DEPARTMENT OF HEAL	FH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SEI	RVICES
	MEDIC	ARE/MEDICAL	D CERTIFICAT	ION A	ND TRANSMITTAL	ID: 57XW	
	PART I -	TO BE COMPI	LETED BY THE	STAT	TE SURVEY AGENCY	Facility ID:	00390
1. MEDICARE/MEDICAID PROVI NO.(L 1) 245367	DER	3. NAME AND AI (L3) MEADOW	DDRESS OF FACILIT MANOR	Y		4. TYPE OF ACTION: <u>7</u> (La 1. Initial 2. Rece	8) rtification
2. STATE VENDOR OR MEDICAI (L 2) 346314100	D NO.	(L4) 210 EAST G (L5) GRAND ME	RAND AVENUE, I CADOW, MN	PO BO	OX 365 (L6) 55936	3. Termination4. CHO5. Validation6. Com)W plaint
5. EFFECTIVE DATE CHANGE OF (L9)	FOWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Othe 8. Full Survey After Complaint	r
 6. DATE OF SURVEY 04/ 8. ACCREDITATION STATUS: 	26/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 10 1 07 X-Ray 11 1	NF ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE:	(L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP 12	RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATIO	ON	10.THE FACILITY	IS CERTIFIED AS:				
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requirements:	
To (b):		0	equirements		2. Technical Personnel	6. Scope of Services Limi	t
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director	
10 T-4-1 E	43 (119)	1. A	cceptable POC		4. 7-Day RN (Rural SN	IF) 8. Patient Room Size	
12. Total Facility Beds	43 (L18)		I I HID		5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	43 (L17)	-	olianceIwithIProgram and/or Applied Waive	ers.	* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN	requirements	und/or rippiled warve		15. FACILITY MEETS	(112)	
18 SNF 18/19 SNF		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
43	19 511	icr	IID		1801 (c) (1) 01 1801 (j) (1).	(110)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY RE	MADES (IE ADDI ICA	DIE SHOW ITC CA		2).			
10. STATE SURVET AGENCT KEI	WARKS (IF AFF LICF	ABLE SHOW LIC CA	INCELLATION DATE	<i></i>).			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Marietta Lee, HFE NE	11)5/02/2016 ^{(I}	L19)	Kamala Fiske-Downing	, Enforcement Specialist	05/02/2016 (L20)
PA	ART II - TO BE			ONAL	OFFICE OR SINGLE S	TATE AGENCY	(*)
19. DETERMINATION OF ELIGIB	ILITY		IPLIANCE WITH CIV	/IL		ncial Solvency (HCFA-2572)	
 Facility is Eligible to 	Participate	RIGI	HTS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-151)	3)
2. Facility is not Eligib	-				5. Both of the Hoove	· · · · · · · · · · · · · · · · · · ·	
g.	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEMENT	Г	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION 12/01/1986	BEGINNING	5 DATE	ENDING DATE		VOLUNTARY 00 01-Merger, Closure 0	<u>INVOLUNTARY</u> 05-Fail to Meet Health	/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		nent
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Ch	ange
(L27)			(L44)			00-Active	
(L27)	B. Rescind St	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29). INTERMEDIARY	CARRIER NO.		30. REMARKS		
	/ - >	03001					
	(L28)		(L	_31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAL DAT	Έ			
	(L32)		(L	_33)	DETERMINATION APPI	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245367

May 2, 2016

Mr. Thomas Stevens, Administrator Meadow Manor 210 East Grand Avenue, Po Box 365 Grand Meadow, MN 55936

Dear Mr. Stevens:

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 March 21, 2016 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 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,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 2, 2016

Mr. Thomas Stevens, Administrator Meadow Manor 210 East Grand Avenue, PO Box 365 Grand Meadow, MN 55936

RE: Project Number S5367026

Dear Mr. Stevens:

On March 11, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 25, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 28, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 25, 2016, effective March 21, 2016 and therefore remedies outlined in our letter to you dated March 11, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		0	DATE OF REVIS	SIT
	B. Wing	Y2	2	4/26/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW MANOR		210 EAST GRAND AVENUE, PO BOX 365			
		GRAND MEADOW, MN 55936			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4		DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
		15	14			15	14			15
ID Prefix	F0167	Correction	ID Prefix	F0278	3	Correction	ID Prefix	F0280		Correction
Reg. #	483.10(g)(1)	Completed	Reg. #	483.20	0(g) - (j)	Completed	Reg. #	483.20(d)(3), 483 (2)	.10(k)	Completed
LSC		03/21/2016	LSC			03/21/2016	LSC			03/21/2016
ID Prefix	F0282	Correction	ID Prefix	F0309)	Correction	ID Prefix	F0315		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	5	Completed	Reg. #	483.25(d)		Completed
LSC		03/21/2016	LSC			03/21/2016	LSC			03/21/2016
ID Prefix	F0329	Correction	ID Prefix	F0356	6	Correction	ID Prefix	F0431		Correction
Reg. #	483.25(l)	Completed	Reg. #	483.30)(e)	Completed	Reg. #	483.60(b), (d), (e)		Completed
LSC		03/21/2016	LSC			03/21/2016	LSC			03/21/2016
ID Prefix	F0465	Correction	ID Prefix	F0520)	Correction	ID Prefix			Correction
Reg. #	483.70(h)	Completed	Reg. #	483.75	ō(o)(1)	Completed	Reg. #			Completed
LSC		03/21/2016	LSC			03/21/2016	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS)	DATE		SIGNATURE O	F SURVEYOR	1		DATE	
		GPN/kfd	05/02/20)16		312	21			/2016
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 2/25/2016						ECTED DEFICIEN CIES (CMS-2567)		A SUMMARY OF HE FACILITY?	I YE	s 🗌 no

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DA	ATE OF REVISI	T
	B. Wing	Y2	<u>,</u> 3/2	28/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW MANOR		210 EAST GRAND AVENUE, PO BOX 365			
		GRAND MEADOW, MN 55936			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEI		DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	101 Completed	Reg. #	Completed
LSC	K0018	03/21/2016	LSC K0025	03/21/2016	LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
REVIEWE		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
		(INITIALS) TL/kfd	05/02/2016		37008	3/28/2016
REVIEWE CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/23/2016			CHECK FOR UNCORREC	R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)	NCIES. WAS A SENT TO THE	SUMMARY OF FACILITY? YES NO



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

MaY 2, 2016

Mr. Thomas Stevens, Administrator Meadow Manor 210 East Grand Avenue, PO Box 365 Grand Meadow, MN 55936

Re: Reinspection Results - Project Number S5367026

Dear Mr. Stevens:

On April 26, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 26, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
00390 _{Y1}	B. Wing	,	Y2	4/26/2016	Y3
	•			<u> </u>	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW MANOR		210 EAST GRAND AVENUE, PO BOX 365			
		GRAND MEADOW, MN 55936			

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE		DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20302	Correction	ID Prefix	20565	Correction	ID Prefix	20570	Correction
Reg. #	MN State Statut 144.6503	e Completed		MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.0405 Subp. 4	Completed
LSC		03/21/2016	LSC		03/21/2016	LSC		03/21/2016
ID Prefix	20830	Correction	ID Prefix	20910	Correction	ID Prefix	21426	Correction
Reg. #	MN Rule 4658.0 Subp. 1	520 Completed		MN Rule 4658.0525 Subp. 5 A.B	Completed	Reg. #	MN St. Statute 144A Subd. 3	.04 Completed
LSC		03/21/2016	LSC		03/21/2016	LSC		03/21/2016
ID Prefix	21535	Correction	ID Prefix	21685	Correction	ID Prefix		Correction
Reg. #	MN Rule4658.13 Subp.1 ABCD	Completed		MN Rule 4658.1415 Subp. 2	Completed	Reg. #		Completed
LSC		03/21/2016	LSC		03/21/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEW		REVIEWED BY (INITIALS) GPN/kfd	DATE 5/2/2016	SIGNATURE OF	SURVEYOR 31221		DA	ATE 4/26/2016
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DA	TE
FOLLOWUP TO SURVEY COMPLETED ON 2/25/2016				CK FOR ANY UNCORREC ORRECTED DEFICIENCI				YES 🗌 NO

DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDI	CAID SERVICES
	MEDICA	ARE/MEDICAL	D CERTIFICA	ATION A	AND TRANSMITTAL		ID: 57XW
	PART I -	TO BE COMPI	LETED BY TH	HE STAT	TE SURVEY AGENCY	1	Facility ID: 00390
1. MEDICARE/MEDICAID PROV NO.(L 1) 245367	IDER	3. NAME AND AI (L3) MEADOW		LITY		4. TYPE OF ACTION 1. Initial	DN: <u>2</u> (L8) 2. Recertification
2. STATE VENDOR OR MEDICA (L 2) 346314100	ID NO.	(L4) 210 EAST G (L5) GRAND ME		E, PO BC	OX 365 (L6) 55936	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE C (L9)	DF OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Afte	9. Other er Complaint
 6. DATE OF SURVEY 02 8. ACCREDITATION STATUS: 	2/25/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR END	ING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Othe		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICAT	ION	10.THE FACILITY	IS CERTIFIED A	.S:			
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requiren	ients:
To (b) :		0	equirements		2. Technical Personnel	6. Scope of S	ervices Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical D	irector
10 T-4-1 F:!!:+- D	43 (1.19)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Roo	om Size
12. Total Facility Beds	43 (L18)	V			5. Life Safety Code	9. Beds/Room	1
13.Total Certified Beds	43 (L17)		npliance with Progra and/or Applied Wa		* Code: B	(L12)	
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY MEETS		
18 SNF 18/19 SN 43	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE		Date :)3/23/2016		18. STATE SURVEY AGENCY Kamala Fiske-Downing		Date:
		COMPLETED I	BY HCFA REG	(L19) GIONAL	OFFICE OR SINGLE S		(L20)
19. DETERMINATION OF ELIGI	BILITY		IPLIANCE WITH	CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-25	72)
1. Facility is Eligible t	o Participate	RIGI	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stm	t (HCFA-1513)
2. Facility is not Eligi	-						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEMI	ENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 12/01/1986	BEGINNING	J DATE	ENDING DATI	E	VOLUNTARY 00 01-Merger, Closure		<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		ler Status Change
(L27)	B Rescind St	uspension Date:	(L44)			00-Active	2
	D. Resente St	aspension Date.	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL I	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered March 11, 2016

Mr. Thomas Stevens, Administrator Meadow Manor 210 East Grand Avenue, PO Box 365 Grand Meadow, MN 55936

RE: Project Number S5367026

Dear Mr. Stevens:

On February 25, 2016, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 <u>Email: gary.nederhoff@state.mn.us</u> Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 6, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 6, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the

level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by May 25, 2016 (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 August 25, 2016 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections State Fire Marshal Division Email: <u>tom.linhoff@state.mn.us</u> Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

		AND HUMAN SERVICES & MEDICAID SERVICES		-	M APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) D	O. 0938-0391 ATE SURVEY OMPLETED
		245367	B. WING	o	2/25/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MEADOV	W MANOR			210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	D	
F 167 SS=C	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electronic be used as verificat Upon receipt of an a on-site revisit of you validate that substa regulations has beet your verification. 483.10(g)(1) RIGHT READILY ACCESS A resident has the r the most recent sur Federal or State su correction in effect of The facility must ma examination and m accessible to resid their availability. This REQUIREMEN by: Based on observat review, the facility factors	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with T TO SURVEY RESULTS -	F 16	7 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	3/21/16
	and the public as re had the potential to	equired by this regulation. This affect families, staff, visitors residing at the facility.		as an admission nor an agreement by th facility of the truth of the facts alleged or conclusions set forth in the statement of	
				deficiencies. The plan of correction	
LABORATORY	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically Signed				03/21/2016

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 167 Continued From page 1 F 167 Findings include: prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving During the initial tour on 2/22/16, at 12:05 p.m. the last posted survey results were dated 3/6/14, the foregoing statement, the facility states and posted in a three ring binder in a wall pocket that with respect to: holder near the bathroom in the common area of On 2/22/2016 the current survey the facility. results were placed in a labeled binder that is kept in a readily accessible Since the 3/6/14, survey there was a location. recertification survey exited 4/2/15. This survey would have required a new posting of survey results. The Social Services Director, (SSD) was interviewed on 2/22/16, at 12:17 p.m. and confirmed the most current survey results posted were dated 3/6/14, and posted in a three ring binder in a wall pocket holder near the bathroom in the common area of the facility. In addition, the SSD confirmed the facility had a more recent survey completed April of 2015. F 278 483.20(g) - (j) ASSESSMENT F 278 3/21/16 ACCURACY/COORDINATION/CERTIFIED SS=D The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 278 Continued From page 2 F 278 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review the The preparation of the following plan of facility failed to accurately code a significant correction for this deficiency does not change Minimum Data Set (MDS) for 1 of 1 constitute and should not be interpreted resident (R31) dental status. as an admission nor an agreement by the facility of the truth of the facts alleged on Findinas include: R31 was admitted to the facility on 12/4/15 conclusions set forth in the statement of deficiencies. The plan of correction according to the facility's admission record. During an observation on 2/22/16, at 1:57 p.m. prepared for this deficiency was executed R31 was sitting in a wheelchair in his room solely because it is required by provisions conversing with dental hygienist (DH). DH of State and Federal law. Without waiving reported she had just completed examining R31's the foregoing statement, the facility states mouth and explained R31 had a lesion on the that with respect to: upper front gum line in tooth areas of 10 and 11. R31 a medical review was R31 opened his mouth, the lesion is white in color completed, care plan was updated to and measured approximately 1 centimeter (cm) in reflect oral status and care. Oral dental diameter and had no natural teeth (edentulous). assessment was completed on 3/14/16. DH explained she had just cleaned and removed R31 will be seen by Apple Tree dental very heavy plague build-up from the dentures and on 4/4/2016. stated the dentures are old. DH held the upper MDS nurse was re-educated denture in her hand and showed the large regarding the accuracy of MDS and data missing broken area of the denture around tooth collection 2/29/2016. numbers 2, 3, and 4. All resident care plans reviewed and

