A stated the facility protocal was for the nurses to refer to the resident's MAR when verfiying the resident's code status, or they could ask someone for assistance to look in the residents medical chart. Administrator and MDSC-A confirmed the code level status for R18 and R38 did not match the code level listed on the forms in their paper medical record, and also was not accurate on the resident's MAR. MDSC-A and the administrator confirmed their expectation was at the time the form was returned signed by the physician, the electronic record should be updated. MDSC-A and the administrator confirmed the information in the electronic medical record and the form in the paper chart should be the same for each	F 578		

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F 578	Continued From page 5 resident. The facility policy titled, Meadow Lane Rehabilitation & Healthcare Center Advanced Directives, undated, was provided by the facility. It identified upon admission, the social services staff or facility representatives were to ensure the resident's choice is honored. Each resident will be offered the opportunity to review, make or revise his/her advanced directive prior to or during the quarterly care conference. The policy lacked guidance to assure all areas of the resident's electronic and paper copy chart included consistent accurate information. The facility policy titled, Do Not Resuscitate Order, undated, was provided by the facility. The policy instructed staff to place the Do Not Resuscitate form in the front of the resident's medical record once completed and signed by the attending physician and resident. The policy lacked instruction on when to update the resident's electronic record, or who was responsible to assure the electronic and paper medical record matched.	F 578		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		2/12/18

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F 623	Continued From page 6 (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,	F 623		

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F 623	Continued From page 7 including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the	F 623		

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F 623	Continued From page 8 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the ombudsman of facility initiated discharges for 2 of 4 resident (R18, R17) who were discharged to the hospital. Findings include: R18 had diagnoses that included dementia with behavioral disturbance, anxiety disorder and depressive disorder per he current face sheet. R18's Progress Notes dated 12/10/17, revealed R18 had a change in level of consciousness, weak and low blood pressure. R18 had been sent to the emergency room for evaluation and at 10:52 a.m. the facility had been notified R18 was admitted to the hospital. Review of R18's Progress Notes dated 1/2/18, revealed R18's primary medical doctor had ordered R18 to be sent to emergency room for evaluation of ongoing symptoms and after evaluation had been readmitted to the hospital. On 1/11/18 at 8:23 a.m. social service designee (SSD)-A confirmed the facility had not notified the ombudsman of facility-initiated transfers/discharges at the time of hospitalizations and the ombudsman was not aware R18 had been discharged to the hospital on 12/10/17 and 1/2/18. SSD-A indicated she was aware that in the past the facility had	F 623	It is the policy of Meadow Lane Rehabilitation and Healthcare Center that the facility properly notifies the ombudsman of residents discharges/transfers. Facility determined that it lacked a system for notification to ombudsman when resident s return was anticipated but resulted in hospitalization for resident R18 and R17. It was reviewed by ED/DON/RNAC/SSC at that time and determined to notify ombudsman monthly of discharges/transfers. Residents who transferred in month of December were reviewed by SSC and notified to ombudsman on January 11th, 2018 via fax; January s residents to be notified in February respectfully. On 1/10/18 it was reviewed with facility IDT team as an improved process, Ad Hoc initiated, staff educated. On 1/11/18 SSC and ED gave surveyor copies of the updated procedure and notified of Ad hoc to be reviewed at QAPI. Also gave surveyor faxed proof of proper notification to ombudsman for residents transferred in December 2017 and reviewed that January s transfers will be notified by SSC in month of February. The updated transfer form checklist for nurses was also provided to surveyor at this time. The facility is to properly notify the	

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F 623	Continued From page 9 problems with notifying the ombudsman's office of discharges from the facilty and the facility was making changes to the protocol for notification. SSD-A indicated she had not notified the ombudsman of R18's discharges to the hospital, staff had not contacted ombudsman and she was not sure what the facility's new protocol would be in regards to contacting the ombudsman. R17's medical record lacked documentation that the Ombudsman was contacted of R17's facility initiated discharge. R17's quarterly Minimum Data Set (MDS) dated 11/17/17, identified R17 was cognitively intact, had diagnoses which included major depressive disorder, heart disease and rheumatoid arthritis. Review of R17's progress note on 12/29/17, after discussion with the phsycian's office regarding R17's health condition, R17 was transferred to the hosptial. On 1/10/18, at 09:08 a.m. social service designee (SDD)-A confirmed the facility process to notify the Ombudsman was done by the nursing staff at the time of transfer. She confirmed the facility did not use a monthly process to inform the Ombudsman of resident transfers, the notice was done by the nurse at the	F 623	ombudsman of all resident□s that discharge/transfer. Residents who transfer in January will be notified in February respectfully. On 1-10-18 IDT team implemented an Ad Hoc for an improved system for proper notification to the ombudsman of residents□ transfers/discharges and educated nurses ongoing of these changes. On 1-18-18 an all licensed staff meeting was held, and this process was again reviewed in more detail. Random audits will be conducted by SSC/Designee and forwarded to Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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F 623	Continued From page 10 time of transfer. On 1/10/18, at 10:36 a.m. administrator and director of nursing (DON) confirmed the Ombudsman was not informed of R17's transfer from the facility. A current policy to notify the Ombudsman of transfers from the facility was requested and not provided. A copy of a Transfer Out Checklist, undated, was provided, which instructed staff to fax a copy of the transfer form and bed hold form to the Office of the Ombudsman of Long Term Care.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		2/12/18

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F 625	Continued From page 11 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 3 of 4 residents (R18, R8, R42) reviewed for hospitalization. Findings include: R18's Progress Notes dated 12/10/17, revealed R18 had a change in level of consciousness, weak and low blood pressure. R18 had been sent to the emergency room for evaluation and at 10:52 a.m. the facility had been notified R18 was admitted to the hospital. Review of R18's Progress Notes dated 1/2/18, revealed R18's primary medical doctor had ordered R18 to be sent to emergency room for evaluation of ongoing symptoms and after evaluation had been readmitted to the hospital. Review of R18's medical record revealed the lack of documentation that R18 or family/legal representative had been provided information on the facility's bed hold policy at the time of the hospital transfer. On 1/101/18 at 1:12 p.m. Minimum Data Set coordinator (MDSC)-A reviewed R18's chart and	F 625	It is the policy of Meadow Lane Rehabilitation and Healthcare Center that the facility ensure that the resident or residents□ representative was informed of the bed hold policy at the time of hospitalization. Upon review of current system, it was determined that the facility lacked a system for proper documentation of obtaining a bed hold when the resident□s return was anticipated but resulted in a hospitalization. A system was in place for offering bed hold policy by the nurse at time of transfer or therapeutic leave. There was not supporting documentation in writing or PCC from nurses requesting bed hold offered via phone when anticipated when return did not occur. This affected R8, R18, and R42. It was identified on 1/10/18 by MDS Coordinator that there was not supporting documentation in PCC or medical record to verify if a bed hold was offered. On 1/10/18, transfer checklist was reviewed by ED/Clinical Manager/MDS Coordinator and updated to include we can email, get a verbal consent over phone, document it and have them sign when they return and the date they return if unable to obtain prior. MDS Coordinator notified Surveyor of this system and provided updated copy	

