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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 57XW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00390

1. MEDICARE/MEDICAID PROVIDER NO.(L 1) **245367**

2. STATE VENDOR OR MEDICAID NO. (L 2) **346314100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW MANOR**
(L4) **210 EAST GRAND AVENUE, PO BOX 365**
(L5) **GRAND MEADOW, MN** (L6) **55936**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B.IIINotIinICmplianceIwithIProgram Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II
05/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/02/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245367 Y1	A. Building B. Wing Y2	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0167	Correction	ID Prefix F0278	Correction	ID Prefix F0280	Correction
Reg. # 483.10(g)(1)	Completed	Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	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	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	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(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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	05/02/2016	31221	4/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/25/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245367 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/28/2016 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 03/21/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 03/21/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 05/02/2016	SIGNATURE OF SURVEYOR 37008	DATE 3/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
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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,

Kamala Fiske-Downing

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00390 Y1	A. Building B. Wing Y2	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 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20302	Correction	ID Prefix 20565	Correction	ID Prefix 20570	Correction
Reg. # MN State Statute 144.6503	Completed	Reg. # 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 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0525 Subp. 5 A.B	Completed	Reg. # MN St. Statute 144A.04 Subd. 3	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 Rule4658.1315 Subp.1 ABCD	Completed	Reg. # 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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	5/2/2016	31221	4/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/25/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 57XW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00390

1. MEDICARE/MEDICAID PROVIDER NO.(L 1) **245367**

2. STATE VENDOR OR MEDICAID NO. (L 2) **346314100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW MANOR**
(L4) **210 EAST GRAND AVENUE, PO BOX 365**
(L5) **GRAND MEADOW, MN** (L6) **55936**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Justin Main, HFE NE II 03/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/25/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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

<u>Informal Dispute Resolution</u> - 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
Email: gary.nederhoff@state.mn.us
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the most recent surveys results, were posted for residents and the public as required by this regulation. This had the potential to affect families, staff, visitors and all 28 residents residing at the facility.	F 167	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	3/21/16

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

Electronically 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.

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F 167	Continued From page 1 Findings include: During the initial tour on 2/22/16, at 12:05 p.m. the last posted survey results 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. Since the 3/6/14, survey there was a 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 167	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: " On 2/22/2016 the current survey results were placed in a labeled binder that is kept in a readily accessible location.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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.	F 278		3/21/16

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F 278	Continued From page 2 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 facility failed to accurately code a significant change Minimum Data Set (MDS) for 1 of 1 resident (R31) dental status. Findings include: R31 was admitted to the facility on 12/4/15 according to the facility's admission record. During an observation on 2/22/16, at 1:57 p.m. R31 was sitting in a wheelchair in his room conversing with dental hygienist (DH). DH reported she had just completed examining R31's mouth and explained R31 had a lesion on the upper front gum line in tooth areas of 10 and 11. R31 opened his mouth, the lesion is white in color and measured approximately 1 centimeter (cm) in diameter and had no natural teeth (edentulous). DH explained she had just cleaned and removed very heavy plaque build-up from the dentures and stated the dentures are old. DH held the upper denture in her hand and showed the large missing broken area of the denture around tooth numbers 2, 3, and 4.	F 278	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: " R31 a medical review was completed, care plan was updated to reflect oral status and care. Oral dental assessment was completed on 3/14/16. " R31 will be seen by Apple Tree dental on 4/4/2016. " MDS nurse was re-educated regarding the accuracy of MDS and data collection 2/29/2016. " All resident care plans reviewed and	

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F 278	Continued From page 3 R31's significant change Minimum Data Set (MDS) dated 1/27/16 identified R31 had no natural teeth, however did not identify the broken dentures. The 14 day MDS dated 12/18/15 and 30 day MDS dated 1/1/16 both indicated broken dentures, however did not identify R31 to be edentulous. During an interview on 2/23/16, at 1:38 p.m. registered nurse (RN)-A MDS coordinator stated knowledge of the broken dentures and was not aware if R31 received new dentures between the assessment dates of 1/1/16 and 1/25/16. RN-A explained a licensed practical nurse (LPN) had completed the oral assessment, and she 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 278	revised with as needed including; admission, quarterly and changes in condition " All Nursing Staff will be re-educated on the completion and accuracy of oral/dental assessment by 3/23/16. " Residents will continue to be assessed for their individual dental and oral needs upon admission, quarterly, with significant change and as needed. " DNS/designee will audit 2 residents per week for 4 weeks, then 1 resident per week X8 weeks for oral/dental needs by observation and medical review.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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	F 280		3/21/16