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 278 Continued From page 3 F 278 R31's significant change Minimum Data Set revised with as needed including; (MDS) dated 1/27/16 identified R31 had no admission, guarterly and changes in natural teeth, however did not identify the broken condition dentures. The 14 day MDS dated 12/18/15 and All Nursing Staff will be re-educated 30 day MDS dated 1/1/16 both indicated broken on the completion and accuracy of dentures, however did not identify R31 to be oral/dental assessment by 3/23/16. edentulous. Residents will continue to be assessed for their individual dental and During an interview on 2/23/16, at 1:38 p.m. registered nurse (RN)-A MDS coordinator stated oral needs upon admission, guarterly, with knowledge of the broken dentures and was not significant change and as needed. aware if R31 received new dentures between the DNS/designee will audit 2 residents assessment dates of 1/1/16 and 1/25/16. RN-A per week for 4 weeks, then 1 resident per explained a licensed practical nurse (LPN) had week X8 weeks for oral/dental needs by completed the oral assessment, and she observation and medical review. transferred the information into the MDS. RN-A stated the information on the oral assessment was not accurate. During an interview on 2/23/16, at 2:11 p.m. the director of nursing indicated and expected the MDS be accurately completed. F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 3/21/16 PARTICIPATE PLANNING CARE-REVISE CP SS=D The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs. and, to the extent practicable, the participation of the resident, the resident's family or the resident's

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PRINTED: 03/21/2016 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245367			02/25/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/25/2010
	W MANOR		:	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIO
F 280	legal representative and revised by a te each assessment.	age 4 e; and periodically reviewed eam of qualified persons after NT is not met as evidenced	F 280		
	by: Based on interview facility failed to rev to reflect new diag spine fractures, an for 1 of 2 residents Findings include: R45 was admitted a fall from standing left sided rib fractu fractures. In additi left pleural effusion fluid builds around back to the facility hospital discharge R45's care plan dic aftercare instructio fractures and pleur had signs and sym breath, decreased of skin integrity due plan indicated R45 mobility related to the care plan was the fall and fracture R45's hospital disc	w and document review, the ise a comprehensive care plan noses of rib fractures, thoracic d pleural effusions after a fall s (R45) reviewed for accidents. to the hospital on 1/28/16 after g height. R45 sustained acute res and closed thoracic on, R45 was diagnosed with hs (condition in which excess the lung). R45 discharged on 1/30/16 according to the summary dated 1/30/16. d not reference or give ns/interventions for rib ral effusions which may have ptoms of pain, shortness of movement, increased chance e to not moving, etc. The care had acute pain and decreased recent right total hip surgery; dated 7/17/15. However, this sessed for current pain after		F 280 The preparation of the following placorrection for this deficiency does not constitute and should not be interpresed as an admission nor an agreement facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was existed by because it is required by provof State and Federal law. Without with foregoing statement, the facility that with respect to: "R45 Care plan has been revised reflect current interventions. R45 C plan has been revised to reflect current interventions. R45 C plan has been revised to reflect current intervention and store and revised as needed including admission, quarterly and significant change "All nursing staff will receive re-education regarding revising and	reted by the ed on ent of ecuted visions vaiving states ed to Care rrent ne /23/16 2016, r

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T				0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245367	B. WING _			02/2	25/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO\	V MANOR				10 EAST GRAND AVENUE, PO BOX 365 RAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 280	Continued From pa	age 5	F 28	30			
	 slow movements Be careful to an may cause further To help preven breaths every hour walks per day, brack while taking deep be the pain. Take pain med heat can help lesse heating pad turned 15-20 minutes even but don't sleep on i additional suggestion interventions for particular than 101.5, cold sy bloody sputum. Seek immediate breath and/or chess severe nausea, von The hospital discharfollowing after care effusions: Will need to comeasures upon dis (cough and take sleep to the severe) and take sleep to the spirometer (use a rhour while awake) 	t pneumonia take 10 deep while awake, take 6 short ce ribs with hands or pillow oreaths or coughing can lessen ications as instructed, use of en the pain or swelling. Use a on low or hot water bottle for ry hour as long as you need it, t. The summary also included ons for non-pharmacological			for current interventions for 4 week then 1 Care plans for 8 weeks. The will be shared at the next quality assurance meeting by the DNS/des for input and further direction " DNS / Designee responsible.	e data	
	pulmonary hygiene Patient may uti pillow against the c control during pulm	lize a rolled up blanket or hest wall to assist with pain					

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM	03/21/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED		
		245367	B. WING			02/2	25/2016	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MEADO\	W MANOR				10 EAST GRAND AVENUE, PO BOX 365 RAND MEADOW, MN 55936			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 280 F 282 SS=D	upright utilizing a we upright to decrease pulmonary hygiene. • avoiding lifting : avoiding overhead a weeks following dis pain/spasms. During an interview director of nursing (a care plan for rib fr DON indicated care revised to reflect loo indicated the discha hospital summary w they give to everybo are not physician's into the care plan. Facility policy Care 8/2013 included, "A individual and/or co address the followir chronic clinical cond receiving medicatio including pain-actua 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided b accordance with ea care.	nary hygiene. , patient encouraged to sleep edge pillows, or to sleep pain and assist with > [more than] 10 pounds and activities for approximately 6 missal to avoid chest wall on 2/24/16, at 1:49 p.m. the DON) indicated there was not ractures or pleural effusions. e plan should have been cations of pain. The DON arge instructions on the vere general care guidelines bdy upon discharge and they orders and do not have to go Plan Completion last revised Il care plans should include mbined focus problems that ng areas:" all current and ditions which they are ns, treatment, and or care al or potential. RVICES BY QUALIFIED		280	F 282		3/21/16	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245367 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 7 F 282 review, the facility failed to identify, monitor, and The preparation of the following plan of provide services to promote healing of correction for this deficiency does not non-pressure related impaired skin areas constitute and should not be interpreted according to the care plan for 1 of 2 residents as an admission nor an agreement by the (R31) reviewed for non-pressure related skin facility of the truth of the facts alleged on conclusions set forth in the statement of issues. Findings include: deficiencies. The plan of correction prepared for this deficiency was executed R31 was admitted to the facility on 12/4/15 with solely because it is required by provisions diagnoses of diabetes type II, obesity, nicotine dependence, chronic obstructive pulmonary of State and Federal law. Without waiving disorder, hyperlipidemia, stroke resulting in left the foregoing statement, the facility states sided weakness, and history of falling. that with respect to: R31's care plan acknowledged diagnoses of R31 areas of scabbing to left arm are diabetes; the plan directed staff to healed at this time. Monitoring was started observe/document/report to medical practitioner on 2/23/2016. for dry skin and poor wound healing. The care R31 scabbed areas to two toes of the plan further identified R31 had a potential to left foot, monitoring in place on 2/24/16 develop pressure ulcers. The care plan included and will continue to be monitored until direction for staff to, "lotion skin daily, observe healed. skin daily with cares and report changes to the Re-education will be done with all nurse, observe/document/report to medical nursing staff regarding documentation and practitioner PRN [as needed] changes in skin notification in change of skin integrity by 3 status: appearance, color, wound healing, s/sx -23-16 All resident care plans reviewed and [signs/symptoms] of infection, wound size, stage, weekly skin inspections." revised with as needed including: SCABBED AREAS TO LEFT FOREARM admission, guarterly and changes in During an observation on 2/22/16, at 1:41 p.m. condition R31 was sitting in wheelchair in his room with a DNS/ Designee will audit skin short sleeve shirt on. His left arm was noted to be alteration documentation and care for 2 edematous when compared to the right. The left residents per week for 4 weeks then 1 upper dorsal side(hand turned so thumb is resident per week for 8 weeks. The data pointing to the right) of the forearm showed one will be shared at the next Quality large scab that measured 1.0 centimeter (cm) in Assurance meeting by the DNS/ Designee diameter and a smaller scab that measured 0.3 for input and further direction. cm in diameter. Both scabs were dark brown/red DNS is responsible. in color and were raised off the skin approximately 1.0-2.0 millimeters. R31 could not remember how he obtained the injuries. R31's record indicated the initial identification of

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 8 F 282 the impaired skin integrity on the left forearm was on 2/17/16 during a weekly Body Audit. The only information on the body audit included, "left forearm scabbed scratches." The measurement and summary area of the audit did not contain any information. The corresponding nurse progress note included, "in general skin is good condition, noted 2 scabbed scratches on left forearm, no redness, or warmth." Documentation in the record did not reflect when the initial injury occurred or what caused or potentially caused the scratches. However, a Care Conference Summary dated 2/9/16 included, "scabbed areas Lt [left] arm-OTA [open to air]" It was not evident in the record if areas on 2/9/16 were the same areas identified on 2/17/16. The record did not reflect monitoring from 2/9/16 through 2/17/16 or a comprehensive evaluation of the scabs stated on 2/9/16. A body audit completed on 2/10/16 indicated the skin was clear and intact and did not identify the scabs, which conflicts with the information recorded the previous day on the Care Conference Summary dated 2/9/16. R31's treatment administration record (TAR) did not reflect routine impaired skin monitoring. A Daily Skin/Wound Monitoring form was not evident in the record until after the surveyor brought it to the facility's attention there was a lack of monitoring. R31's Daily Skin/Wound monitoring form was initiated on 2/23/16; fourteen days after if the wounds were first identified on 2/9/16 or five days after if the wounds were first identified on 2/17/16. R31's record lacked a comprehensive assessment of the impaired skin, did not reflect monitoring of the impaired skin for healing and signs and symptoms of infection as instructed by the care plan. During an interview on 2/23/16, at 12:39 p.m.

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		AND HUMAN SERVICES			FORM	03/21/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245367	B. WING		02/2	25/2016
NAME OF I	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MEADO\	W MANOR			210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	nursing assistant (N been there for quite how long they have them. During an interview licensed practical n did not reflect moni arm. SCABBED AREAS During an observat nursing assistant (N and shoes. The left scabs on the secon the right foot fourth reddened area. The dressing or protecti time R31's socks al R31 stated he was scabs had been the were from his shoe indicated no treatm stated "they put lar last night." Registe room, indicated she scabbed areas on t scabs on the left for measured 0.6 cm b fourth digit reddene 1.3 cm. R31's record was re not reflect identifica integrity on the R31 2/11/16 simply state resident to have lar The progress note use of the lamb's w	age 9 NA)-B stated the scabs have a some time and not aware been there or what caused on 2/23/16, at 12:47 p.m. urse (LPN)-B stated the TAR toring of the scabs on the left TO LEFT FOOT TOES ion on 2/24/16, at 7:45 a.m. NA)-B removed R31's socks foot showed light brown and and third digits (toes) and digit showed a blanchable are was not any type of on noted to be in place at the nd shoes had been removed. aware of the scabs, indicated are for awhile now, stated they s and hammer toes, and ents were being applied. R31 mb's wool between my toes ared nurse (RN)-B entered the a was not aware of the the feet. RN-B measured the ot; scab on second digit by 0.4 cm, scab on third digit by 0.8 cm, and the right foot ad area measured 1.0 cm by eviewed. Documentation did attion of the impaired skin 's toes. A progress note dated and the physician ordered mb's wool between his toes. did not reflect the indication for rool and a signed physician's n for use was not evident. A	F 282			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 10 F 282 Body Audit performed the previous day on 2/10/16 reported feet/ankles/toes were clear of any forms of impaired skin integrity and did not identify R31 had hammertoes. R31's Body Audit performed on 2/17/16 reported feet/ankles/toes were clear of any forms of impaired skin integrity and did not identify R31 had hammertoes. R31's February 2016 treatment administration record (TAR) reflected the physician's order, "lamb's wool between toes daily, change q [every] HS [before bed]." Documentation indicated the first placement of lamb's wool occurred on 2/15/16; four days after the physician gave the order to initiate. R31's Daily Skin/Wound Monitoring indicated monitoring was put in place for the scabs after the surveyor brought it to the attention to RN-B. Documentation reflected the first day of routine monitoring was 2/24/16. R31's care plan did not reflect the scabbed areas to the toes. R31's record lacked a comprehensive assessment of the impaired skin on the toes, lacked routine monitoring for healing, and did not reflect monitoring of the impaired skin for signs and symptoms of infection, as directed by the care plan. During an interview on 2/25/16, at 9:13 a.m. DON explained her expectations for non-pressure related skin concerns to follow the policy, procedures and care plan. DON stated when the wound is identified nurses need to make a note, monitor, document, and treat according to the flow sheet. A facility policy for non-pressure related wounds was requested and not received. F 309 483.25 PROVIDE CARE/SERVICES FOR F 309 3/21/16