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F 625	Continued From page 12 confirmed R18 and/or her responsible party had not been provided a bed hold policy/information prior to her discharge to the hospital on 12/10/17 and 1/2/18. The MDSC-A indicated the usual facility protocol was for staff to call the family/legal representative and update them on transfers and provide information in regards to the bed hold policy. MDSC-A indicated the floor nurse should of completed the bed hold policy according to the facility transfer check list. MDSC-A indicated her expectation of staff would be to complete the transfer discharge form and the bed hold policy. Review of Notice Of Bed Hold Policy undated, indicated the notice of bed hold policy was provided to the resident/financially responsible party upon admission and at the time of leave. R8's electronic record and paper chart lacked documentation of a bed hold policy provided to R8 during his hospitalization on 6/13/17, to 6/20/17. R8's quarterly Minimum Data Set (MDS) dated 10/26/17, identified R8 was cognitively intact, had diagnoses which included depression, hypertension and deep vein thrombosis (DVT) (blood clot) of his lower extremities. Review of R8's progress notes from 6/13/17, to 6/20/17, revealed the following: -6/13/17, R8 departed at 11:15 a.m. for an appointment with a neuromuscular specialist, for leg swelling.	F 625	with new addition to instruct nurses how to document the offering of a bed hold policy. All residents or resident□s representative who transfer out of the facility are to be properly informed of the bed hold policy. On 1-10-18 IDT team implemented an Ad Hoc for an improved system for how to properly document efforts to obtain bed hold when return was anticipated but did not occur. Nurses were immediately educated of this. On 1-18-18 an all licensed staff meeting was held and again this process was reviewed at that time. Random audits will be conducted by SSC/Designee and forwarded to Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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F 625	Continued From page 13 -6/14/17, R8 had been admitted to the hospital due to a femoral clot in his leg. On 1/08/18, 10:32 a.m. R8 shook his head back and forth and indicated he had not received a bed hold policy from the facility during his hospitalization. On 1/10/18, at 2:49 p.m. adminstrator confirmed R8 was transferred to the hospital on 6/13/17, and indicated R8 contacted the facility to tell them he was transferred to the hospital from his clinical appointment. Administrator indicated a bed hold policy would not be provided or sent to the hospital if he called them to inform the facility of his transfer. She indicated it would of been discussed verbally. Review of R42's Admission Record indicated R42 had diagnoses which included chronic	F 625		

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F 625	Continued From page 14 lymphocytic leukemia of B-cell type not having achieved remission, encephalitis, seizures and chronic atrial fibrillation. Review of R42's progress notes from 12/15/17, through 12/27/17, revealed R42 had been hospitalized on 12/26/17. The medical record lacked documentation that bed hold information was sent to the hospital for R42, or given to R42's resident representative at the time of transfer to the hospital. On 1/11/18, at 4:40 p.m. registered nurse (RN)-A stated that R42 had been to an appointment the day prior to his hospitalization. RN-A confirmed bed hold information had not been given to R42.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	F 636		2/12/18

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F 636	Continued From page 15 (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.	F 636		

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F 636	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately complete the Minimum Data Set (MDS) for 2 of 2 residents (R20, R8) who had not been assessed for mood status. Findings include; R20's Admission Minimum Data Set (MDS) dated 11/3/17, revealed R20 had moderate cognitive impairment and diagnoses which included Parkinson's disease, heart failure, arthritis and secondary pulmonary hypertension. R20's MDS also indicated R20 received an antipsychotic daily. R20's Admission MDS lacked data collection for Section D: Mood. R20's MDS identified R20 had not been interviewed on mood symptoms, however, the staff assessment of resident mood section had not been completed on the MDS. Review of R20's Care Area Assessments (CAA) results dated 11/9/17, revealed R20 had diagnoses of Parkinson's disease with psychosis and anxiety. However, the CAA lacked a comprehensive assessment of R20's current mood status. On 1/11/18, at 10:33 a.m. social services designee (SSD)-A stated that she completed Section D of the MDS, which included the Patient Health Questionnaire-9 (PHQ-9) (a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) on every resident for their Admission, Quarterly and Significant Change MDS. SSD-A stated that if a resident was unable to complete the PHQ-9, then	F 636	It is the policy of Meadow Lane Rehabilitation and Healthcare Center that the facility is to accurately complete the Minimum Data Set (MDS) for all residents. Upon review of current system, it was determined that the facility failed to accurately complete the mood status for R8 and R20. SSC had since obtained PHQ-9 on R8 and R20; however, the MDS had already been completed and submitted. According to RAI manual on page D4 it states to conduct the interview preferably the day before or the day of the ARD, so modification after that date is not appropriate. Accurate completion of the MDS affects all residents who reside at Meadow Lane. MDS Coordinator reviewed the last 30 days of MDSs for accurate completion of each section. The SSC was re-educated by ED and MDS coordinator to ensure that she understands her responsibility to complete her assigned sections of the MDS. The MDS Coordinator was reeducated by ED to verify completion and consistency before signing. On 1-11-18 it was reviewed with all Interdisciplinary team members their responsibility to complete their sections within the MDS during their designated time frame and reviewed that the MDS coordinator is responsible to schedule assessment and after verifying consistency and completion prior to signing them.	

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F 636	Continued From page 17 staff interviews would be conducted to gather the needed data. SSD-A reviewed R20's Admission MDS and confirmed that a resident or staff interview for PHQ-9 was not completed. SSD-A indicated the PHQ-9 and Mood CAA were an important part of her job. She stated R20 had a rough adjustment period to the facility. On 1/11/18, at 11:40 a.m. Minimum Data Set coordinator (MDSC)-A stated an Admission MDS would require completion of Section D of the MDS to be considered a complete, comprehensive assessment. On 1/11/18, at 1:37 p.m. director of nursing (DON) stated MDSC-A was responsible for MDS assessments for the facility. DON stated that she would expect each MDS to be complete including Section D of the MDS. DON stated that an MDS would not be a comprehensive assessment if Section D was not completed. R8's admission record listed diagnoses which included major depressive disorder, recurrent, deep vein thrombosis (DVT) (blood clot) of his lower extremities, and irritable bowel syndrome. R8's quarterly MDS dated 10/26/17, identified R8 was cognitively intact, had diagnoses which included depression, hypertension and DVT of his lower extremities, and required extensive assistance for bathing, dressing, hygiene toileting and transfers. R8's quarterly MDS dated 10/26/17, lacked documentation of a mood interview completed of	F 636	Random audits will be conducted by MDS Coordinator/Designee and forwarded to Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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F 636	Continued From page 18 R8 or staff interview. The MDS section for mood assessment had not been completed. R8's annual MDS dated 7/27/17, lacked documentation of a mood interview completed of R8 or staff interview. The MDS section for mood assessment had not been completed. R8's CAA summary dated 7/27/17, included various triggered areas such as activities of daily living (ADL) function, urinary incontinence and and pressure ulcer. However, the CAA lacked documentation of comprehensive assessment of Psychosocial Well-Being, Mood State and Activities for R8. On 1/11/18, at 11:24 a.m. MDSC-A confirmed R8' diagnosis of depression. She confirmed R8's mood fluctuated, was at times crabby or sad, or was up beat. MDSC-A confirmed the mood assessment portions of the annual MDS dated 7/27/17, and the quarterly MDS dated 10/26/17, had not been completed. MDSC-A confirmed (SSD)-A was responsible for completion of the Mood section of the MDS and indicated she had inaccurately signed the MDS's, which indicated both of the MDS' were complete. On 1/11/18, at 12:45 p.m. SSD-A confirmed she was responsible for the mood assessments for each resident's MDS and R8's mood assessment had not been completed for the annual MDS dated 7/27/17, and the quarterly MDS 10/26/17. She confirmed R8 had a diagnosis of major depressive disorder and indicated she did not know why she had not completed the mood assessments for either MDS. SSD-A confirmed the lack of comprehensive assessment would affect R 8's CAAs completed and his	F 636		