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F 280	Continued From page 4 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise a comprehensive care plan to reflect new diagnoses of rib fractures, thoracic spine fractures, and pleural effusions after a fall for 1 of 2 residents (R45) reviewed for accidents. Findings include: R45 was admitted to the hospital on 1/28/16 after a fall from standing height. R45 sustained acute left sided rib fractures and closed thoracic fractures. In addition, R45 was diagnosed with left pleural effusions (condition in which excess fluid builds around the lung). R45 discharged back to the facility on 1/30/16 according to the hospital discharge summary dated 1/30/16. R45's care plan did not reference or give aftercare instructions/interventions for rib fractures and pleural effusions which may have had signs and symptoms of pain, shortness of breath, decreased movement, increased chance of skin integrity due to not moving, etc. The care plan indicated R45 had acute pain and decreased mobility related to recent right total hip surgery; the care plan was dated 7/17/15. However, this had not been reassessed for current pain after the fall and fractures. R45's hospital discharge summary included the following after care instructions for rib fractures: · Rib fractures usually heal on their own in 6-8 weeks. It is important you rest well while it heals. · Avoid strenuous activity.	F 280	F 280 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: " R45 Care plan has been revised to reflect current interventions. R45 Care plan has been revised to reflect current pain needs related to recent rib/spine fractures. Revision completed on 3/23/16 " R45 was seen by MD on 2/11/2016, lung sounds clear, with no cough or shortness of breath noted. " All resident Care Plans will be reviewed and revised as needed including admission, quarterly and with a significant change " All nursing staff will receive re-education regarding revising and updating of the Care plan by 3-23-16 " DNS/Designee will audit 2 Care plans	

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F 280	Continued From page 5 · When pain decreases, you may begin normal slow movements · Be careful to avoid bumping injured ribs, they may cause further pain. · To help prevent pneumonia take 10 deep breaths every hour while awake, take 6 short walks per day, brace ribs with hands or pillow while taking deep breaths or coughing can lessen the pain. · Take pain medications as instructed, use of heat can help lessen the pain or swelling. Use a heating pad turned on low or hot water bottle for 15-20 minutes every hour as long as you need it, but don't sleep on it. The summary also included additional suggestions for non-pharmacological interventions for pain control. · Contact primary care provider if fever greater than 101.5, cold symptoms or a cough, thick or bloody sputum. · Seek immediate attention for shortness of breath and/or chest pain, difficulty breathing, severe nausea, vomiting, or abdominal pain. The hospital discharge summary included the following after care instructions for the pleural effusions: · Will need to continue pulmonary hygiene measures upon dismissal including coughing (cough and take slow deep breaths at least once every hour), deep breathing, use of incentive spirometer (use a minimum of 10 times every one hour while awake) and mobilizing as tolerated. · Patient should continue with oral/transdermal pain control regimen to allow for participation in pulmonary hygiene. · Patient may utilize a rolled up blanket or pillow against the chest wall to assist with pain control during pulmonary hygiene. · Patient encouraged to be out of bed as much as possible (when allowed) to decrease debility	F 280	for current interventions for 4 weeks and then 1 Care plans for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction " DNS / Designee responsible.	

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F 280	Continued From page 6 and improve pulmonary hygiene. · Upon dismissal, patient encouraged to sleep upright utilizing a wedge pillows, or to sleep upright to decrease pain and assist with pulmonary hygiene. · avoiding lifting > [more than] 10 pounds and avoiding overhead activities for approximately 6 weeks following dismissal to avoid chest wall pain/spasms. During an interview on 2/24/16, at 1:49 p.m. the director of nursing (DON) indicated there was not a care plan for rib fractures or pleural effusions. DON indicated care plan should have been revised to reflect locations of pain. The DON indicated the discharge instructions on the hospital summary were general care guidelines they give to everybody upon discharge and they are not physician's orders and do not have to go into the care plan. Facility policy Care Plan Completion last revised 8/2013 included, "All care plans should include individual and/or combined focus problems that address the following areas:" all current and chronic clinical conditions which they are receiving medications, treatment, and or care including pain-actual or potential.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 282	F 282	3/21/16

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F 282	Continued From page 7 review, the facility failed to identify, monitor, and provide services to promote healing of non-pressure related impaired skin areas according to the care plan for 1 of 2 residents (R31) reviewed for non-pressure related skin issues. 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. R31's care plan acknowledged diagnoses of diabetes; the plan directed staff to observe/document/report to medical practitioner for dry skin and poor wound healing. The care 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." SCABBED AREAS TO LEFT FOREARM 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 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	F 282	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: " R31 areas of scabbing to left arm are healed at this time. Monitoring was started on 2/23/2016. " R31 scabbed areas to two toes of the left foot, monitoring in place on 2/24/16 and will continue to be monitored until healed. " Re-education will be done with all nursing staff regarding documentation and notification in change of skin integrity by 3 -23-16 " All resident care plans reviewed and revised with as needed including; admission, quarterly and changes in condition " DNS/ Designee will audit skin alteration documentation and care for 2 residents per week for 4 weeks then 1 resident per week for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. " DNS is responsible.	