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		AND HUMAN SERVICES			FORM	03/21/2016 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245367		B. WING		02/25/2016	
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•=/=	
			2	10 EAST GRAND AVENUE, PO BOX 365		
MEADO	W MANOR		G	RAND MEADOW, MN 55936		
(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 309 SS=D	Continued From pa HIGHEST WELL B	-	F 309			
	provide the necess or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment				
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed comprehensively asses, monitor for effectiveness of impaired skin interventions to promote healing and prevent new ones from developing for 1 of 3 residents (R31) who was diabetic. Findings include: R31 was admitted to the facility on 12/4/15 with diagnoses of diabetes type II, obesity, nicotine dependence, chronic obstructive pulmonary disorder, hyperlipidemia, stroke resulting in left sided weakness, and history of falling. According to the significant change Minimum Data Set dated 1/27/16 R31 was not cognitively impaired with a Brief Interview for Mental Status score of 13. During an observation on 2/22/16, at 1:41 p.m. R31 was sitting in wheelchair in his room with a short sleeve shirt on. His left arm was noted to be edematous when compared to the right. The left upper dorsal side(hand turned so thumb is pointing to the right) of the forearm showed one large scab that measured 1.0 centimeter (cm) in diameter and a smaller scab that measured 0.3 cm in diameter. Both scabs were dark brown/red			F 309 The preparation of the following pla correction for this deficiency does n constitute and should not be interpr as an admission nor an agreement facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exe solely because it is required by prov of State and Federal law. Without we the foregoing statement, the facility that with respect to: "R31 a comprehensive audit was completed and care plan revised or 3/18/16. "All residents receive a comprehe body audit on admission, quarterly, annually, significant change, and as needed. "Staff will be re-education regar skin care, revision of care plan and condition/follow up documentation to -16 "DNS/ Designee will audit 2 resire records for completed documentation	eted by the ed on ent of ecuted visions vaiving states as n hensive s ding by 3-23 dent	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 309 Continued From page 12 F 309 in color and were raised off the skin per week times 4 weeks and then 1 resident record per week times 8 weeks. approximately 1.0-2.0 millimeters. R31 could not remember how he obtained the injuries. The data will be shared with the next R31's care plan acknowledged diagnoses of Quality Assurance meeting for input and further direction. Quality Assurance diabetes: the plan directed staff to observe/document/report to medical practitioner meeting for input and further direction. for dry skin and poor wound healing. The care DNS is responsible. plan further identified R31 had a potential to develop pressure ulcers. The care plan included direction for staff to, "lotion skin daily, observe skin daily with cares and report changes to the nurse, observe/document/report to medical practitioner PRN [as needed] changes in skin status: appearance, color, wound healing, s/sx [signs/symptoms] of infection, wound size, stage, weekly skin inspections." R31's record indicated the initial identification of the impaired skin integrity on the left forearm was on 2/17/16 during a weekly Body Audit. The only information on the body audit included. "left forearm scabbed scratches." The measurement and summary area of the audit did not contain any information. The corresponding nurse progress note included, "in general skin is good condition, noted 2 scabbed scratches on left forearm, no redness, or warmth." Documentation in the record did not reflect when the initial injury occurred or what caused or potentially caused the scratches. However, a Care Conference Summary dated 2/9/16 included, "scabbed areas Lt [left] arm-OTA [open to air]" It was not evident in the record if areas on 2/9/16 were the same areas identified on 2/17/16. The record did not reflect monitoring from 2/9/16 through 2/17/16 or a comprehensive evaluation of the scabs stated on 2/9/16. A body audit completed on 2/10/16 indicated the skin was clear and intact and did not identify the scabs, which conflicts with the information recorded the previous day on the

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 309 Continued From page 16 F 309 the request. MD-A stated he did not have a visit or visualize R31's feet at the time of the order. MD-A stated he did not make a visit note pertaining to the order. During an interview on 2/25/16, at 9:13 a.m. DON explained her expectations for non-pressure related skin concerns to follow the policy. procedures and care plan. DON stated when the wound is identified nurses need to make a note. monitor, document, and treat according to the flow sheet. DON explained documentation should include location, size, any symptoms or signs of infection, and treatments ordered. DON explained the initial assessment needs to include root cause analysis of what caused the impaired skin integrity and a care plan developed with appropriate interventions and initiated. DON indicated the nurse who requested the lamb's wool should have made a progress note indicating the reason for the request and follow the procedure for documenting any impaired skin integrity at the time related to the request. A facility policy for non-pressure related wounds was requested and not received. Facility did provide Daily Skin/Wound Monitoring Form Guidelines used for nurse documentation. The guidelines included, "Daily monitoring of skin integrity promotes the early recognition of problems with infection, wound healing, a dressing failure, and unrelieved pain associated with the wound or dressing change. To complete this form the nurse must inspect any alteration in skin integrity listed for the resident. Skin integrity include but are not limited to bruises, abrasions, skin tears, lacerations, rashes, burns, and pressure ulcers, vascular, and diabetic ulcers." The guidelines directed nurses to assess dressing/description/color of drainage, amount of drainage, surrounding skin color, surrounding

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· · · · · · · · · · · · · · · · · · ·	DATE SURVEY COMPLETED
		A. BUILDING	i		
		245367	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	02/25/2016
NAME OF PROVIDER OR SUPPLIER MEADOW MANOR			:		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	GRAND MEADOW, MN 55936 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 309 F 315 SS=D	skin condition, and 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi infections and to re- function as possible This REQUIREMEN by: Based on interview facility failed to com change in urinary cor resident (R35) revie continence status. Findings include: R35 had a decline i	Based on interview and document review, the facility failed to comprehensively reassess a change in urinary continence status for 1 of 1 resident (R35) reviewed who had a change in continence status. Findings include: R35 had a decline in continence and had not been reassessed to determine interventions to		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE	
	incontinent (this wa was not on a toiletir extensive assistanc assessment of 1/5/ program was not be	indicated R35 was frequently s a decline for R35) of urine, ng program and required the to toilet. The MDS 16 indicated that a toileting bing used to manage urinary ever, the admission MDS		 R 35 a comprehensive assessmer was completed. Care plan/NAR sheets revised to reflect current care needs. All residents receive a continence evaluation upon admission, quarterly a with a significant change in condition. 	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 315 Continued From page 18 F 315 dated 12/7/15, indicated R35 was occasionally DNS/ Designee will complete a incontinent of urine, and was not on a toileting continence evaluation audit for 2 residents per week for 4 weeks then 1 resident per program. week for 8 weeks. The data will be shared at the next Quality Assurance meeting by R35's Continence Evaluation dated 12/10/15 indicated. "Intermittently incontinent of urine. the DNS/ Designee for input and further continent of stool. Wears depends through out direction. [sic] day and night. Peri care assisted by staff." DNS is responsible. R35's Nurse progress note dated 12/10/15 indicated, "Continence evaluation was completed for [R35]. Experiences episodes of bladder incontinence. Products used include uses product. Possible diagnosis that may affect continence include. Possible medications include. Perineum is intact. Able to use the following Toilet. Other contributing factors include Mobility. Treatment options include." R35's Continence Evaluation dated 1/5/16 indicated, "Frequently incont [incontinent] of urine with aware of urge to void, cont/incont. [Continent/ incontinent] of bowel. Wears depends/pull up. Staff assist w/toileting needs." R35's Nurse progress note dated 1/5/16 indicated, "Continence evaluation was completed for [R35]. Experiences episodes of both incontinence. Products used include uses product. Possible diagnosis that may affect continence include. Possible medications include. Perineum is intact. Able to use the following Toilet. Other contributing factors include Mobility. Treatment options include Personal Hygiene Incontinence Product." R35's comprehensive care plan for toileting 12/17/15 indicated, "R35 has occasional Bladder Incontinence r/t [related to] poor balance, requires staff assist with toileting/ADLs. [activities of daily living] recent non-displaced fx [fracture] of greater

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		AND HUMAN SERVICES			FORM	03/21/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245367	B. WING		02/;	25/2016
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
MEADO	W MANOR			10 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	trochanter, Parkins degeneration, HTN DM [diabetes]." Inte "Provide for toileting meals, and per her nursing if incontine Observe/document PRN [as needed] p incontinence: bladd of bladder tone, we decreased bladder medication side effe and change as nee On 2/23/2016 at 1: while in her room. F incontinent of urine home and stated st about how she can R35 stated she put go to the bathroom take her to the bath when she needs to she dribbles a lot. F with going to the bat On 2/24/2016 at 12 (RN)-A verified she decline in bladder fu assessments that v and 1/5/16. RN-A s identified in urinary at why the resident would complete a 3 assessment to see resident was incont appropriate toileting restore the bladder	on's disease, Macular [high blood pressure], type II erventions directed staff to, g upon arising, between request, Activities staff: notify int during activities, /report to medical practitioner ossible medical causes of ler infection, constipation, loss akening of control muscles, capacity, diabetes, Stroke, ects, Use disposable briefs ded." 57 p.m. R35 was interviewed R35 stated she had been prior to coming to the nursing raff have not talked to her improve her incontinence. her light on when she had to and stated staff also offer to broom. R35 stated she can tell go to the bathroom and stated R35 stated she needed help athroom so she did not fall. 22 p.m. registered nurse had not identified R35 had a unction according to the MDS vere completed on 12/7/15 tated when a decline was incontinence you would look had a change in continence, a day bowel and bladder what times of the day a inent to determine an g schedule to attempt to	F 315			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	03/21/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		245367	B. WING		02/2	25/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W MANOR			210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	indicated R35 was verified the facility h into place to help re- prior level of function On 02/24/2016 at 1 (FM)-A stated when she was scheduled toileting every two h a problem with mar when she lived in th R35 has had proble years. FM-A stated February 11, 2016 s about setting a toilet for R35 and she sta would be a good ide toileting R35 every urinary tract infection her incontinent proof frequently if she we and stated R35 was always been a plea people for help. Facility policy titled Procedure: Contine instructed staff to, " each resident that is bowel is identified a opportunity to achier much normal bladd possible. Appropria be offered to restor possibleeach res [evaluated] on adm	 accasionally incontinent and had not put any interventions estore R35's bladder to the oning. :37 p.m., family member a R35 lived in assisted living to have assistance with nours and stated there was not haging R35's incontinence he assisted living. FM-A stated ems with dribbling urine for at the care conference held she talked to the facility staff sting schedule every two hours ated the facility thought that ea. FM-A stated she thought two hours would help prevent ons, as R35 dribbled urine and duct would be changed more re toileting every two hours, as a creature of habit, had ser and did not want to bother Practice Guideline and ance Evaluation dated 2014Each facility will ensure that s incontinent of bladder and/or and assessed, given the eve continence or restore as er and/or bowel function as te treatment and services will e as much function as ident will be evaluate ission, quarterly with a n status or when there has he residents current 	F 315	5		

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		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245367		B. WING			02/25/2016		
NAME OF F	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V MANOR				10 EAST GRAND AVENUE, PO BOX 365 RAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS		F	329			3/21/16
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral interven contraindicated, in a drugs.	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above. The ensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by: Based on observat review the facility fa use of an antidepre	tion, interview and document ailed to justify the continued assant medication for 1 of 5 iewed for unnecessary			F 329 The preparation of the following plan correction for this deficiency does no constitute and should not be interpre as an admission nor an agreement facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of correction	ot eted by the ed on	
	R28 was observed on on 2/23/16 at 12:42 p.m.,				prepared for this deficiency was exe	cuted	

Facility ID: 00390

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 22 F 329 R28 was in the dining hall eating with other solely because it is required by provisions residents. She was noted to appear calm. of State and Federal law. Without waiving the foregoing statement, the facility states During an observation on 2/24/15 at 8:48 a.m., that with respect to: R28 was reviewed for unnecessary R28 was currently seated in the dining hall with other residents. She appeared calm. medication. Zoloft dose was reduced from 150mg daily to 100mg PO daily per MD on 3/3/2016. During an observation on 2/25/16 at 8:55 a.m., R28 was in the hallway speaking with a nurse. R28 a comprehensive mood and She was noted to be calm. behavior assessment was completed on 3/18/16. R28's admission record, dated 6/6/13, indicated All residents receive a that the resident had diagnoses of Alzheimer's comprehensive mood and behavior disease and dysthymic disorder (chronic assessment upon admission, quarterly depressed mood). and with a significant change in condition. DNS/ Designee will audit 2 resident records for evidence of documentation to R28's care plan, dated 9/17/2013, indicated that the resident used antidepressant medication justify the continued use of an (Zoloft) related to depression. The care plan's antidepressant per week for 4 weeks then 1 resident record for 8 weeks. The data stated goal was that R28 was to be free from discomfort or adverse reactions related to will be shared at the next Quality antidepressant therapy. It recommended Assurance meeting by the DNS/ Designee consultations with R28's pharmacist and medical for input and further direction. DNS is responsible. practitioner to consider a dosage reduction when clinically appropriate. It also recommended to give antidepressant medications ordered by the medical practitioner. It recommended to observe, document and report to the medical practitioner ongoing signs and symptoms of depression unaltered by antidepressant medications. R28's consultant pharmacist review, dated 6/10/15, indicated that the resident had been taking Zoloft 150 mg by mouth every day. R28's consultant pharmacist review, dated 8/24/15, indicated that the resident's Zoloft had been decreased on 7/23/15 to 100 mg by mouth daily.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	03/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245367	B. WING			02/2	25/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	W MANOR				210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ige 23	F:	329			
	10/22/15, indicated been increased on explanation, it state due to a failed grad However, there was of how the failed Gi R28's Drug History, Sheet (no date) sta been prescribed Zc 150 mg per day. It her dose lowered o yearly gradual dose that on 10/1/15, the increased to 150 m reduction attempt.	harmacist review, dated that the resident's Zoloft had 10/1/15 to 150 mg. As an ed that the increase had been lual dose reduction (GDR). s no supporting documentation DR had been determined. /Gradual Dose Reduction Flow ted that R28 had originally bloft on 6/6/13 and received stated that the resident had in 7/23/15 to 100 mg for a e reduction attempt. It stated e dose of Zoloft had been ig due to a failed gradual dose Again there was not supporting ord as to why the GDR had					
		ta Set (MDS), dated 9/5/15, ent had no symptoms of					
		ehavior Evaluation, dated at the resident exhibited no s.					
	September 2015, d	es, reviewed for the month of lid not mention once that the suffering from any moods or					
	10/1/15, indicated t seen by a physiciar visit. It stated, "Nurs	ce progress note, dated hat the resident had been n for a sixty day nursing home ses have noted her saying ifect of not wanting to go on					

Facility ID: 00390

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		AND HUMAN SERVICES				FORM	03/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245367	B. WING	à		02/:	25/2016
NAME OF I	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEADO	W MANOR				210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	little over two month Zoloft from 150 mg almost (sic) year ar it from 100 to 150." because of time to reduction and she s then." The note sta R28 stated that she particularly depress the physician order mg daily. It stated, check in 3 or 4 weat that." Again there i the GDR failed nor increased at this tim R28's Progress Nor through 2/21/16, ind no moods or behav R28's family praction 12/3/15, indicated t seen by a physiciar visit. It stated, "No of been heard recently R28's Minimum Da indicated the resided depression. R28's Documentati that nursing assista residents), reviewed	and feeling discouraged. A hs ago, we decreased her back to 100 mg daily. About nd a half ago we had increase We decreased it in July [2015] consider a gradual dosage seemed to be doing okay ated that at the visit on 10/1/15 e felt okay and did not feel sed. At the end of the report, ed an increase in Zoloft to 150 "Again, will get a progress eks to see how she is doing on s no clear indication as to why why the medication was ne. tes, reviewed from 10/1/15 dicated that the resident had viors noted once. ce progress note, dated hat the resident had been n for a sixty day nursing home depressive statements have y." ta Set (MDS), dated 12/5/15, ent had no symptoms of	F	329	9		