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F 636	Continued From page 19 comprehensive care plan. On 1/11/18, at 1:02 p.m. DON confirmed the mood assessments of R8's quarterly MDS dated 10/26/17, and R8's annual MDS dated 7/27/17, were not completed. DON confirmed by not completing the mood assessments it would absolutely affect R8's CAAs and comprehensive care plan. DON indicated her expectation was for all areas of the MDS were to be entered before the MDS was signed off as completed. The facility policy titled Superior Healthcare Management, Care Planning (MDS/RAI Process), revised 1/30/17, identified the MDSC was responsible to establish an assessment date for initial assessments and would establish a schedule for each subsequent assessment. The interdisciplinary team members were responsible to complete their assigned sections of the MDS. The registered nurse would verify assessment completion and review the resident's entire MDS form, CAAs and care plans for completeness and consistency before signing.	F 636		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer,	F 640		2/12/18

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F 640	Continued From page 20 reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 640	It is the policy of Meadow Lane	

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F 640	Continued From page 21 facility failed to complete, encode and transmit a Discharge Return Not Anticipated (DCRNA) Minimum Data Set (MDS) assessment for 1 of 1 resident (R1) reviewed for resident assessment. Findings include: R1's admission MDS dated 7/18/17, revealed R1 had intact cognition and diagnoses which included encephalopathy (abnormal brain function), manic depression, psychotic disorder and Schizophrenia. The MDS also indicated R1 required extensive assistance from facility staff for bed mobility, dressing, toileting and personal hygiene. The MDS further indicated that R1 was receiving occupational and physical therapies. R1's Care Area Assessment (CAA) dated 7/21/17, revealed R1 was admitted to the facility for short-term rehab care and therapies. R1's care plan dated 7/24/17, revealed R1's focus was to be discharged home. R1's care plan listed various interventions for this goal which included: establishing a pre-discharge plan with the resident/family/caregivers and evaluate progress, revise plan weekly and making arrangements with required community resources to support independence post-discharge. Review of R1's progress notes from 8/2/17, through 8/12/17, revealed: -8/2/17, R1 attended the care conference where the progress of R1's short-stay for recovery and therapy were discussed. R1 planned to discharge this Friday. -8/7/17, R1 has had health concerns the past	F 640	Rehabilitation and Healthcare Center that the facility is to complete, encode and transmit a Discharge Return Not Anticipated Minimum Data Set as required. It was determined that this affected resident R1. Upon learning of this error, MDS Coordinator completed R1□s DCRNA MDS at that time. This has the potential to affect all residents who discharge from the facility. MDS Coordinator Reviewed the Electronic Dashboard to ensure no other DCRNA□s had been missed. Education was provided to MDS Coordinator on responsibility to complete, encode and transmit a DCRNA MDS on 1-11-18 by ED/DON. Random audits will be conducted by DON/Designee and forwarded to Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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F 640	Continued From page 22	F 640		

several days. A clinic appointment was made that morning. Facility received a phone call from the clinic at 12:45 p.m. that R1 was transferred to St. Cloud hospital.

-8/12/17, Call placed to hospital and confirmed that R1 would discharge from the hospital to home with oxygen. R1 came to nursing home with discharge to home orders. Current medications were released to R1.

On 1/10/18, at 1:26 p.m. minimum data set coordinator (MDSC)-A confirmed she was responsible for completion and submission of MDS data for the facility. MDSC-A verified R1 discharged from the facility on 8/7/17 and that a DCRNA MDS assessment was not completed, encoded or transmitted. MDSC-A stated she would complete R1's DCRNA MDS that day.

On 1/11/18, at 11:35 a.m. MDSC-A stated her usual process for ensuring that a DCRNA MDS was completed, encoded and transmitted was to check the electronic health record dashboard which had a section for admissions, discharges and transfers into and out of the facility. MDSC-A stated she just missed R1's discharge. She confirmed R1's DCRNA MDS should have been completed 14 days after the discharge date of 8/7/17.

On 1/11/18, at 1:37 p.m. director of nursing (DON) confirmed MDSC-A was responsible for MDS completion. DON confirmed she would expect all required MDS assessments to be completed, including the DCRNA MDS.

A facility policy titled, MDS Completion and Submission Timeframe's (undated), revealed a

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F 640	Continued From page 23 DCRNA MDS should be completed by the discharge date, plus 14 calendar days and should be transmitted to the Center for Medicare and Medicaid Services (CMS) 14 calendar days after the MDS completion date.	F 640		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		2/12/18

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F 655	Continued From page 24 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop an accurate base line care plan for 1 of 1 newly admitted resident (R244) with an indwelling catheter. Findings include: On 1/08/18, at 2:38 p.m. R244 was observed lying in bed, covered up with a blanket. A catheter bag and tubing, with yellow liquid, was visible hanging from under the blanket at R244's mid thigh area and attached to the bed frame. R244 stated he had completed self catheterization at home, but had an indwelling foley catheter placed during his recent hospitalization to promote wound healing of a wound. R244 had diagnoses which included spina bifida, unspecified open wound of left buttock and depressive disorder documented on his order summary report signed 1/3/18. R244's baseline care plan revised 1/4/18, identified R244 was incontinent of bowel and bladder. R8's care plan lacked documentation or	F 655	It is the policy of Meadow Lane Rehabilitation and Healthcare Center that the facility is to develop an accurate baseline care plan on newly admitted residents within 48 hours of the resident□s admission. The facility failed to develop an accurate base line care plan for R244 regarding his indwelling catheter. R244□s care plan updated to identify indwelling catheter, staff educated on ensuring accuracy on baseline care plans. The facility is to develop an accurate base line care plan within 48 hours for all residents who admit to the facility. All current 48-hour care plans were reviewed by DON/Clinical Manager/MDS Coordinator to assure for accuracy. Education was provided to all licensed nurses responsible for initiating and assuring accuracy of baseline care plans on 1-18-18 by DON/Clinical Manager. Random audits will be conducted by	