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		AND HUMAN SERVICES				FORM	03/21/2016 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE	E SURVEY PLETED
		245367	B. WING	ì		02/2	25/2016
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEADO	W MANOR				210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	had no moods or be When interviewed of Nursing Assistant (I have any moods or resident liked to real When interviewed of registered nurse (R time R28 was happ that she had never RN-D stated that if communication the When interviewed of licensed practical n had never seen R2 crying. When interviewed of Nursing Assistant (I cried or seemed de had seemed happy known R28 for as lo resided at the facilit When interviewed of director of social se justification to incre- there had been no the resident had be prior to the increase have been more to dosage of the Zolof Review of the docu Behavior Documen 2014), stated that the	ehaviors noted at all. on 2/24/16 at 12:42 p.m., NA)-A stated that R28 did not behaviors. She stated that the ad a lot. on 2/25/16 at 9:01 a.m., N)-D stated that most of the by and liked to talk. She stated seen R28 in a sad mood. R28 was engaged in resident was very pleasant. on 2/25/16 at 10:00 a.m., urse (LPN)-A stated that she 8 have a depressed mood or on 2/25/16 at 10:09 a.m., NA)-B stated that R28 never epressed. She stated that R28 . She stated that she had ong as the resident had ty. on 2/25/16 at 10:40 a.m., the ervices was asked about the ase Zoloft on 10/1/15 when documentation to indicate that en having moods or behaviors e. She stated that there should justify the increase in the ft medication. ment titled, Mood and tation Guidelines (November	F	329			

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		AND HUMAN SERVICES				FORM	03/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245367	B. WING			02/:	25/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W MANOR				10 EAST GRAND AVENUE, PO BOX 365 RAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329 F 356 SS=C	behaviors and prov for practice decision resident plan of car behavior evaluation residents on admiss prior to the use of a psychoactive medic the medication and related to the use of a behavior note wat documenting incide Documentation ent each episode which exception. 483.30(e) POSTED INFORMATION The facility must por a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sl - Registered nu - Licensed pract vocational nurses (- Certified nurse o Resident census. The facility must por specified above on of each shift. Data o Clear and readab	ide documentation of evidence ins and modifications to the e. It stated that a mood and a would be completed for all sion, quarterly, annually and and/or dose change of a cation to evaluate the need for determine the target behavior if the medication. It stated that is to be completed for ents of behaviors for residents. ries were to be completed with a were to be charted by 0 NURSE STAFFING ost the following information on and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). e aides. ost the nurse staffing data a daily basis at the beginning must be posted as follows: le format. ace readily accessible to	F 3				3/21/16

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/21/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245367	B. WING			/25/2016
NAME OF F	PROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	20/2010
					10 EAST GRAND AVENUE, PO BOX 365	
MEADOV	V MANOR				RAND MEADOW, MN 55936	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	make nurse staffing for review at a cost standard. The facility must ma staffing data for a m required by State la This REQUIREMEN by: Based on observat review, the facility fa posting of the daily posting was current affect 28 residents and visitors. Findings include: During the initial tou 12:05 p.m., the faci was posted on a bu listed as 31. Howev for the current day, surveyor entrance t On 02/22/16 at 12:2 director (SSD)-A ve residents in the buil were three resident verified the census indicated there were have indicated 28 m resident currently in On 02/25/2016 at 1	aintain the posted daily nurse not to exceed the community aintain the posted daily nurse ninimum of 18 months, or as aw, whichever is greater. NT is not met as evidenced tion, interview and document ailed to ensure the required census on the daily nurse staff t. This had the potential to residing in the facility, staff, ur of the facility on 2/22/16, at lity staff posting dated 2/22/16, at lity staff posting dated 2/22/16, and the census ter, the actual facility census 2/22/16, was 28 upon the facility. 20 p.m., social services crified the current number of ding was 28 and stated there is in the hospital. SSD-A sheet posted for 2/22/16 e 31 residents and should esidents, the actual number of the building. 2:20 p.m., SSD-A stated the	F 3	56	F 356 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: " Licensed staff will receive re-education on the policy/procedure of updating posted staffing hours by 3-23-16 " Accurate nursing hours are posted. " Executive director/ Designee will audi posted staffing hours 3 times weekly for 4 weeks then 2 times weekly for 8 weeks to ensure the proper staffing hours are posted. At next QA meeting the committee will review the findings and determine the frequency and duration of the audits. " Data will be reviewed/ discussed at	t
		onsible to update the daily -A stated the census was to			" Data will be reviewed/ discussed at monthly QA. The QA committee ill make	

Facility ID: 00390

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY
		245367	B. WING		02	/25/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO\	W MANOR			210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROD DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 356	residents that were counted in the daily The facility policy, 1 2015 did not direct	rrently in the building and in the hospital were not to be nursing hours. Nursing Hours Posting, revised the facility to include the daily	F 35	6 decisions/ recommendations rega any necessary follow up. " Executive Director is responsi	-	
F 431 SS=D	The facility must er a licensed pharmad of records of receip controlled drugs in accurate reconcilia records are in orde		F 43	1		3/21/16
	labeled in accordar professional princip appropriate access	als used in the facility must be nee with currently accepted bles, and include the ory and cautionary e expiration date when				
	facility must store a locked compartment	State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys.				
	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit				

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		AND HUMAN SERVICES			FORM	03/21/201 APPROVE 0938-039	
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
		245367	B. WING _		02/2	25/2016	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
MEADO	W MANOR			210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936	X 365		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 431		bution systems in which the ninimal and a missing dose can	F 4:	31			
	by: Based on observat review, the facility f medications for 2 o reviewed during me addition, the facility administration of ex- solution for 2 reside Findings include: R33's Order Summ had handwritten ord Tramadol (a pain m three times, give at stated to give with hip pain. R33's Medication A reviewed from 2/18 that the resident ha mg by mouth three and 8 p.m. During an observat administration on 2 Registered Nurse (R33's medications. Tramadol contained three times a day a	NT is not met as evidenced tion, interview and document ailed to properly label of 2 residents (R33, R9) edication administration. In trailed to prevent the kpired tuberculin testing ents (R54, R55) reviewed. hary Report, dated 2/18/16, ders by the physician: nedication) 50 mg by mouth to a a.m., 1 p.m. and 8 p.m. It Tylenol. The indication was left administration Record (MAR), b/16 through 2/29/16 indicated ad been receiving Tramadol 50 times a day at 8 a.m., 1 p.m. ion of a medication /22/16 at 6:59 p.m., RN)-C prepared to administer The medication package for d the label: 50 mg by mouth is needed. When asked about a label, RN-C stated that the		F 431 The preparation of the following correction for this deficiency doe constitute and should not be inter as an admission nor an agreem facility of the truth of the facts all conclusions set forth in the state deficiencies. The plan of correct prepared for this deficiency was solely because it is required by of State and Federal law. Witho the foregoing statement, the fact that with respect to: "R33 upon notification of me label discrepancy a change labe implemented. Pharmacy was no order was changed in the pharm system on 3/18/16. "R9 upon notification of me label discrepancy a change labe implemented. Pharmacy was no order was changed in the pharm system on 3/18/16. "R54 and R 55 upon notificat given expired tuberculin testing their mantoux series were resta 3/1/2016. "All medications will be revie accuracy of label to include nam medication, dose route and time	es not erpreted ent by the leged on ement of ion executed provisions ut waiving ility states dication el was otified and hacy dication el was otified and hacy dication el was otified and hacy dication el was		

Facility ID: 00390

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245367 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 431 Continued From page 30 F 431 as the order had recently changed. RN-C stated All licensed staff will be provided that a sticker should have been placed on the re-education on proper verification of medication labels by 3-23-16 including package which would have indicated there was an order change. medications with shortened expiration dates, information will be available to all nursing staff. R9's Order Summary Report, dated 11/11/11, had DNS/ Designee will audit 2 medication a physician order for Aspart insulin (a fast-acting labels per week for 4 weeks then 1 insulin): 6 units at 8:00 a.m., 12:00 p.m. and 4:00 medication labels for 8 weeks. The data p.m. There was an additional order, dated will be shared at the next Quality 6/16/11, that R9 was to get additional units of Assurance meeting by the DNS/ Designee Aspart insulin which depended on what her blood for input and further direction. sugar was when she was to be administered DNS is responsible. insulin. R9's Medication Administration Record (MAR), dated 1/14/16, indicated that the order for Aspart insulin 6 units at 8:00 a.m., 12:00 p.m., and 4:00 p.m. had been discontinued by the physician. During an observation of a medication administration on 2/24/16 at 11:59 a.m., Registered Nurse (RN)-D had obtained R9's blood sugar which was 417. The label on R9's insulin stated to give 6 units subcutaneously (under the skin) three times a day. RN-D then drew up 14 units of Aspart insulin from this same vial and administered the insulin to the resident. RN-D stated that the medication order on the label was an old order and it had since changed approximately a month ago. She stated that the insulin should have had a sticker on it in order to alert the staff that there had been a medication order change. During an observation of the medication room on 2/25/16 at 9:52 a.m. with Licensed Practical Nurse (LPN)-A, there was observed to be in the refrigerator one opened vial of tuberculin testing

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		AND HUMAN SERVICES				FORM): 03/21/2016 / APPROVED). 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		245367	B. WING			02	/25/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W MANOR				210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 431	solution and one ur testing solution. The an opened date of tuberculin testing so days and should ha administered to any on 2/13/16. R54's order summa indicated that the re a 1st step tuberculin for the presence of had received an out testing solution. R55's order summa indicated that the re the 1st step Mantou received an outdate vial with open date During an interview (DON) on 2/25/16 a she could not verify had not received th beyond the 30 day been opened. She testing solution sho 30 days once the vi Review of the facilit Labels (2006), it sta inaccurately labeled rejected and returne pharmacy. It stated directions for use co inaccurate, the nurs	ary report, dated 2/16/16, esident had an order to receive uberculosis) on 2/18/16, esident had an order to receive ary report, dated 2/18/16, esident had an order to receive n skin test (TST) (used to test tuberculosis) on 2/16/16. R54 totated dose of tuberculin		431			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUIT	IPLE CONSTRUCTION (X	3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		245367	B. WING _		02/25/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W MANOR			210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 431 F 465 SS=C	directions for use. If appeared on the co- was to check the re- administration reco- information. It then pharmacy was to be refill of the prescrip would show an acc- 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro-	te there was a change in the t stated that when such a label ontainer, the medication nurse esident's medication rd (MAR) for current stated that the dispensing e informed prior to the next tion so the new container urate label. AL/SANITARY/COMFORTABL	F 43		3/21/16	
	by: Based on observat review, the facility fain place to identify of repairs were compl rooms (1, 2, 7, 9, 1) Findings include: Environment tour w 2/24/16, at 1:00 a.m observations: Room 1-metal bath metal near the floor Room 2-metal bath	NT is not met as evidenced tion, interview, and document ailed to ensure a system was ongoing physical environment eted for 8 of 23 resident 1, 13, 14, and 17). With maintenance director on h., revealed the following room door frame missing r, sharp edges exposed.		F 465 The preparation of the following plan correction for this deficiency does not constitute and should not be interpret as an admission nor an agreement by facility of the truth of the facts alleged conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exect solely because it is required by provisi of State and Federal law. Without was the foregoing statement, the facility st that with respect to: "Upon notification of needed repail room(s) 7 and 14; maintenance direct corrected the issues and repairs have been completed, effective 3/21/16. "Upon notification of needed repail	ed on of uted ions ving ates r in cor	

Facility ID: 00390

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245367 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 465 Continued From page 33 F 465 Room 7--large gouge in wall between closet door room 9: maintenance director has ordered and bathroom. material to resolve the observation and plan for repair will be completed by Room 9-two closet doors with lower edges 3/23/16. Upon notification of needed repair in missing wood. room(s) 1. 2. and 13: maintenance Room 11---two nightstands with areas of worn director has received material guotes and varnish and bare wood exposed, missing labor estimates for repair of metal bathroom door frame(s). A plan for repair baseboard behind the room door. will be implemented by 3/23/16. Room 13-one nightstand with areas of worn Upon notification of needed repair in varnish and bare wood exposed, metal bathroom room(s) 11, 13, and 17; maintenance door frame missing metal near the floor, sharp director has received material quotes for edges exposed. additional nightstands. A plan for repair of nightstands or purchase of additional nightstands will be completed by 3/23/16. Room 14-missing baseboard on wall by room All Staff will be re-educated on how to door. report areas needing repair by 3/23/16. Room 17-one nightstand with areas of worn ED/Designee will monitor resident varnish and bare wood exposed. rooms weekly for 4 weeks and monthly there after for physical environment During interview on 2/24/16, at 1:00 p.m., issues. Data will be shared at next QA maintenance director verified these areas of committee by ED/Designee. needed repairs. Maintenance director stated not aware of the areas that needed repairs. He stated the facility system was for staff to notify maintenance of needed repairs by completing a maintenance request form, verbal tell him, send him an emails, texts, and/or voice mail. During interview on 2/25/16, at 8:30 a.m., social services director stated when staff were hired. they were educated to notify maintenance when repairs were needed. F 520 483.75(o)(1) QAA F 520 3/21/16 COMMITTEE-MEMBERS/MEET SS=F QUARTERLY/PLANS

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	03/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245367	B. WING			02/2	25/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	V MANOR			2	10 EAST GRAND AVENUE, PO BOX 365		
				Ģ	RAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From pa	ige 34	F	520			
	assurance committ nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the					
	committee meets a issues with respect and assurance actin develops and imple	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies.					
	disclosure of the re except insofar as s	retary may not require cords of such committee uch disclosure is related to the committee with the s section.					
		s by the committee to identify deficiencies will not be used as is.					
	by: Based on interview facility failed to ens and Assurance (QA sustained ongoing quality deficiencies accuracy, monitori issues, medication which were identifie survey exited 4/2/15	NT is not met as evidenced y and document review, the ure the Quality Assessment (&A) committee effectively compliance related to repeat in Minimum Data Set ng non-pressure related skin labeling, and infection control, ed during the recertification 5. This had the potential to nts who resided in the facility.			F 520 The preparation of the following plan correction for this deficiency does no constitute and should not be interpre as an admission nor an agreement b facility of the truth of the facts alleged conclusions set forth in the statemen deficiencies. The plan of correction prepared for this deficiency was exect solely because it is required by provisi of State and Federal law. Without was the foregoing statement, the facility s	ot eted by the d on nt of cuted isions aiving	