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F 655	Continued From page 25 interventions, necessary for care of R244's indwelling foley catheter. R244's hospital transfer and order forms dated 1/2/18, included a hospital order dated 1/2/18, for a consult for possible need of suprapubic cystostomy (surgical opening into the bladder) until patient's deep ischial ulcer was healed. The forms also included a hand written note on page 1 which indicated a urology consult would be scheduled prior to discharge. The form indicated R244 was incontinent by a checked box which indicated incontinence for elimination. On 1/11/18, at 1:08 p.m. licensed practical nurse (LPN)-A confirmed R244 utilized a foley catheter. She indicated the certified nursing assistants were responsible for completing catheter cares. LPN-A was unaware of what information was on R244's care plan for catheter care, however, she confirmed the only direction on the treatment electronic record (TAR) was to monitor intake and output with no other direction to address R244's catheter cares or monitoring. On 1/11/18, at 2:23 p.m. certified nursing assistant (CNA)-A confirmed R244 had an indwelling foley catheter. CNA-A indicated she had emptied R244's catheter at noon, but he refused cares. CNA-A indicated knowledge of basic catheter cares she would perform for residents with catheters, however, was not aware of R244's instructions for care of his indwelling catheter. On 1/11/18, at 3:43 p.m. director of nursing (DON) and surveyor reviewed R244's paper and electronic chart . DON confirmed R244's base	F 655	Clinical Manager/Designee and forwarded to the Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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F 655	Continued From page 26 line care plan identified R244 as incontinent of bowel and bladder. DON confirmed his baseline care plan did not include documentation or interventions for a foley indwelling catheter. DON indicated she would expect the base line careplan to include documentation and interventions for catheter cares. DON stated R244's current physician orders did not include a foley indwelling catheter and indicated orders were necessary for foley catheter cares, including monitoring, when to change the catheter and the size of the catheter. DON indicated she would expect the base line care plan and orders to include the use of the indwelling catheter for R244, to assure staff provided appropriate catheter cares were provided for R244. A facility form titled Admission checklist, undated, identified under #15, staff were to complete an IPOC (immediate plan of care pertinent to admission, diagnosis and at risk for) and place in care plan section of resident's chart. Under #25, the form instructed staff to complete necessary assessments if applicable, including catheter use. The facility policy titled Superior Healthcare Management, Care Planning (MDS/RAI Process), revised 1/30/17, identified the basic or baseline care plan is completed within 48 hours of admission, and provides effective and person-centered care that meets professional standards of quality.	F 655		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		2/12/18

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F 686	Continued From page 27 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate wound care to promote healing and prevent infection/sepsis for 1 of 1 resident (R244) with a current stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed and often includes undermining and tunneling); and 3 current stage 3 pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). R244 suffered actual harm, when the stage 4 and stage 3 pressure ulcers were left open to air without the prescribed wound vac reapplied, which failed to promote healing, and increased the risk for potential worsening or further development of pressure ulcers, and increased potential for sepsis due to infected pressure ulcers. Findings include: Review of R244's hospital history and physical dated 12/20/17, identified R244 had a	F 686	It is the policy of Meadow Lane Rehabilitation and Healthcare Center that the facility provides appropriate wound care to promote healing to prevent infection/sepsis. R244 had been found to not have his wound vac on and intact; documentation in PCC from nurses did not support as to why it was off. This increased the risk for potential worsening or further development of pressure ulcers, and increased potential for sepsis due to infected pressure ulcers. DON/Clinical Manager updated in Treatment Administration Record (TAR) to monitor pain and dressing placement 5 times per day. Updated TAR to also check wound vac for pressure setting and proper function, and dressing site every shift. All residents with wound vacs would have the potential for worsening ulcers or potential for sepsis, presently there is one resident residing at facility that has a wound vac. Education on wound vac□s and training	

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F 686	Continued From page 28 full-thickness pressure ulcer to the left of his sacrum and central buttocks area. The note further identified R244 had pressure ulcers present on posterior bilateral thighs by identifying very light almost abraded skin, which laid exactly where the edge of his wheelchair fabric rubbed against his legs. The documentation indicated the resident had chronic buttock and leg wounds/pressure decubitus. Review of R244's order summary report signed 1/3/18, identified R244 had diagnoses which included spina bifida, unspecified open wound of left buttock and depressive disorder. R244's Skin assessment, dated 1/2/18 identified the following; -skin concern 1; left upper thigh stage 3, description; pressure ulcer, no measurements -skin concern 2; right upper thigh, stage 3, description; pressure ulcer, no measurements. - skin concern 3; left buttock, no stage identified, no description, measurements; size; 6" X 4" X 4" -Braden score(tool for predicting pressure sore risk) incorrectly scored R244 as 22, not at risk for the development of pressure ulcers. The 1/2/18 skin assessment lacked comprehensive descriptions of R244's multiple pressure ulcers, and failed to identify the use of the wound vac. R244's baseline care plan revised 1/4/18, indicated R244 had a current pressure ulcer and utilized a wound vac.The baseline care plan included various interventions including use of a specialty mattress, wound vac use, dressing changes as ordered, and wound nurse to see	F 686	was provided by DON to Licensed staff on 1-11-18. It was identified that one LPN who was just completing orientation had not had previous training on wound vac by facility and was provided one on one training at that time. All other nurses in facility had received training. A refresher Interactive training was provided to all licensed staff on 1-18-18 by KCI, as well as review of how to access facility policies and procedures on shared drive. Random audits will be conducted by Clinical Manager/Designee and forwarded to the Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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F 686	Continued From page 29	F 686		

weekly.

On 1/8/18, at 2:43 p.m. R244 stated during interview that he'd had pressure ulcers for the past year and a half. He stated the wound care got to be too much to do at home, he'd been hospitalized due to getting sick, and had came to the facility. R244 also stated he felt facility staff did not know how to manage his wound vac.

On 1/10/18, at 12:09 p.m. R244 was seated on the edge of his bed, with family member (FM)-A present in his room. R244 had a shirt on however, no undergarments and he'd started pulling up his pants, which were observed to be pulled up to his knees. R244 turned over independently and exposed his buttocks and thighs to show his wounds. There were no dressings in place, nor was a wound vac in place. R244 had a large, deep open area on his left buttocks. The skin around the open area was observed to be red with several superficial open areas observed across his buttocks and thigh area. Pink drainage was observed on R244's bedspread which covered an area approximately 4-8 inches in size. R244 turned back over and began to finish pulling up his pants while he sat on the edge of the bed. R244 voiced concerns of things not being done for him at the facility. FM-A and R244 stated FM-A had been called to come to the facility to change R244's wound vac dressings four times since he had been at the facility. FM-A stated she felt it was her fault, since she'd told staff they could call her when they had trouble with the wound vac. R244 and FM-A confirmed R244 had not yet been seen by a wound nurse at the facility. FM-A stated the director of nursing (DON) had e-mailed the wound care nurse and from what she understood,

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the DON was waiting for a response. R244 indicated at that time that he was not in a good mood and his plan was to return after his medical appointment to get his items then leave the facility. FM-A indicated R244 and her would discuss his options for further care at the physician appointment.

On 1/11/18, at 1:08 p.m. LPN-A stated during interview that R244's wound vac was not on at present, and had not been on during the previous night either. LPN-A stated the wound vac had "fallen off" when R244 was transferring out of a vehicle the prior evening. LPN-A also said she was waiting for someone to replace it and said she didn't know whether the night nurse had attempted to reapply the wound vac last evening. LPN-A said she didn't know how to apply the wound vac and thought a wound care nurse would normally do so. She stated one of the registered nurses could probably do it, but confirmed she had not informed a registered nurse that the resident's wound vac was not in place.