Facility ID: 00390

If continuation sheet Page 35 of 37

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245367 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 MEADOW MANOR **GRAND MEADOW, MN 55936** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 520 Continued From page 35 F 520 that with respect to: During interview on 2/25/16, at 2:30 p.m., facility QA committee meetings are held executive director, verified QA&A met guarterly. monthly with involvement from facility He stated the committee would be starting a new designated physician at least quarterly; pain tracking program and psychoactive and at least 3 other members of the medication program beginning 3/1/16. During facility s staff. interview at that time, executive director stated ED/Designee, is responsible for he was not sure if the QA&A committee had facilitating meeting, effective 3/17/16. All department supervisors will be developed and implemented plans of action to sustain compliance with repeat deficiencies in provided education on the Plan Do Study Minimum Data Set accuracy, monitoring Act (PDSA) model; to address non-pressure related skin issues, medication problematic areas and create a process of labeling, and infection control. These deficiencies improvement for identified issues with were identified during the recertification survey respect to which quality assessment and exited 4/2/15. assurance activities are necessary. Training to be completed on or before See F278: The facility failed to accurately code 3/23/16. ED/designee is responsible. an admission Minimum Data Set (MDS) for 1 of 1 Regarding infection control; F441 was resident (R35) reviewed for urinary incontinence. removed. In addition, the facility failed to accurately Regarding medication labeling; see complete a comprehensive assessment for POC for F431. dental status for 1 of 1 residents (R31) reviewed Regarding MDS accuracy; see POC for dental status. for F278. See F309: The facility failed to comprehensively Regarding MDS accuracy; see POC asses and monitor impaired skin integrity for 1 of for F309. 1 residents (R31) who was diabetic. Planned QA committee agenda for April 2016 has included items e g, as See F431: The facility failed to properly label referenced above. ED/designee is medications for 2 of 2 residents (R33, R9) responsible for completion of QA reviewed during medication administration. In committee agenda. addition, the facility failed to prevent the administration of expired tuberculin testing solution for 1 of 1 employees (E)-A and two residents (R54, R55) reviewed. See F441: The facility failed to properly secure a dressing for 1 of 1 resident observed with an open, large and dry wound who was seen at the dining hall without a dressing (R28). In addition,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	03/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245367	B. WING		·····	02/2	25/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W MANOR				10 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	infection for an inha located in the medi Document review of and Performance In Implementation pol oversight responsib quality measures a data collection tools Centers for Medica reports and Minnes Page three directed conduct PIPs (Perf	prevent the potential for aler with a spacer attached cation cart (R31). of facility Quality Assurance mprovement (QAPI) icy, undated, directed facility pilities on page two, included nd survey outcomes. QAPI s on page three included re and Medicaid (CASPER) sota quality indicator reports. d "The community shall ormance Improvement o achieve and sustain	F	520			

Facility ID: 00390

If continuation sheet Page 37 of 37

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

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PRINTED: 03/24/2016 FORM APPROVED OMB NO 0938-0391

CENTER	TO FUR MEDICARE	& MEDICAID SERVICES	<u> </u>		0	ND NO.	0300-0331
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '		E CONSTRUCTION D1 - MAIN BUILDING 01		E SURVEY PLETED
		245367	B. WING			02/:	23/2016
NAME OF	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W MANOR			_	IO EAST GRAND AVENUE, PO BOX 365 RAND MEADOW, MN 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.					
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departn Marshal Division of time of this survey, in substantial comp for participation in I Subpart 483.70(a), 2000 edition of Nat Association (NFPA	Survey was conducted by the nent of Public Safety, Fire n February 23,2016. At the Meadow Manor was found not bliance with the requirements Medicare/Medicaid at 42 CFR, Life Safety from Fire, and the tional Fire Protection) Standard 101, Life Safety ter 19 Existing Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO: Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	OR THE FIRE SAFETY aspections Division Suite 145			EPOC		
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Flectror	hically Signed						03/21/2016

Electronically Signed

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.

Facility ID: 00390

	MENT OF HEALTH							APPROVED
	RS FOR MEDICARE							0938-0391 SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SU IDENTIFICATIC		I * <i>'</i>	IPLE CONSTRUCTION NG 01 - MAIN BUILD		COM	PLETED
		245	367	B. WING			02/2	23/2016
NAME OF F	PROVIDER OR SUPPLIER					CITY, STATE, ZIP CODE		
MEADOV	V MANOR				210 EAST GRAND GRAND MEADO	AVENUE, PO BOX 36 W, MN 55936	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICI Y MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRE DRRECTIVE ACTION SHO FERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	Continued From pa By email to: Marian.Whitney@s Angela.Kappenmai	tate.mn.us and		K 00	00			
	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:							
	1. A description of to correct the defici		or will be, done					
	2. The actual, or pr	oposed, comple	tion date.					
	3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Meadow Manor is a 1-story building . The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction, with a partial basement. In 1990, an addition was added to the South and was determined to be Type II (111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.							
	The building is fully fire alarm system v the corridors and s that is monitored for notification.	with partial smok paces open to t	te detection in he corridors					
	The facility has a c census of 27 at the							
	The requirement a							
FORM CMS-2	567(02-99) Previous Version	s Obsolete	Event ID: 57XW	21	Facility ID: 00390	lf c	ontinuation she	eet Page 2 of 5

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PRINTED: 03/24/2016

		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION (X D1 - MAIN BUILDING 01		SURVEY	
		245367	B. WING		02/2	3/2016	
NAME OF F	PROVIDER OR SUPPLIER	·	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
MEADOV	W MANOR			210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)			(X5) COMPLETION DATE	
K 000	Continued From pa	-	K 000				
K 018 SS=E	NOT MET as evide NFPA 101 LIFE SA	enced by: AFETY CODE STANDARD	K 018			3/21/16	
	required enclosure hazardous areas s as those construct core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist th no impediment to to open devices that pushed or pulled a provided with a me door closed. Dutch permitted. Door fra made of steel or of with 8.2.3.2.1. Roll CMS regulations in 19.3.6.3 This STANDARD Based on observa facility failed to ma doors in the mean the requirements a Section 19.3.6.3. a fire emergency, thi adversely affect ar within the affected FINDINGS INCLU During the facility for the facility failed to the facility for an of the facility facility facility facility facility facility facility facility match affected	orridor openings in other than as of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ance between bottom of door is not exceeding 1 inch. Doors smoke compartments are only he passage of smoke. There is the closing of the doors. Hold release when the door is re permitted. Doors shall be eans suitable for keeping the n doors meeting 19.3.6.3.6 are ames shall be labeled and ther materials in compliance er latches are prohibited by in all health care facilities. is not met as evidenced by: ation and a staff interview, the intain one or more corridor s of egress in accordance with at NFPA 101 (2000) Chapter 19, and Chapter 7, Section 7.2. In a is deficient practice could by patients, staff or visitors smoke compartment. DE: tour between the hours of 9:30 on 2/23/2016, observation		The preparation of the following plan correction for this deficiency does no constitute and should not be interpre- as an admission nor an agreement be facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exe solely because it is required by provious of State and Federal law. Without was the foregoing statement, the facility so that with respect to: "Upon notification of needed reparation."	ot eted don nt of cuted isions aiving states		
		#16 did not positively latch is warped and in disrepair.		room 16; maintenance director soug a quote for material needed for repa a new door was ordered, effective			

	RS FOR MEDICARE					-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X 01 - MAIN BUILDING 01	3) DATE SURV COMPLETE		
		245367	B, WING		02/23/20	16	
NAME OF	PROVIDER OR SUPPLIER		S.	TREET ADDRESS, CITY, STATE, ZIP CODE			
MEADO\	W MANOR		210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		X5) PLETIO ATE	
K 018	Continued From pa Superior at the time	-	K 018	 The maintenance director and/or designee will visually inspect all facilit doors to ensure doors positively latch not to affect a smoke compartment. The maintenance director is responsible for this area of compliant 	ty n, as		
K 025 SS=F	Smoke barriers sha least a one half hor constructed in acco barriers shall be per atrium wall. Windo fire-rated glazing o steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD Based on observa facility failed to ma accordance with th 2000 edition, Secti and 8.3.6. This de 27 residents within Findings include: On facility tour betw on 02/23/2016, it w west wings had pe barrier doors above	is not met as evidenced by: tion and staff interview, the intain the smoke barrier in e requirements of NFPA 101 - ons 19.3.7, 19.3.7.3, 8.3, 8.3.2 afficient practice could affect all the smoke compartments. ween 09:00 AM and 12:30 PM vas observed that the aest and netrations that the smoke e ceiling tiles around wires.	K 025	The preparation of the following plar correction for this deficiency does no constitute and should not be interpre as an admission nor an agreement b facility of the truth of the facts alleged conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exect solely because it is required by provi- of State and Federal law. Without was the foregoing statement, the facility st that with respect to: "Upon notification of needed repar room 16; maintenance director soug a quote for material needed for repar a new door was ordered, effective 3/14/16. "The maintenance director and/or designee will visually inspect all facili doors to ensure doors positively latch not to affect a smoke compartment. "The maintenance director is	t ted by the d on t of cuted sions aiving states hir in ht out ir, and r his ity		

Facility ID: 00390

If continuation sheet Page 4 of 5

ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA	. 0938-039
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG 01 - MAIN BUILDING 01		MPLETED
		245367	B. WING		02	/23/2016
AME OF PF	ROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP C		
IEADOW	MANOR			210 EAST GRAND AVENUE, PO BO GRAND MEADOW, MN 55936	X 365	
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Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted March 11, 2016

Mr. Thomas Stevens, Administrator Meadow Manor 210 East Grand Avenue, PO Box 365 Grand Meadow, MN 55936

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5367026

Dear Mr. Stevens:

The above facility was surveyed on February 22, 2016 through February 25, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. Meadow Manor March 11, 2016 Page 2

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

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

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

Please 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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00390	B. WING		02/2	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEADO	W MANOR		GRAND AV	ENUE, PO BOX 365 N 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf elicensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	ftware. to	
	epartment of Health	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITI F		(X6) DATE

Electronically Signed

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If continuation sheet 1 of 34

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY LETED
		00390	B. WING		02/2	5/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
IEADOV	V MANOR		' GRAND AV IEADOW, M	ENUE, PO BOX 365 N 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, the corrected prior to el Minnesota Departm On February 22, 23 this Department's s and the following co Please indicate in y correction that you	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health. 4, 24 & 25, 2016 surveyors of taff, visited the above provider prrection orders are issued. our electronic plan of have reviewed these orders, e when they will be completed.		The assigned tag number ap far left column entitled "ID P The state statute/rule out of listed in the "Summary State Deficiencies" column and rep Comply" portion of the correct This column also includes the which are in violation of the se after the statement, "This Ru as evidence by." Following the findings are the Suggested M Correction and Time period the PLEASE DISREGARD THE THE FOURTH COLUMN WI STATES, "PROVIDER'S PLA CORRECTION." THIS APP FEDERAL DEFICIENCIES C WILL APPEAR ON EACH PA THERE IS NO REQUIREME SUBMIT A PLAN OF CORRI VIOLATIONS OF MINNESO STATUTES/RULES.	refix Tag." compliance is ment of blaces the "To ction order. e findings state statute ile is not met he surveyors Aethod of for Correction. HEADING OF HICH AN OF LIES TO DNLY. THIS AGE.	
2 302	MN State Statute 14 or related disorder t	44.6503 Alzheimer's disease train	2 302			3/21/16
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related o segregated or gene care staff	ity serves persons with lisorders, whether in a ral unit, the facility's direct rs must be trained in dementia				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00390	B. WING		02/2	25/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MEADO	W MANOR		T GRAND AV MEADOW, M	'ENUE, PO BOX 365 N 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL P		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 302	Continued From pa	age 2	2 302			
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shal written or electronic training program, th trained, the frequen topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;				
	by: Based on interview facility failed to pro- facility's dementia p written or electronic During an interview licensed social wor does not currently	/ on 2/25/16, at 9:43 a.m. ker (LSW) stated the facility	r	Corrected		
nnesota D	facility could review dementia training a electronic commun communicating the consumer. The fac communication into	THOD OF CORRECTION: The v the Minnesota statutes for and develop a written or lication means of vir dementia training to the ility could implement the their admission process. The streate and implement an				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		e survey Ipleted
		00390	B. WING		02/	/25/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MEADO	W MANOR		「GRAND AV /IEADOW, M	ENUE, PO BOX 365 N 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 302	Continued From pa	ge 3	2 302			
	auditing system as program to maintai	part of their quality assurance n compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			3/21/16
		omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility f provide services to non-pressure relate according to the ca (R31) reviewed for issues. Findings include: R31 was admitted t diagnoses of diabe dependence, chron disorder, hyperlipid sided weakness, ar R31's care plan act diabetes; the plan co observe/document/ for dry skin and poor plan further identifie develop pressure u direction for staff to	ed impaired skin areas re plan for 1 of 2 residents non-pressure related skin to the facility on 12/4/15 with tes type II, obesity, nicotine ic obstructive pulmonary emia, stroke resulting in left nd history of falling. knowledged diagnoses of		Corrected		

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED			
		00390	B. WING		02/	25/2016			
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE					
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365					
(X4) ID PREFIX TAG			SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PL/ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIV				I OF CORRECTION (X ACTION SHOULD BE COM TO THE APPROPRIATE D		
2 565	Continued From pa	ge 4	2 565						
	practitioner PRN [a status: appearance [signs/symptoms] o weekly skin inspect SCABBED AREAS During an observat R31 was sitting in v short sleeve shirt of edematous when c upper dorsal side(h pointing to the right large scab that mea diameter and a sma cm in diameter. Bot in color and were ra approximately 1.0-2 remember how he R31's record indica the impaired skin in on 2/17/16 during a information on the R forearm scabbed st and summary area any information. Th progress note inclu condition, noted 2 s forearm, no redness in the record did no occurred or what ca scratches. Howeve Summary dated 2/S Lt [left] arm-OTA [o] in the record if area areas identified on reflect monitoring fr a comprehensive e on 2/9/16. A body a indicated the skin w	TO LEFT FOREARM ion on 2/22/16, at 1:41 p.m. wheelchair in his room with a n. His left arm was noted to be ompared to the right. The left and turned so thumb is) of the forearm showed one asured 1.0 centimeter (cm) in aller scab that measured 0.3 th scabs were dark brown/red							