On 1/11/18, at 1:18 p.m. R244 was lying on his abdomen on his bed. RN-A and surveyor entered room to visualize R244's pressure ulcer. R244 independently repositioned himself to his left side. He was lying on an absorbent cloth pad, which appeared to be approximately 75% saturated with a large amount of red/pink drainage. His sweat pants were saturated from his buttocks to mid thigh with the drainage. RN-A slid R244's pants down to his thighs revealing no dressings or wound vac in place. RN-A verbally confirmed this observation, and verified there was no dressing or wound vac on the resident's bedding, and no wound vac alarm was sounding. RN-A stated

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F 686	Continued From page 31 R244's pressure ulcer was a large open area on left buttocks, with some yellow drainage on the bottom of the open wound. She stated it had a beefy red center, and was white around the open wound. RN-A also indicated R244's wounds would be measured when they were cleansed prior to dressings being applied. At that time, R244 verified the wound vac was not on, and stated it was still in the bag since he'd returned to the facility "last evening". RN-A stated she had not been aware the wound vac was not in place, nor that it had fallen out the prior evening. RN-A could not confirm other dates the wound vac had not been utilized while the resident had been at the facility. She indicated she thought the wound vac would alarm if it was not on properly. On 1/11/18, at 1:43 p.m. the director of nursing (DON) stated she was unaware R244's wound vac had not been on, until it had been reported to her 5 minutes prior. The DON stated, "it is absolutely unacceptable" for the wound vac and dressings not tp be in place for R244. The DON then explained her expectation that nursing staff check the wound vac placement and dressing at least every shift. The DON confirmed R244's record lacked documentation of any attempt to replace his dressing or wound vac when he'd returned to the facility the previous evening, and also confirmed there was no documentation to indicate whether the wound vac had been checked during the night shift. The DON then stated, "most" of the nurses had been trained on the wound vac, but confirmed LPN-A had not received training on the use of the wound vac yet. The DON stated LPN-A should have reported to the RN that R244 did not have the wound vac or dressings in place.	F 686		

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F 686	Continued From page 32 On 1/11/18, at 2:26 p.m. LPN-B entered R244's room with LPN-A to reapply R244's dressings and wound vac. R244 was lying on his stomach and had red sweat pants on, which were visibly saturated on the back from the elastic band to mid thighs from apparent wound drainage. The absorbent cloth pad under R244 was also observed to be saturated with pink drainage. LPN-A removed R244's pants while LPN-B began cleaning the wounds by dabbing them with a 4x4 gauze and wound cleanser. R244's sweat pants were observed to be stuck to a wound on his left thigh. LPN-A was observed to apply spray wound cleanser to R244's sweat pants to loosen them so the pants could be removed. At the same time, LPN-B measured R244's multiple pressure ulcers: the left buttock stage 4 pressure ulcer, which required the wound vac treatment, measured 5 centimeters (cm) wide (W) X 7 cm long (L) and 3.5 cm in depth, a right thigh stage 3 pressure ulcer measured 9 cm L, X 11.6 W and had reddish, brown drainage from the pressure ulcer, left upper thigh stage 3 pressure ulcer measured 10 cm W X 1.8 cm L, lower stage 3 pressure ulcer area on left thigh measured 12.8 cm W X 4.8 cm L, left lower buttock stage 3 pressure ulcer measured 11 cm W X 10 cm L. Review of R244's progress notes from 1/2 to 1/11/18, identified the following: -1/2/18, R244 had been admitted to the facility with 3 significant wounds; one on each thigh and one on left buttock crease with wound vac. -1/3/18, R244's wound vac was in place. R244 refused his wounds to be measured, due to being measured at the hospital the day before. A call was placed to the wound care nurse at Glacier	F 686		

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Ridge clinic/hospital for wound vac instructions.

-1/3/18, R244's wound vac was in place and was functioning.

-1/4/18, R244's wound vac alarm sounded for a leaking seal, and staff applied another seal over the top, the wound vac worked properly. At 2:21 p.m. note revealed R244 was seen by his primary physician for a routine visit, wound dressing was observed, and R244's physician had ordered a wound care consult ASAP (as soon as possible). 5:35 p.m. R24's wound vac fell off while he turned in bed. R244's wound vac came loose 3 times and was re-secured each time without difficulty. At 10:12 p.m. the note revealed R244's wound vac was working correctly.

-1/5/18, R244's wound vac continued to be on and was to be changed that afternoon.

-1/6/18, R244 had removed his wound vac after it was caught in his pants. The note did not indicate if the wound vac had been replaced at that time.

-1/7/18, R244 shut off his wound vac twice and then refused staff to check it or change the dressings until he received his pain medication at 2 p.m.

-1/8/18, wound nurse from the clinic called to check on R244 and confirmed R244 was scheduled to have the dressings changed on 1/10/18 at the clinic and she instructed staff to send his dressing supplies with to the appointment. The note indicated the dressing was intact at that time.

-1/10/18, R244's wound vac was making

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suctioning sounds and the alarm was not sounding. The note indicated R244 informed surveyor and mother wound vac not in place for days and no one had changed it. Writer informed R244 she had changed his dressing and R244 then confirmed writer had changed his wound vac dressings. R244 was assisted to get ready for his appointment and into the vehicle. R244's wound vac supplies were sent with his mother. At 11:35 p.m. the note indicated the wound vac was changed at his appointment, but had came undone. Appointments were scheduled for 1/19/18, with wound care nurse and 1/26/18 with physician and wound care nurse. The note did not indicate if the wound vac or dressing had been reapplied at that time.

Review of R244's treatment administration record (TAR) for January 2018, included;

-change dressing 3x week, may change PRN (as needed) vac continuous at 125 mmHg, one time a day every Mon, Wed, Fri, for dressing change wound vac, clean all wounds with Hibiclens (skin cleanser). Apply Aquacel (wound dressing) to left distal back of thigh wound. TAR revealed treatment completed on 1/8/18, and 1/10/18, however, lacked documentation the dressing change had been completed on 1/5/18.

-check wound vac for pressure setting and proper function. Check dressing site every shift for unspecified open wound of left buttock. TAR lacked documentation the wound vac and dressing site had been checked on the night shift, 1/10/18.

-change dressing 3x week, may change PRN if needed, vac continuous at 125 mmHg (measure

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F 686	Continued From page 35 of pressure) as needed for wound vac dressing change. Change PRN if needed. TAR revealed PRN dressing change completed on 1/6/18 only. Review of R244's clinical record revealed the following; -R244's hospital transfer form, dated 1/2/18 identified R244 had an infected ischial ulcer and was incontinent of urine. R244 had a wound vac to left buttocks and needed a consult for evaluation of placement of a suprapubic cystostomy (surgical opening to bladder) until R244's deep ischial ulcer was healed. -1/3/18, admission orders included; follow up with primary physician 1/10/18 at 1:30 p.m. Change wound vac dressing 3x week, M, W, F, may change PRN if loose, if needed. Vac continues at 125 mmHg. Clean all wounds with hibiclens. Apply skin prep to peri wound skin. Apply calmoseptine to peri wound skin. Apply Aquacel to L groin, right back of thigh and Left distal back of thigh wound. Change every day. Diagnoses; bilateral stage 2 and 3 pressure injuries back of thighs. -1/4/18, a routine physician's rounds progress note dated 1/4/18, indicated R244 had a diagnosis of decubitus ulcer of left ischium, stage 4. The physician had also ordered, "wound care consult ASAP (as soon as possible)." -1/5/18; faxed order to schedule general surgery consult and wound care follow up appointments...next 1-2 weeks. Diagnosis stage 4 decubitus ulcer. On 1/11/18, at 3:05 p.m. during phone interview	F 686		