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE				ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	information recorde Care Conference S R31's treatment ad not reflect routine in Daily Skin/Wound N evident in the recor brought it to the fac lack of monitoring. monitoring form wa days after if the wor 2/9/16 or five days identified on 2/17/17 R31's record lacked assessment of the in signs and symptom the care plan. During an interview nursing assistant (N been there for quite how long they have them. During an interview licensed practical n did not reflect moni arm. SCABBED AREAS During an observat nursing assistant (N and shoes. The left scabs on the secon the right foot fourth reddened area. The dressing or protecti time R31's socks al R31 stated he was scabs had been the were from his shoe	ed the previous day on the summary dated 2/9/16. ministration record (TAR) did npaired skin monitoring. A Monitoring form was not d until after the surveyor ility's attention there was a R31's Daily Skin/Wound s initiated on 2/23/16; fourteer unds were first identified on after if the wounds were first 6.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
				NUE, PO BOX 365		
MEADO	W MANOR	GRAND	MEADOW, MN	55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ge 6	2 565			
	last night." Register room, indicated she scabbed areas on the scabbed areas on the fourth digit reddenee 1.3 cm. R31's record was re- not reflect identification and reflect identification sedent to have lar The progress note of use of the lamb's wo order with indication Body Audit perform 2/10/16 reported fer any forms of impair identify R31 had ha R31's Body Audit per feet/ankles/toes we impaired skin integr had hammertoes. R31's February 201 record (TAR) reflec "lamb's wool betwe HS [before bed]." first placement of la 2/15/16; four days a order to initiate. R31's Daily Skin/W monitoring was put the surveyor brough Documentation refle-	erformed on 2/17/16 reported re clear of any forms of rity and did not identify R31 16 treatment administration ted the physician's order, en toes daily, change q [every] Documentation indicated the amb's wool occurred on after the physician gave the ound Monitoring indicated in place for the scabs after nt it to the attention to RN-B. ected the first day of routine	r			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00390	B. WING	B. WING		25/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 7	2 565			
	lacked routine mon reflect monitoring o and symptoms of ir care plan. During an interview explained her expe related skin concer procedures and car wound is identified monitor, document, flow sheet. A facility policy for r was requested and SUGGESTED MET facility could review	impaired skin on the toes, itoring for healing, and did not f the impaired skin for signs ifection, as directed by the on 2/25/16, at 9:13 a.m. DON ctations for non-pressure ns to follow the policy, re plan. DON stated when the nurses need to make a note, and treat according to the non-pressure related wounds not received. THOD OF CORRECTION: The their policies and procedures mprehensive care plans,				
	develop and provid following the care p nursing documenta impaired skin integ then develop and ir as part as quality as compliance.	e education pertaining to olan, and review standards of tion and monitoring for for any rity issues. The facility could nplement and auditing system ssurance to maintain	/			
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			3/21/16
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs practicable, with the	,			

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STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:		:		PLETED
		00390	B. WING		02/25/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
MEADOV	V MANOR		Γ GRAND AV /IEADOW, M	'ENUE, PO BOX 365 N 55936		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
2 570	Continued From pa	ige 8	2 570			
	guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.				
	by: Based on interview facility failed to revis to reflect new diagr spine fractures, and for 1 of 2 residents Findings include: R45 was admitted t a fall from standing left sided rib fractur fractures. In addition left pleural effusions fluid builds around to back to the facility of hospital discharge of R45's care plan did aftercare instruction fractures and pleura had signs and symp breath, decreased of of skin integrity due plan indicated R45 mobility related to re the care plan was of	ent is not met as evidenced and document review, the se a comprehensive care plan toses of rib fractures, thoracic d pleural effusions after a fall (R45) reviewed for accidents. to the hospital on 1/28/16 after height. R45 sustained acute es and closed thoracic on, R45 was diagnosed with s (condition in which excess the lung). R45 discharged on 1/30/16 according to the summary dated 1/30/16. not reference or give ns/interventions for rib al effusions which may have ptoms of pain, shortness of movement, increased chance to not moving, etc. The care had acute pain and decreased ecent right total hip surgery; lated 7/17/15. However, this		Corrected		
	the fall and fracture R45's hospital discl following after care · Rib fractures us weeks. It is importa · Avoid strenuou	harge summary included the instructions for rib fractures: sually heal on their own in 6-8 int you rest well while it heals.				
nnesota De	epartment of Health					

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00390	B. WING		02/25/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 9	2 570			
	 may cause further for the provent of the provent of the provent of the pain. Take pain med the pain. Take pain med theat can help lessed the pain. Take pain med theat can help lessed the pain. Take pain med theat can help lessed the pain. Take pain med theat can help lessed the pain. Take pain med theat can help lessed theating pad turned 15-20 minutes every but don't sleep on it additional suggestic interventions for pathematical suggestic interventions for pathematical suggestic interventions for pathematical suggestic interventions for pathematical severe nausea, vor The hospital dischar following after care effusions: Will need to comeasures upon dis (cough and take sleevery hour), deep the spirometer (use a rhour while awake) so Patient should pain control regime pulmonary hygiene Patient may utipillow against the control during pulmonary hygiene Patient encoura as possible (when a and improve pulmonary pulmonary pulmonary pulmonary hygiene) 	t pneumonia take 10 deep while awake, take 6 short be ribs with hands or pillow oreaths or coughing can lessen ications as instructed, use of en the pain or swelling. Use a on low or hot water bottle for ry hour as long as you need it, t. The summary also included ons for non-pharmacological in control. y care provider if fever greater mptoms or a cough, thick or te attention for shortness of t pain, difficulty breathing, miting, or abdominal pain. arge summary included the instructions for the pleural ntinue pulmonary hygiene emissal including coughing bw deep breaths at least once oreathing, use of incentive ninimum of 10 times every one and mobilizing as tolerated. continue with oral/transdermal en to allow for participation in lize a rolled up blanket or hest wall to assist with pain ionary hygiene. aged to be out of bed as much allowed) to decrease debility				

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
MEADO	W MANOR		Γ GRAND AVE MEADOW, MN	NUE, PO BOX 365			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C			
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
2 570	Continued From pa	ge 10	2 570				
	upright to decrease pulmonary hygiene. avoiding lifting avoiding overhead a weeks following dis pain/spasms. During an interview director of nursing (a care plan for rib fn DON indicated care revised to reflect loo indicated the discha hospital summary w they give to everybo are not physician's into the care plan. Facility policy Care 8/2013 included, "A individual and/or co address the followin chronic clinical com receiving medicatio including pain-actual SUGGESTED MET facility could review care plan and upda could then educatio planning with acute the resident's care goals and intervent highest practical lew could then develop system as part of th to maintain complia	 [more than] 10 pounds and activities for approximately 6 missal to avoid chest wall on 2/24/16, at 1:49 p.m. the DON) indicated there was not ractures or pleural effusions. a plan should have been cations of pain. The DON arge instructions on the vere general care guidelines ody upon discharge and they orders and do not have to go Plan Completion last revised II care plans should include mbined focus problems that ng areas:" all current and ditions which they are ns, treatment, and or care al or potential. THOD OF CORRECTION: The procedures for revision of te if necessary. The facility on nurses on principles of care condition changes and revise plan to include acute condition ions for returning to the vel of well-being. The facility and implement an auditing neir quality assurance program 					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00390	B. WING		02/25/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEADO	W MANOR		GRAND AV	ENUE, PO BOX 365 N 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLE	
2 830	Continued From pa	ge 11	2 830			
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830		3/21/16	
	receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from th	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility fa monitor for effective interventions to pro	ent is not met as evidenced on, interview, and document ailed comprehensively asses, eness of impaired skin mote healing and prevent new ng for 1 of 3 residents (R31)		Corrected		
	Findings include:					
	diagnoses of diabet dependence, chron disorder, hyperlipide sided weakness, ar to the significant ch 1/27/16 R31 was no Brief Interview for M During an observation	o the facility on 12/4/15 with tes type II, obesity, nicotine ic obstructive pulmonary emia, stroke resulting in left ad history of falling. According ange Minimum Data Set dated of cognitively impaired with a Mental Status score of 13. ion on 2/22/16, at 1:41 p.m. wheelchair in his room with a				

STATEME	ota Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MEADO	W MANOR		Г GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 12	2 830			
	be edematous whe left upper dorsal sic pointing to the right large scab that mea diameter and a sma cm in diameter. Bot in color and were ra approximately 1.0-2 remember how he of R31's care plan ack diabetes; the plan of observe/document/ for dry skin and poor plan further identified develop pressure u direction for staff to skin daily with cares nurse, observe/doc practitioner PRN [a: status: appearance [signs/symptoms] o weekly skin inspect R31's record indica the impaired skin in on 2/17/16 during a information on the k forearm scabbed so and summary area any information. Th progress note inclu- condition, noted 2 s forearm, no redness in the record did no occurred or what ca scratches. Howeve Summary dated 2/S Lt [left] arm-OTA [op in the record if area	2.0 millimeters. R31 could not obtained the injuries. knowledged diagnoses of directed staff to report to medical practitioner or wound healing. The care ed R31 had a potential to lcers. The care plan included , "lotion skin daily, observe s and report changes to the ument/report to medical s needed] changes in skin , color, wound healing, s/sx f infection, wound size, stage,				

	NT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 830	reflect monitoring fr a comprehensive er on 2/9/16. A body a indicated the skin w identify the scabs, w information recorde Care Conference S R31's treatment add not reflect routine in Daily Skin/Wound N evident in the record brought it to the fac lack of monitoring. monitoring form wa days after if the wor 2/9/16 or five days a identified on 2/17/10 R31's record lacked assessment of the in monitoring for heali monitoring of the im symptoms of infecti plan. During an interview nursing assistant (N been there for quite how long they have them. During an observati nursing assistant (N and shoes. The left scabs on the secon the right foot fourth reddened area. Ski	om 2/9/16 through 2/17/16 or valuation of the scabs stated audit completed on 2/10/16 vas clear and intact and did no which conflicts with the ed the previous day on the ummary dated 2/9/16. ministration record (TAR) did npaired skin monitoring. A Monitoring form was not d until after the surveyor ility's attention there was a R31's Daily Skin/Wound s initiated on 2/23/16; fourteer unds were first identified on after if the wounds were first 6.				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00390	B. WING			05/0010
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S			
MEADO	W MANOR		I GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 14	2 830			
	shoes had been rer	moved. R31 stated he was				
	aware of the scabs	, indicated scabs had been				
	there for awhile now	w, stated they were from his				
	shoes and hammer	r toes, and indicated no				
		eing applied. R31 stated,				
	"They put lamb's wool between my toes last					
		having discomfort. Registered				
		ed the room, indicated she				
		ne scabbed areas on the feet.				
	RN-B measured the scabs on the left foot; scab					
	on second digit measured 0.6 cm by 0.4 cm, scab					
	on third digit measured 0.6 cm by 0.8 cm, and the right foot fourth digit reddened area measured 1.0					
	cm by 1.3 cm.					
	R31's record was reviewed. Documentation did					
		not reflect identification of the impaired skin integrity on the R31's toes. A progress note dated				
		ed the physician ordered				
		nb's wool between his toes.				
		did not reflect the indication for	-			
		ool and a signed physician's				
		n for use was not evident. A				
	Body Audit perform	ed the previous day on				
		et/ankles/toes were clear of				
	any forms of impair	ed skin integrity and did not				
	identify R31 had ha					
		erformed on 2/17/16 reported				
		ere clear of any forms of				
		rity and did not identify R31				
	had hammertoes.					
		16 treatment administration				
		ted the physician's order,				
		en toes daily, change q [every]				
		Occumentation indicated the				
		amb's wool occurred on				
		after the physician gave the				
		e TAR reflected wool was				
		om 2/15/16 through 2/25/16				
		of 2 days (documentation treatment was not performed				
	epartment of Health	ireauneni was nui penunneu				

Minnesota Department of Health STATE FORM

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 15	2 830			
	evaluation of the sk the effectiveness of R31's Daily Skin/W monitoring was put the surveyor brough Documentation refil monitoring was 2/2 R31's care plan did to the toes. R31's record lacked assessment of the lacked routine mon reflect monitoring of and symptoms of in care plan. During an interview NA-B stated she wa goes in-between his During an interview LPN-B indicated a p the lamb's wool rela unsure if the lamb's r/t resident refusal f The record did not and the medical rec concerns with mois During an interview director of nursing of could not be found ordered the lamb's possibly related for interview on 2/25/10 physician rounds w nurse had written a did not indicate rea if there were open a request. During an interview	I not reflect the scabbed areas d a comprehensive impaired skin on the toes, itoring for healing, and did not of the impaired skin for signs infection, as instructed by the on 2/23/16, at 12:39 p.m. as not aware of anything that s toes. on 2/23/16, at 12:47 p.m., podiatrist had recommended ated to moisture and was not s wool was in place at that time for nurse to view toes. Of note; reflect a podiatry visit for R31 cord did not reflect any				