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with physician (MD)-A, MD-A confirmed she had seen R244 on 1/4/18 at the facility. MD-A stated she'd recommended R244 be followed for wound care at the clinic. MD-A als stated if R244's wound vac came loose she would expect it be replaced within a reasonable amount of time, such as 3-4 hours. MD-A stated the wound was in a difficult location and the goal was to have the wound vac on at all times and if it was not on, she would expect the nursing staff to at least attempt to replace it. She indicated if staff were not able to replace the wound vac dressings as ordered, she would prefer they call her, rather than attempting a different type of dressing. MD-A confirmed R244 had potential for more skin breakdown, and reitereated the goal was to keep the pressure ulcers dry, and further stated R244's infected stage 4 pressure ulcer was chronic.

On 1/11/18, at 4:42 p.m. during a telephone interview with R244's primary physician MD-B, the physician confirmed R244 had been seen at the clinic for wound care yesterday (1/10/18). MD-B stated he felt the facility staff needed education on the use of the wound vac and confirmed the clinic's wound nurse was making arrangements for someone to go to the facility to provide the education. MD-B further stated if the wound vac came off, the nurse should have replaced it if she had the skills and confidence to do so. If not, he would expect the nurse to apply a dressing over the wound until another nurse could re-apply the wound vac dressings, or have R244 seen at the clinic to have the dressings and wound vac re-applied. MD-B confirmed when the pressure ulcers were not covered with dressings, there was potential for further skin breakdown or infection and that R244's pressure ulcer should be kept dry. He stated he would expect the

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F 686	Continued From page 37 nursing staff to contact him if they were having issues with the dressings or with the wound vac being kept in place. The facility's undated policy Negative Pressure Wound Therapy, identified the purpose of the procedure was to provide guidelines for establishing and maintaining the negative pressure wound therapy. The policy included instructions and supplies to use. It instructed staff to report if any problems with the procedure.	F 686		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		2/12/18

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F 756	Continued From page 38 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's consultant pharmacist failed to identify the need for identified parameters for use of dual analgesics for 1 of 5 residents (R20) reviewed for unnecessary medications. Findings include: R20's admission Minimum Data Set (MDS) dated 11/3/17, revealed R20 had moderate cognitive impairment and diagnoses which included Parkinson's disease, heart failure, arthritis and secondary pulmonary hypertension. The MDS also indicated R20 required extensive assistance from facility staff for activities of daily living (ADL's), and received as needed (prn) pain medications. The MDS revealed R20 had occasional mild pain that did not limit his day-to-day activities, or did not make it hard to sleep at night. R20's Care Area Assessment (CAA) dated 11/7/17, revealed R20 had moderate cognitive impairment, intermittent confusion and chronic	F 756	It is the policy of Meadow Lane Rehabilitation and Healthcare Center that the facilities consult pharmacist identifies the need for identified parameters for use of dual analgesics for 1 of 5 residents reviewed for unnecessary medications. The Clinical Pharmacists monthly consult for R20 was January 8th and onsite January 12, where recommendation was at that time to use T3 and plain Tylenol with relevant clinical decision, and to have provider clarify the to use which medication. Provider clarified parameters for medication on 1-28-18. All residents of the facility have the potential to be affected by this practice. DON/Clinical Manager reviewed all residents for identified parameters for use of dual analgesics. Education provided by DON/Clinical Manager on 1-18-18 to all licensed nurses in regards to dual analgesics.	

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F 756	Continued From page 39 low back pain. The CAA further revealed R20 did not always verbalize his needs. R20's care plan revised 1/10/18, revealed R20 had chronic pain related to complaints of leg and back pain and listed various interventions which included directing staff to administer analgesia (pain medication) as per orders. Review of R20's physician orders signed 1/4/18, revealed the following orders for pain: - acetaminophen tablet give 650 milligrams (mg) by mouth every 8 hours as needed for pain. Give one tab for pain rated 1-5 and two tabs for pain rated 6-10. -acetaminophen-codeine tablet 300-30 mg give 1 tablet by mouth every 12 hours as needed for pain. - Biofreeze Gel 4% apply to affected areas topically every 6 hours as needed for pain control related to pain in left shoulder. - gabapentin 600 mg by mouth two times a day for neuropathy (nerve pain), check pain levels every 8 hours offer as needed Tylenol and offer prn pain medication every a.m. and p.m. if non-verbal signs of pain was indicated for pain-mild. R20's physician orders lacked guidance for what level of pain was indicated to use the acetaminophen-codeine prn for pain. Review of R20's medication administration records (MAR) from October 2017, to January 2018, revealed the following: -October 2017, R20 received acetaminophen-codeine three times for a pain level of 4 on a numeric pain scale (0 being no	F 756	Random audits will be conducted by Clinical Manager/Designee and forwarded to the Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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F 756	Continued From page 40 pain and 10 being the worst pain imaginable.) The MAR further revealed R20 had not received any prn acetaminophen analgesic. The MAR revealed all 3 doses were effective in relieving R20's pain. -November 2017, R20 had received acetaminophen-codeine 15 times for pain levels that ranged from 2-4, and R20 had received acetaminophen 7 times for pain levels ranging from 1-4. The MAR revealed all but one dose of acetaminophen only were effective in relieving R20's pain, and all but two doses of acetaminophen-codeine were effective in relieving R20's pain. -December 2017, R20 had received acetaminophen-codeine 21 times for pain levels that ranged from 2-5, and R20 had received acetaminophen 2 times for pain levels of 2 and 4. The MAR revealed all but one dose of acetaminophen-codeine were effective in relieving R20's pain, and one acetaminophen only dose was marked as unknown in the effectiveness in reliving R20's pain. -January 2018, R20 had received acetaminophen-codeine 7 times for pain levels that ranged from 1-4, and R20 received acetaminophen 1 time for a pain level of a 5. The MAR revealed all doses of acetaminophen-codeine and acetaminophen only were effective in relieving R20's pain. Review of R20's monthly Consultant Pharmacy Medication Review forms from 11/10/17, to 12/8/17, revealed no recommendation for parameters of indication of use for acetaminophen-codeine.	F 756		

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F 756	Continued From page 41 On 1/11/18, at 1:30 p.m. director of nursing (DON) stated she would have expected R20's acetaminophen-codeine prn order to contain parameters for use. DON stated staff should be using the least effective dose for prn analgesics. DON stated she would have expected the pharmacy consultant to have identified R20's prn analgesic order was missing parameters and submitted an irregularities report. On 1/11/18, at 1:46 p.m. during a telephone interview pharmacy consultant (PC) stated she was unable to complete an interview at that time and would call back once available. At 3:03 p.m. PC returned telephone call and stated she would have expected parameters for R20's prn acetaminophen-codeine order due to multiple prn analgesics ordered. PC confirmed that this was an irregularity and something she should have identified and included on an irregularity report for R20. A facility policy titled Pharmacy Services, revised 1/30/17, indicated a licensed pharmacist will review the drug regimen of each resident at least once per month and report any irregularities to the attending physician, the director of nursing and the medical director.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		2/12/18

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F 757	Continued From page 42 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify parameters for the us of as needed (PRN) pain medication for 1 of 5 residents (R20) reviewed for unnecessary medications. Findings include: R20's admission Minimum Data Set (MDS) dated 11/3/17, revealed R20 had moderate cognitive impairment and diagnoses which included Parkinson's disease, heart failure, arthritis and secondary pulmonary hypertension. The MDS also indicated R20 required extensive assistance from facility staff for activities of daily living (ADL's), and received as needed (prn) pain medications. The MDS revealed R20 had occasional mild pain that did not limit his day-to-day activities, or made it hard to sleep at night.	F 757	It is the policy of Meadow Lane Rehabilitation and Healthcare Center to identify the need for identified parameters for use of analgesics reviewed for unnecessary medications. Clinical Pharmacists monthly consult for R20 was January 8th and onsite January 12, where recommendation was at that time to use T3 and plain Tylenol with relevant clinical decision, and to have provider clarify the to use which medication. Primary Physician clarified parameters for medication on 1-28-18. The DON/Clinical Manager reviewed all residents to identify the need for identifying parameters for the use of analgesics reviewed for unnecessary medications. Education provided by DON/Clinical	

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F 757	Continued From page 43 R20's Care Area Assessment (CAA) dated 11/7/17, revealed R20 had moderate cognitive impairment, intermittent confusion and chronic low back pain. The CAA further revealed R20 did not always verbalize his needs. R20's care plan revised 1/10/18, revealed R20 had chronic pain related to complaints of leg and back pain and listed various interventions which included, staff were to administer analgesia (pain medication) as per orders. Review of R20's physician orders signed 1/4/18, revealed the following orders for pain: - acetaminophen tablet give 650 milligrams (mg) by mouth every 8 hours as needed for pain. Give one tab for pain rated 1-5 and two tabs for pain rated 6-10. - acetaminophen-codeine tablet 300-30 mg give 1 tablet by mouth every 12 hours as needed for pain - BioFreeze Gel 4% apply to affected areas topically every 6 hours as needed for pain control related to pain in left shoulder. - gabapentin 600 mg by mouth two times a day for neuropathy (nerve pain), check pain levels every 8 hours offer as needed Tylenol and offer prn pain medication every a.m. and p.m. if non-verbal signs of pain were indicated for pain-mild. R20's physician orders lacked guidance for what level of pain was indicated to use the acetaminophen-codeine prn for pain. Review of R20's medication administration records (MAR) from October 2017, to January 2018, revealed the following:	F 757	Manager on 1-18-18 to all licensed nurses in regards to parameters for analgesics reviewed for unnecessary medications. Random audits will be conducted by Clinical Manager/Designee and forwarded to the Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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F 757	Continued From page 44 -October 2017, R20 received acetaminophen-codeine three times for a pain level of 4 on a numeric pain scale (0 being no pain and 10 being the worst pain imaginable.) The MAR further revealed R20 had not received any prn acetaminophen. The MAR revealed all 3 doses were effective in relieving R20's pain. -November 2017, R20 had received acetaminophen-codeine 15 times for pain levels that ranged from 2-4, and R20 had received acetaminophen 7 times for pain levels ranging from 1-4. The MAR revealed all but one dose of acetaminophen were effective in relieving R20's pain, and all but two doses of acetaminophen-codeine were effective in relieving R20's pain. -December 2017, R20 had received acetaminophen-codeine 21 times for pain levels that ranged from 2-5, and R20 had received acetaminophen 2 times for pain levels of 2 and 4. The MAR revealed all but one dose of acetaminophen-codeine were effective in relieving R20's pain, and one acetaminophen only dose was marked as unknown in the effectiveness in reliving R20's pain. -January 2018, R20 had received acetaminophen-codeine 7 times for pain levels that ranged from 1-4, and R20 received acetaminophen 1 time for a pain level of a 5. The MAR revealed all doses of acetaminophen-codeine and acetaminophen only were effective in relieving R20's pain. Review of R20's Consultant Pharmacy Medication Review forms from 11/10/17, to 12/8/17, revealed no recommendation for	F 757		

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F 757	Continued From page 45 parameters of indication of use for acetaminophen-codeine. On 1/11/18, at 9:18 a.m. licensed practical nurse (LPN)-D confirmed R20 had physician orders for both prn acetaminophen and prn acetaminophen-codeine. LPN-D confirmed the prn acetaminophen order had parameters of when to use, but the prn acetaminophen-codeine order lacked parameters of what pain levels R20 would have to utilize this order. LPN-D indicated she felt R20's pain monitoring was "tricky", but felt R20 would usually verbalize pain. LPN-D stated when R20 could not verbalize pain levels, she would input non-verbal indicators of pain into R20's progress notes and administer the acetaminophen-codeine order if it had been more than 12 hours since the last prn dose, and if it had been less than 12 hours since the last prn acetaminophen-codeine dose she would administer the prn acetaminophen order. On 1/11/18, at 11:46 a.m. LPN-A confirmed R20's physician orders included an order for prn acetaminophen-codeine and prn acetaminophen. LPN-A confirmed R20 received both prn analgesics for pain. LPN-A stated if R20's pain was above a 5 she would utilize the prn acetaminophen-codeine order and if under 5 she would use the prn acetaminophen order. LPN-A confirmed that the prn orders did not clarify what pain level would indicate when to use the acetaminophen-codeine order. On 1/11/18, at 1:30 p.m. director of nursing (DON) stated she would have expected R20's acetaminophen-codeine prn order to contain parameters for use. DON stated staff should be using the least effective dose for prn analgesics.	F 757		

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F 757	Continued From page 46 DON stated she would have expected the pharmacy consultant to have identified R20's prn analgesic order was missing parameters and submitted an irregularities report. On 1/11/18, at 1:46 p.m. during a telephone interview pharmacy consultant (PC) stated she was unable to complete an interview at that time and would call back once available. At 3:03 p.m. PC returned telephone call and stated she would have expected parameters for R20's prn acetaminophen-codeine order due to multiple prn analgesics ordered. PC confirmed that this was an irregularity and something she should have identified and included on an irregularity report.	F 757		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		2/12/18