STATE FORM

6899

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2016	
		00390	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MEADO\	W MANOR		Г GRAND AVE ЛЕАDOW, MN	NUE, PO BOX 365 I 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830		ge 16 the lamb's wool, "but I haven't	2 830			
	the slightest idea w nurses may have w the request. MD-A s or visualize R31's f MD-A stated he did pertaining to the ord During an interview explained her expe related skin concer procedures and car wound is identified monitor, document, flow sheet. DON ex include location, siz infection, and treath the initial assessme analysis of what ca integrity and a care appropriate interver indicated the nurse wool should have m indicating the reaso the procedure for d integrity at the time A facility policy for m was requested and Facility did provide Form Guidelines us The guidelines inclu- integrity promotes to problems with infec- dressing failure, an with the wound or of this form the nurse skin integrity listed	hy." MD-A explained the ritten down the indication on stated he did not have a visit eet at the time of the order. not make a visit note der. on 2/25/16, at 9:13 a.m. DON ctations for non-pressure ns to follow the policy, re plan. DON stated when the nurses need to make a note, and treat according to the plained documentation should te, any symptoms or signs of nents ordered. DON explained ent needs to include root cause used the impaired skin plan developed with ntions and initiated. DON who requested the lamb's nade a progress note on for the request and follow ocumenting any impaired skin related to the request. non-pressure related wounds				
interests D	skin tears, laceratic pressure ulcers, va	ns, rashes, burns, and scular, and diabetic ulcers." cted nurses to assess				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00390	B. WING		02 /	25/2016
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	dressing/description drainage, surroundi skin condition, and SUGGESTED MET facility could review for skin care protoc present education p nursing practice for documentation of ir facility could then d auditing system as maintain compliance	n/color of drainage, amount of ing skin color, surrounding associated pain. HOD OF CORRECTION: The their policies and procedures cols. Review, develop, and pertaining to standards of identification, monitoring, and mpaired skin integrity. The evelop and implement and part as quality assurance to				
2 910	Incontinence Subp. 5. Incontinent have a continuous of management to reconnected a continuous of management to reconnected a continuous of comprehensive resident were A. a resident were without an indwelling unless the resident that catheterization B. a resident were receives appropriate prevent urinary trace	5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home og catheter is not catheterized 's clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to ct infections and to restore as ler function as possible.	2 910			3/21/16
	This MN Requireme	ent is not met as evidenced				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MEADO	W MANOR		T GRAND AV MEADOW, M	ENUE, PO BOX 365 N 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 910	Continued From pa	age 18	2 910			
	facility failed to com change in urinary c	and document review, the nprehensively reassess a ontinence status for 1 of 1 ewed who had a change in		Corrected		
	Findings include:					
	been reassessed to	in continence and had not o determine interventions to further loss of continence.				
	(MDS) dated 1/5/16 incontinent (this wa was not on a toiletin extensive assistant assessment of 1/5/ program was not be incontinence. Howe dated 12/7/15, indic	ondition Minimum Data Set 6 indicated R35 was frequently as a decline for R35) of urine, ing program and required ce to toilet. The MDS (16 indicated that a toileting eing used to manage urinary ever, the admission MDS cated R35 was occasionally a, and was not on a toileting	,			
	indicated, "Intermitt continent of stool. N [sic] day and night. R35's Nurse progre- indicated, "Contine for [R35]. Experien- incontinence. Produ- product. Possible d continence include. Perineum is intact. Toilet. Other contrib	Evaluation dated 12/10/15 tently incontinent of urine, Wears depends through out Peri care assisted by staff." ess note dated 12/10/15 nce evaluation was completed ces episodes of bladder ucts used include uses liagnosis that may affect . Possible medications include Able to use the following puting factors include Mobility.				
	indicated, "Frequer	include." Evaluation dated 1/5/16 htly incont [incontinent] of urine to void, cont/incont.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	-	
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 910	Continued From pa	ge 19	2 910			
		ent] of bowel. Wears aff assist w/toileting needs."				
	indicated, "Continen for [R35]. Experience incontinence. Produ product. Possible d continence include. Perineum is intact. Toilet. Other contribution	ess note dated 1/5/16 nce evaluation was completed ces episodes of both ucts used include uses iagnosis that may affect Possible medications include. Able to use the following puting factors include Mobility. nclude Personal Hygiene ct."				
	12/17/15 indicated, Incontinence r/t [rel staff assist with toile living] recent non-di trochanter, Parkinsi degeneration, HTN DM [diabetes]." Inte "Provide for toileting meals, and per her nursing if incontine Observe/document PRN [as needed] p incontinence: bladd of bladder tone, we decreased bladder	/report to medical practitioner ossible medical causes of ler infection, constipation, loss akening of control muscles, capacity, diabetes, Stroke, ects, Use disposable briefs				
	while in her room. F incontinent of urine home and stated st about how she can	57 p.m. R35 was interviewed R35 stated she had been prior to coming to the nursing aff have not talked to her improve her incontinence. her light on when she had to				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00390	B. WING		02/	25/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	W MANOR			NUE, PO BOX 365		
	GRAND MEADOW, MN 5593					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ge 20	2 910			
	when she needs to she dribbles a lot. F	room. R35 stated she can tell go to the bathroom and stated R35 stated she needed help throom so she did not fall.				
	(RN)-A verified she decline in bladder fi assessments that w and 1/5/16. RN-A si identified in urinary at why the resident would complete a 3 assessment to see resident was incont appropriate toileting restore the bladder functioning. RN-A indicated R35 was verified the facility h	verified R35's care plan occasionally incontinent and had not put any interventions estore R35's bladder to the				
	(FM)-A stated when she was scheduled toileting every two h a problem with man when she lived in th R35 has had proble years. FM-A stated February 11, 2016 s about setting a toile for R35 and she sta	:37 p.m., family member n R35 lived in assisted living to have assistance with nours and stated there was not haging R35's incontinence he assisted living. FM-A stated ems with dribbling urine for at the care conference held she talked to the facility staff ting schedule every two hours ated the facility thought that here a FM-A stated she thought				
	toileting R35 every urinary tract infection her incontinent proof frequently if she we	ea. FM-A stated she thought two hours would help prevent ons, as R35 dribbled urine and duct would be changed more re toileting every two hours, s a creature of habit, had				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00390	B. WING		02 /	2/25/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
MEADO\	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	ige 21	2 910				
	always been a plea people for help.	ser and did not want to bother					
	Procedure: Contine instructed staff to, ' each resident that i bowel is identified a opportunity to achie much normal bladd possible. Appropria be offered to restor possibleeach res [evaluated] on adm significant change	Practice Guideline and ence Evaluation dated 2014 Each facility will ensure that s incontinent of bladder and/or and assessed, given the eve continence or restore as ler and/or bowel function as the treatment and services will re as much function as sident will be evaluate ission, quarterly with a in status or when there has he residents current ."	r				
	director of nursing staff education/train ensure based on th assessment, a nurs resident who is inco appropriate treatme	THOD OF CORRECTION: The or designee would provide ning and complete audits to be comprehensive resident sing home must ensure that a portinent of bladder receives ent and services to restore as ler function as possible.	•				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One	,				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			3/21/16	
	maintain a compred infection control pro current tuberculosis issued by the Unite	e provider must establish and nensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease ntion (CDC), Division of					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MEADO	W MANOR		T GRAND AV MEADOW, M	'ENUE, PO BOX 365 N 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21426	Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must	21426			
	by: Based on interview facility failed to mos guidelines for scree employees reviewe of 6 residents (R35 received tuberculos skin testing (TST) a failed to ensure 41 tuberculosis trainin affect all 28 resider visitors. Findings include: LACK OF TB SCRI TST FOR EMPLOY E-C had hire date of record lacked evide tuberculosis and lat	ent is not met as evidenced and document review, the st current tuberculosis ening and education for 4 of 6 ed (E-C, E-D, E-E, E-F) and 5 b, R39, R31, R38, R51) who sis screening and tuberculosis according to protocol; and of 41 staff received g. This had the potential to other in the facility, staff, and EENING AND/OR TWO STEP YEE: of 11/23/15. E-C's personnel ence of symptom screening for cked evidence of two-step est before working with		Corrected		

STATE FORM

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MEADOW MANOR 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 (X) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Construct and the construction should be cross-reference to the Appropriate DEFICIENCY 21426 Continued From page 23 21426 90 days of hire and should have had the first TST on hire. E-D received a second tuberculin skin test on 2/8/10/16, time unknown, 0 millimeters induration. 21426 E-E had hire date of 12/30/15. E-E's tuberculin skin testing record revealed E-E received a first step tuberculin skin test on 1/10/16 or ten days after being hire and should have been on hire also the results were read on 1/12/16, at 2:00 p.m., less then 48 hours but should have been after 48 hours of receiving the tuberculin skin testing record revealed E-F received a first step tuberculin skin test on 1/13/16 or 13 days after being hire cord revealed E-F received a first step tuberculin skin test on 1/13/16 or 13 days after hire date, at 6:00 a.m. results were read on 11/15/16 at 10:00 a.m. The first TST should have been given on hire. During interview on 2/23/16, at 2:00 p.m., director of nursing verified E-C, P. E-E, E-F did not receive TB skin test or TB skin test of TB skin test of the store to the store TF FOR RESIDENTS: R35 lacked evidence of first step TST results, and lacked evidence of first step TST results, and lacked evidence of second TST. R35 was admitted to the facility on 11/30/15, according to	COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MEADOW MANOR 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 MEADOW MANOR 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) 21426 90 days of hire and should have had the first TST on hire. E-D received a second tuberculin skin test on 2/8/16 at 11:15 a.m. Results were read on 2/10/16, time unknown, 0 millimeters induration. 21426 E-E had hire date of 12/30/15. E-E's tuberculin skin testing record revealed E-E received a first step tuberculin skin test on 1/10/16 or ten days after being hired and should have been on hire also the results were read on 1/15/16 at 10:00 a.m. The first TST should have been given on hire. During interview on 2/23/16, at 2:00 p.m., director of nursing verified E-C, E-D, E-E, E-F did not receive TB skin test or TB skin test or 0 hire. LACK OF TB SCREENING AND/OR TWO STEP TST FOR RESIDENTS: R35 lacked evidence of first step TST results, and lacked evidence of second TST. R35 was admitted to the facility on 11/30/15, according to		
BUMMARY STATEMENT OF DEFICIENCIES GRAND MEADOW, MN 55936 (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 CORRECTIVA (EACH OERICENT X MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTIVA (EACH OCRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) 21426 90 days of hire and should have had the first TST on hire. E-D received a second tuberculin skin test on 2/8/16 at 11:15 a.m. Results were read on 2/10/16, time unknown, 0 millimeters induration. 21426 E-E had hire date of 12/30/15. E-E's tuberculin skin testing record revealed E-E received a first step tuberculin skin test on 1/12/16, at 2:00 p.m., less then 48 hours but should have been after 48 hours of receiving the tuberculin test. E-F had hire date of 12/30/15. E-F's tuberculin skin testing record revealed E-F received a first step tuberculin skin test on 1/13/16 or 13 days after hire date, at 6:00 a.m. results were read on 1/15/16 at 10:00 a.m. The first TST should have been given on hire. During interview on 2/23/16, at 2:00 p.m., director of nursing verified E-C, E-D, E-E, E-F did not receive TB skin test or TB skin test done on hire. LACK OF TB ScheENING AND/OR TWO STEP TST FOR RESIDENTS: R35 lacked evidence of first step TST results, and lacked evidence of first step TST results, admitted to the facility on 11/30/15, according to	02/25/2016	
MEADOW MANCH GRAND MEADOW, MN 55936 [X4] ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICENCY WIST TAG 21426 Continued From page 23 21426 90 days of hire and should have had the first TST on hire. E-D received a second tuberculin skin test on 2/8/16 at 11:15 a.m. Results were read on 2/10/16, time unknown, 0 millimeters induration. 21426 E-E had hire date of 12/30/15. E-E's tuberculin skin testing record revealed E-E received a first step tuberculin skin test on 1/10/16 or ten days after being hire dand should have been on hire also the results were read on 1/12/16, at 2:00 p.m., less then 48 hours but should have been on hire also the results were read on 1/12/16, at 2:00 p.m., less then 48 hours but should have been on hire also the results were read on 1/13/16 or 13 days after hire date, at 6:00 a.m. results were read on 1/15/16 at 10:00 a.m. The first TST should have been given on hire. During interview on 2/23/16, at 2:00 p.m., director of nursing verified E-C, E-D, E-E, E-F did not receive TB skin test or TB skin test done on hire. LACK OF TB SCREENING AND/OR TWO STEP TST FOR RESIDENTS: R35 lacked evidence of first step TST results, and lacked evidence of second TST. R35 was admitted to the facility on 11/30/15, according to		
(Xi) 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) 21426 Continued From page 23 21426 90 days of hire and should have had the first TST on hire. E-D received a second tuberculin skin test on 2/8/16 at 11:15 a.m. Results were read on 2/10/16, time unknown, 0 millimeters induration. 21426 E-E had hire date of 12/30/15. E-E's tuberculin skin testing record revealed E-E received a first step tuberculin skin test on 1/10/16 or ten days after being hired and should have been on hire also the results were read on 1/12/16, at 2:00 p.m., less then 48 hours but should have been after 48 hours of receiving the tuberculin test. E-F had hire date of 12/30/15. E-F's tuberculin skin testing record revealed E-F received a first step tuberculin skin test on 1/13/16 or 13 days after hire date, at 6:00 a.m. results were read on 1/15/16 at 10:00 a.m. The first TST should have been given on hire. During interview on 2/23/16, at 2:00 p.m., director of nursing verified E-C, E-D, E-E, E-F did not receive TB skin test or TB skin test done on hire. LACK OF TB SCREENING AND/OR TWO STEP TST FOR RESIDENTS: R35 lacked evidence of first step TST results, and lacked evidence of second TST. R35 was admitted to the facility on 11/30/15, according to		
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on hire. E-D received a second tuberculin skin test on 2/8/16 at 11:15 a.m. Results were read on 2/10/16, time unknown, 0 millimeters induration. E-E had hire date of 12/30/15. E-E's tuberculin skin testing record revealed E-E received a first step tuberculin skin test on 1/10/16 or ten days after being hired and should have been on hire also the results were read on 1/12/16, at 2:00 p.m., less then 48 hours but should have been after 48 hours of receiving the tuberculin test. E-F had hire date of 12/30/15. E-F's tuberculin skin testing record revealed E-F received a first step tuberculin skin test on 1/13/16 or 13 days after hire date, at 6:00 a.m. results were read on 1/15/16 at 10:00 a.m. The first TST should have been given on hire. During interview on 2/23/16, at 2:00 p.m., director of nursing verified E-C, E-D, E-E, E-F did not receive TB skin test or TB skin test done on hire. LACK OF TB SCREENING AND/OR TWO STEP TST FOR RESIDENTS: R35 lacked evidence of first step TST results, and lacked evidence of first step TST results, and lacked evidence of second TST. R35 was admitted to the facility on 11/30/15, according to		
admission record. Document review of R35's immunization record revealed first step skin test was administered on 11/30/15. There was no further evidence of symptom screening been completed or if a second TST was completed. R39 lacked evidence of skin test read within 48-72 hours. R39 was admitted to the facility on 12/21/15, according to admission record. Document review of R39's tuberculin skin testing record revealed first step skin test was administered on 12/21/15, at 9:30 p.m. Results were read on 12/23/15, at 9:00 p.m., less than 48		

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00390	B. WING		02/	25/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	ge 24	21426			
	12/4/16, according Document review of record revealed first administered on 12 were read on 12/6/7 hours, 0 millimeters test was administer time unknown. Res time unknown, 0 m R38 lacked evidend 48-72 hours. R38 v 5/3/15, according to Document review of record revealed the administered on 5/19/7 millimeters induration R51 lacked evidend 48-72 hours. R51 v 1/4/16, according to Document review of record revealed first on 1/4/16, at 2:30 p the skin test results Second TST was a 11:00 p.m. Results 10:00 p.m., less that millimeters induration During interview on of nursing stated sh tests to be read 48 administered. TUBERCULOSIS E Although requested provide evidence of During interview on	 /4/15, at 1:15 p.m. Results 15, at 12:30 p.m., less than 48 a induration. Second step skin red on 12/18/15, at 7:00 p.m., sults were read on 12/20/15, illimeters induration. ce of skin test read within was admitted to the facility on o admission record. f R38's tuberculin skin testing e second TST was 17/15, time unknown. Results 15, time unknown. Mon. ce of skin test read within was admitted to the facility on o admission record. f R51's tuberculin skin testing t step skin test administered o.m. There was no evidence o o following the TST on 1/4/16. dministered on 1/18/16, at were read on 1/20/16, at an 48 hours, results 0 on. 2/23/16, at 1:24 p.m., director the expected tuberculin skin hours to 72 hours after EDUCATION: the facility was unable to f staff tuberculosis education. 2/24/16, at 8:15 a.m., director acility lacked evidence of staff 	f			

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00390	B. WING		02/	25/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W MANOR		' GRAND AVE IEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21426	Testing (TST) Proto Workers policy, und on page one: "Provide written ren for reading in 48 to was applied within 4 If under 48 hours, e hours and before 7 SUGGESTED MET The director of nurs implement policies State tuberculosis g nursing could provid all staff. The direct audits to ensure sta	bool for Screening Health Care dated, revealed the following ninder to employee to return 72 hours." "Confirm that TST 48 to 72 hours prior to reading. Employee must return after 48 2 hours." THOD FOR CORRECTION: sing could develop and and procedures related to the guidelines. The director of de tuberculosis education to or of nursing could perform	21426			
21535	Drug Usage; Gener Subpart 1. Genera must be free from u unnecessary drug is A. in excessive therapy; B. for excessiv C. without adeo D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, the with provisions in the	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug	21535			3/21/16

Minnesota Department of Health STATE FORM

If continuation sheet 26 of 34

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00390	B. WING		02/2	25/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MEADO\	W MANOR		T GRAND AV MEADOW, M	ENUE, PO BOX 365 N 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 26	21535			
	Operations Manual Long-Term Care Fa Department of Hea Health Care Financ This standard is inc available through th	Appendix P of the State , Guidance to Surveyors for acilities, published by the lth and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan ate Law Library. It is not change.				
	by: Based on observat review the facility fa use of an antidepre	ent is not met as evidenced ion, interview and document ailed to justify the continued essant medication for 1 of 5 riewed for unnecessary		Corrected		
	Findings include:					
	R28 was in the dini	on on 2/23/16 at 12:42 p.m., ng hall eating with other noted to appear calm.				
		ion on 2/24/15 at 8:48 a.m., seated in the dining hall with e appeared calm.				
		ion on 2/25/16 at 8:55 a.m., way speaking with a nurse. be calm.				
	that the resident ha	ecord, dated 6/6/13, indicated ad diagnoses of Alzheimer's mic disorder (chronic				
		ated 9/17/2013, indicated that intidepressant medication				

		alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00390	B. WING		02 /	25/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	stated goal was tha discomfort or adver antidepressant ther consultations with F practitioner to consi clinically appropriate give antidepressant medical practitioner document and repo ongoing signs and s unaltered by antide R28's consultant ph 6/10/15, indicated th taking Zoloft 150 m R28's consultant ph 8/24/15, indicated th been decreased on daily. R28's consultant ph 10/22/15, indicated th been decreased on daily. R28's consultant ph 10/22/15, indicated th been increased on explanation, it state due to a failed grad However, there was of how the failed GI R28's Drug History/ Sheet (no date) state been prescribed Zo 150 mg per day. It s her dose lowered o yearly gradual dose that on 10/1/15, the increased to 150 m	ge 27 epression. The care plan's t R28 was to be free from se reactions related to apy. It recommended R28's pharmacist and medical ider a dosage reduction when e. It also recommended to t medications ordered by the r. It recommended to observe, of the medical practitioner symptoms of depression pressant medications. harmacist review, dated hat the resident had been g by mouth every day. harmacist review, dated hat the resident's Zoloft had 7/23/15 to 100 mg by mouth harmacist review, dated that the resident's Zoloft had 10/1/15 to 150 mg. As an d that the increase had been ual dose reduction (GDR). s no supporting documentation DR had been determined. Gradual Dose Reduction Flow ted that R28 had originally loft on 6/6/13 and received stated that the resident had n 7/23/15 to 100 mg for a e reduction attempt. It stated dose of Zoloft had been g due to a failed gradual dose Again there was not supporting				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
00390		B. WING		02/	25/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MEADO\	W MANOR		T GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 28	21535			
	failed.					
		ta Set (MDS), dated 9/5/15, ent had no symptoms of				
		ehavior Evaluation, dated at the resident exhibited no s.				
	September 2015, d	es, reviewed for the month of lid not mention once that the suffering from any moods or				
	10/1/15, indicated t seen by a physiciar visit. It stated, "Nur something to the ef living much longer little over two mont Zoloft from 150 mg almost (sic) year ar it from 100 to 150. because of time to reduction and she sthen." The note sta R28 stated that she particularly depress the physician order mg daily. It stated, check in 3 or 4 weat that." Again there i	ce progress note, dated that the resident had been in for a sixty day nursing home ses have noted her saying ffect of not wanting to go on and feeling discouraged. A hs ago, we decreased her back to 100 mg daily. About ind a half ago we had increase We decreased it in July [2015] consider a gradual dosage seemed to be doing okay ated that at the visit on 10/1/15 e felt okay and did not feel sed. At the end of the report, red an increase in Zoloft to 150 "Again, will get a progress eks to see how she is doing on is no clear indication as to why why the medication was ne.				
		tes, reviewed from 10/1/15 dicated that the resident had <i>v</i> iors noted once.				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00390	B. WING		02/	25/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MEADO	W MANOR		T GRAND AVE MEADOW, MN	ENUE, PO BOX 365 I 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 29	21535			
	12/3/15, indicated t seen by a physiciar visit. It stated, "No been heard recentl	ce progress note, dated that the resident had been n for a sixty day nursing home depressive statements have y." tta Set (MDS), dated 12/5/15,				
		ent had no symptoms of				
		ehavior Evaluation, dated hat the resident had no moods	3			
	that nursing assista residents), reviewe through January 20	ion Survey Report (a report ants used to chart on d from September 2015 016, indicated that the resident ehaviors noted at all.				
	Nursing Assistant (on 2/24/16 at 12:42 p.m., NA)-A stated that R28 did not r behaviors. She stated that the ad a lot.	9			
	registered nurse (F time R28 was happ that she had never RN-D stated that if	on 2/25/16 at 9:01 a.m., RN)-D stated that most of the by and liked to talk. She stated seen R28 in a sad mood. R28 was engaged in e resident was very pleasant.				
	licensed practical n	on 2/25/16 at 10:00 a.m., hurse (LPN)-A stated that she 28 have a depressed mood or				
		on 2/25/16 at 10:09 a.m., NA)-B stated that R28 never				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W MANOR		Γ GRAND AVE MEADOW, MN	NUE, PO BOX 365 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	cried or seemed de had seemed happy known R28 for as lo resided at the facilit When interviewed of director of social se justification to increa- there had been no of the resident had be prior to the increase have been more to dosage of the Zolof Review of the docum Behavior Document 2014), stated that th communicate conce behaviors and provi for practice decision resident plan of car behavior evaluation residents on admiss prior to the use of a psychoactive medic the medication and related to the use o a behavior note was documenting incide Documentation entre each episode which exception. SUGGESTED MET director of nursing of staff on monitoring to why the medication	pressed. She stated that R28 She stated that she had ong as the resident had y. on 2/25/16 at 10:40 a.m., the rvices was asked about the ase Zoloft on 10/1/15 when documentation to indicate that en having moods or behaviors be stated that there should justify the increase in the t medication. ment titled, Mood and tation Guidelines (November		DEFICIENC	Υ)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00390		. ,	LE CONSTRUCTION (.	X3) DATE SURVEY COMPLETED	
		B. WING		02/25/2016	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	02/23/2010
MEADO	V MANOR		[.] GRAND AV IEADOW, M	/ENUE, PO BOX 365 IN 55936	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE
21535	Continued From pa	age 31	21535		
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685		3/21/16
	including walls, floc systems, and equip continuous state of with regard to the h well-being of the re	olant. The physical plant, brs, ceilings, all furnishings, oment must be kept in a good repair and operation lealth, comfort, safety, and esidents according to a written be and repair program.			
	by: Based on observat review, the facility f in place to identify of	ent is not met as evidenced ion, interview, and document ailed to ensure a system was ongoing physical environment leted for 8 of 23 resident 1, 13, 14, and 17).		Corrected	
	Findings include:				
		<i>v</i> ith maintenance director on n., revealed the following			
		room door frame missing r, sharp edges exposed.			
		room door frame missing r, sharp edges exposed.			
	Room 7large gour and bathroom.	ge in wall between closet door			
	Room 9-two closet	doors with lower edges			

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
00390			B. WING		02/25/201	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEADO\	W MANOR		GRAND AV	ENUE, PO BOX 365 N 55936		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 32	21685			
	missing wood.					
		itstands with areas of worn ood exposed, missing he room door.				
	varnish and bare w	stand with areas of worn ood exposed, metal bathroom metal near the floor, sharp				
	Room 14-missing b door.	aseboard on wall by room				
	Room 17-one night varnish and bare w	stand with areas of worn ood exposed.				
	maintenance direct needed repairs. Ma aware of the areas stated the facility sy maintenance of nee maintenance reque	2/24/16, at 1:00 p.m., or verified these areas of intenance director stated not that needed repairs. He rstem was for staff to notify eded repairs by completing a st form, verbal tell him, send s, and/or voice mail.				
	services director sta	2/25/16, at 8:30 a.m., social ated when staff were hired, I to notify maintenance when d.				
	The administrator of maintenance to dev maintenance of nee maintenance direct	or could educate all staff to of needed repairs. The				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		00390	B. WING		02/:	25/2016
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		20/2010
MEADOV	V MANOR		[.] GRAND AVE IEADOW, MN	NUE, PO BOX 365		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21685	Continued From pa	ige 33	21685			
	-	R CORRECTION: Twenty-one				
nesota D	epartment of Health					

Huntington's Disease F21 0VenOther Spec Rehab. F23 0	tilator/Respiratory Care	e F22 0
Does the facility currently have an organized re	esident group? F24	Yes
Does the facility currently have an organized g members of residents? F25	roup of family	No
Does the facility conduct experimental research	h? <mark>F26</mark>	No
Is the facility part of a continuing care retireme (CCRC)? F27	ent community	No
If the facility currently has a staffing waiver, in the date(s) of the last approval. Indicate the nu granted. If the facility does not have a waiver,	mber of hours waived f	or each type of waiver
Waiver of seven day RN requirement.	Date: mm/dd/yy F28	Hours waived per week: F29
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30	Hours waived per week: F31
Does the facility currently have an approved nu competency program? F32	urse aide training and	No
The following three questions are to be com	pleted by the survey to	eam.
1) Was this a staggered Survey?	No - Not S	taggered
2) If staggered, day of the week starting?	Surveyor	to Complete
3) If staggered, starting time?	Surveyor	to complete AM

FACILITY STAFFING								
	В	С	D					
	Tag #	Services Provided 123	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)			
Administration	F33		148	0	0			
Physician Services	F34	No No Yes						
Medical Director	F35		0	0	20			
Other Physician	F36		0	0	0			
Physician Extender	F37	No No No	0	0	0			

Nursing Services	F38	Yes Yes No			
RN Director of Nursing	F39		80	0	0
Nurses with Admin Duties	F40				0
Registered Nurses	F41		291	26	0
Licensed Practical/ Vocational Nurses	F42		281		0
Certified Nurse Aides	F43		550	249	0
Nurse Aides in Training	F44		0	0	0
Medication	F45		0	0	0
Pharmacists	F46	No No Yes	0	0	8
Dietary Services	F47	YesYes No			
Dietitian	F48		0	0	6
Food Service Workers	F49		92	519	0
Therapeutic Services	F50				
Occupational Therapist	F51	Ye Yes No	0	31	0
Occupational Therapy Assistant	F52		0	38	0
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Ye Yes No	0	18	0
Physical Therapy Assist	F55		0	83	0
Physical Therapy Aides	F56		0	0	0
Speech/Language	F57	Ye Yes No	0	4	0
Therapeutic Recreation Spec.	F58	NO NO NO	0	0	0
Qualified Activities Prof.	F59	Yes Yes No	95	39	0
Other Activities Staff	F60	No No No	0	0	0
Qualified Social Workers	F61	Yes No No	84	0	0

Other Social Services Staff	F62	No No No	0	0	0
Dentists	F63	No No Yes	0	0	2
Podiatrists	F64	No No Yes	0	0	4
Mental Health Services	F65	No No No	0	0	0
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	No No No			
Diagnostic X-ray Services	F68	No No No			
Administration Storage of Blood	F69	No No No			
Housekeeping Services	F70	No No Yes	0	0	140
Other	F71		78	0	0
Name of Person Completing Form: Tom Stevens					

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