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F 880	Continued From page 47 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 48 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the common use blood glucometer machine was disinfected after resident use for 1 of 3 residents (R36) who received blood sugar testing on the board and care unit of the facility. This had the potential to affect all 3 residents (R3, R9, R36) on the board and care unit who received routine blood glucose testing. In addition, the facility failed to ensure appropriate hand hygiene was completed between residents to prevent the spread of infection for 2 of 2 residents (R27, 124) who were observed to receive blood glucose testing. Findings include: On 1/9/18, at 4:54 p.m. TMA-C donned gloves, gathered supplies to perform a blood glucometer check for R 36. TMA-C cleansed R36 finger with an alcohol wipe, let it air dry, used a lancet, placed the glucometer strip near the blood on R36's finger and inserted the strip into a blue colored glucometer. TMA-C returned to the nursing cart near the nurse's desk, placed the lancet and glucometer strip into the sharps container, placed trash into the waste bin on the side of the nurse's cart and then wrapped the glucometer with a wet wipe removed from a plastic, white container labeled PDI Sani-Hands (alcohol based hand sanitizer). TMA-C placed the wrapped glucometer on the top surface of the medication cart.	F 880	It is the policy of Meadow Lane Rehabilitation and Healthcare Center to ensure that the common use blood glucometer machine was disinfected after each resident use and to ensure that appropriate hand hygiene was completed between residents to prevent the spread of infection for residents who received blood glucose testing. Corrective action was taken by assigning glucometers to each resident needing blood sugar monitoring. No glucometer's will be designated for multiple resident use. Nursing staff re-educated on Handwashing/Hand Hygiene and Blood Sampling policies. All residents who reside at the facility have the potential to be affected by not properly washing hands and by contamination of sharing glucometers. All licensed staff were trained on 1-18-18 of proper infection control practices. Employees and contracted services employed at facility are being tested out on handwashing and will be completed by 2-12-18. Upon hire and annually each employee and contracted service employee are required to attend training on handwashing and infection control.	

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F 880	Continued From page 49 On 1/9/18, at 4:58 p.m. TMA-C stated her usual practice of cleansing her hands and the glucometer was to use the PDI hand sanitizer. TMA-C indicated the glucometer was cleaned with the PDI hand sanitizer wipe and the wipe was then wrapped around the Prism brand glucometer and left wrapped for three minutes before using it again. TMA-C verified the glucometer was now clean and would be used for blood sugar checks for two other residents this evening. On 1/9/18, at 5:48 p.m. TMA-C cleaned the top surface and sides of the medication cart and the counter top of the nurse's desk with a Clorox bleach solution wipe. TMA-C verified the bleach solution wipe was used only for surfaces like counter tops and not used for the glucometer. On 1/9/18, at 6:00 p.m. the director of nursing (DON) verified the PDI hand sanitizer wipe was not adequate to disinfect glucometers. The DON indicated the PDI hand sanitizer wipes were only used to clean residents hands before and after meals and were usually only available in the dining room. On 1/9/18, at 7:28 p.m. the DON indicated the facility glucometers had been disinfected with the appropriate bleach wipes and staff were educated on proper infection control measures regarding the glucometers and bleach disinfectant wipes.	F 880	Random audits will be conducted by Clinical Manager/Designee and forwarded to the Administrator. Results will be forwarded to QAPI for review and recommendation. DON is responsible to monitor.	

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MEADOW LANE REHABILITATION & HEALTHCARE CTR	**2209 UTAH AVENUE BENSON, MN 56215**

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F 880	Continued From page 50 On 1/8/18 at 11:52 a.m. during observation of medication administration pass, trained medication aid (TMA)-D was gathering her supplies to perform blood glucose testing (to measure blood sugar). TMA-D had a red square tray which had a sharps container on it, a clear plastic medication cup with cottons balls in it, a clear plastic medication cup with lancets (needles) in it, several packages of alcohol wipes, container of blood glucose test strips, blue colored glucose machine and several bleach wipes laying on the tray. TMA-D proceeded to walk down the west hallway with the red tray, entered R27's room, set tray on counter. R27 was seated in her wheelchair, TMA-D proceeded to don gloves on both hands, put blood glucose stick in glucose machine, obtained alcohol wipe, cleaned R27's right ring finger with alcohol, poked R27's finger with lancet, drew blood to put on glucose stick, then wiped R27's finger with alcohol. The TMA-D read glucose of 181 and proceeded to throw lancet and glucose strip in the sharps container, removed right glove from her hand, threw it in the garbage. She immediately walked out of R27's room holding red tray with her right hand and the glucose machine in her left gloved hand down the entire west wing back to her medication cart. TMA-D proceeded to set the tray and glucose machine on her medication cart, removed the glove from her left hand and threw it in the garbage. At 11:55 a.m., TMA-D picked up a Clorox wipe (bleach solution) and wiped down the surface of the glucose machine and then wrapped the machine with the bleach wipe and laid it on the red tray. At 11:58 a.m. without washing or sanitizing her hands, TMA-D picked up the red tray on the medication cart and proceeded to walk down the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE REHABILITATION & HEALTHCARE CTR	**2209 UTAH AVENUE BENSON, MN 56215**

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F 880	Continued From page 51 west hallway to R124's room, entered the room, reached for a paper towel, set the paper towel on R124's bed side table, then placed the red tray on R124's bedside table. TMA-D donned gloves on both hands, took bleach wipe off glucose machine, threw it in the garbage and proceeded to obtain a blood sample from R124's finger and tested R124's blood glucose reading. After TMA-D disinfected the machine, discarded the supplies, she removed her gloves and washed her hands in the sink, and walked back to the medication cart. On 1/8/18 at 2:33 p.m. TMA-D confirmed she had not washed or sanitized her hands before and after gloving and in- between while performing blood glucose testing for R27 and R124. TMA-D indicated she should of washed her hands and usually carried sanitizer in her pocket but "forgot it." On 1/11/18 at 2:18 p.m. director of nursing (DON) indicated she would expect staff to wash hands before and after gloving while performing blood glucose testing and she would expect staff to follow the facility policy. The Prism glucometer product information sheet revised 8/2015, revealed the following: Cleaning and Disinfection. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-born pathogens. The recommended brand name disinfectants were, Clorox Germicidal wipes, Dispatch Hospital cleaner disinfectant towels with bleach, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 01/11/2018

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MEADOW LANE REHABILITATION & HEALTHCARE CTR	**2209 UTAH AVENUE BENSON, MN 56215**

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F 880	Continued From page 52 CaviWipes1. The undated PDI hand sanitizing wipes product information identified the following: Active ingredient: Alcohol 65.9% Uses: antiseptic; For hand washing to decrease bacteria on the skin. The wipe was not a disinfectant as recommended by the manufacturers instructions. Review of the undated facilty policy titled, Blood Sampling- Capillary (finger stick), indicated procedure that staff should wash hands, don gloves before and remove gloves/wash hands after performing blood sampling and to use an approved EPA registered disinfectant for cleaning of sampling device. Further, the policy directed to follow the manufacturer's instruction, clean and disinfect reusable equipment, parts, and or devices after each use. Review of the undated facility policy titled, Handwashing/Hand Hygiene, indicated under number seven for staff to use an alcohol based hand rub containing at least 62% alcohol or alternatively soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents, before preparing or handling medications, after contact with a residents intact skin, after contact with blood or bodily fluids, after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident, and after removing gloves.	F 880		

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

F5313026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/09/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE REHABILITATION & HEALTH(	**2209 UTAH AVENUE** **BENSON, MN 56215**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 09, 2018. At the time of this survey, Meadow Lane Rehabilitation Center was found to be 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Meadow Lane Rehabilitation Center is a 1 story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1958, it is an NF2 facility and was determined to be of Type V(000) construction. In 1970, the SNF/NF facility was built that was determined to be of Type II(222) construction. In 1976 an addition was added to connect the SNF/NF building to the NF2 building which was determined to be of Type II(000) construction. Because the original building and the 2 additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a licensed capacity of 62 and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	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.