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F 282	Continued From page 8 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.	F 282		

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F 282	Continued From page 9 nursing assistant (NA)-B stated the scabs have been there for quite some time and not aware how long they have been there or what caused them. During an interview on 2/23/16, at 12:47 p.m. licensed practical nurse (LPN)-B stated the TAR did not reflect monitoring of the scabs on the left arm. SCABBED AREAS TO LEFT FOOT TOES During an observation on 2/24/16, at 7:45 a.m. nursing assistant (NA)-B removed R31's socks and shoes. The left foot showed light brown scabs on the second and third digits (toes) and the right foot fourth digit showed a blanchable reddened area. There was not any type of dressing or protection noted to be in place at the time R31's socks and shoes had been removed. R31 stated he was aware of the scabs, indicated scabs had been there for awhile now, stated they were from his shoes and hammer toes, and indicated no treatments were being applied. R31 stated "they put lamb's wool between my toes last night." Registered nurse (RN)-B entered the room, indicated she was not aware of the 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 2/11/16 simply stated the physician ordered resident to have lamb's wool between his toes. The progress note did not reflect the indication for use of the lamb's wool and a signed physician's order with indication for use was not evident. A	F 282		

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(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 282	Continued From page 10 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 282		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		3/21/16

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	245367	A. BUILDING _____ B. WING _____	02/25/2016

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F 309 SS=D	Continued From page 11 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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	F 309 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: " R31 a comprehensive audit was completed and care plan revised on 3/18/16. " All residents receive a comprehensive body audit on admission, quarterly, annually, significant change, and as needed. " Staff will be re-education regarding skin care, revision of care plan and condition/follow up documentation by 3-23 -16 " DNS/ Designee will audit 2 resident records for completed documentation 2	

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F 309	Continued From page 12 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 care plan acknowledged diagnoses of diabetes; the plan directed staff to observe/document/report to medical practitioner for dry skin and poor wound healing. The care 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	F 309	per week times 4 weeks and then 1 resident record per week times 8 weeks. The data will be shared with the next Quality Assurance meeting for input and further direction. Quality Assurance meeting for input and further direction. " DNS is responsible.	

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F 309	Continued From page 13 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, lacked routine monitoring for healing, and did not reflect monitoring of the impaired skin for signs and symptoms of infection, as instructed by the care plan. During an interview on 2/23/16, at 12:39 p.m. nursing assistant (NA)-B stated the scabs have been there for quite some time and not aware how long they have been there or what caused them. During an interview on 2/23/16, at 12:47 p.m. licensed practical nurse (LPN)-B stated the TAR did not reflect monitoring of the scabs on the left arm. During an observation on 2/24/16, at 7:45 a.m. nursing assistant (NA)-B removed R31's socks and shoes. The left foot showed light brown scabs on the second and third digits (toes) and the right foot fourth digit showed a blanchable reddened area. Skin on both feet appeared dry. There was not any type of dressing or protection noted to be in place at the time R31's socks and shoes had been removed. R31 stated he was aware of the scabs, indicated scabs had been there for awhile now, stated they were from his shoes and hammer toes, and indicated no treatments were being applied. R31 stated,	F 309		

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F 309	Continued From page 14 "They put lamb's wool between my toes last night." R31 denied having discomfort. Registered nurse (RN)-B entered the room, indicated she was not aware of the 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 2/11/16 simply stated the physician ordered resident to have lamb's wool between his toes. The progress note did not reflect the indication for use of the lamb's wool and a signed physician's order with indication for use was not evident. A 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. The TAR reflected wool was placed everyday from 2/15/16 through 2/25/16 with the exception of 2 days (documentation lacked reason why treatment was not performed for 2/19/16 and 2/20/16); the record lacked evaluation of the skin at the time of treatment and the effectiveness of the prescribed treatment. R31's Daily Skin/Wound Monitoring indicated	F 309		

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F 309	Continued From page 15	F 309		

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 instructed by the care plan.
During an interview on 2/23/16, at 12:39 p.m. NA-B stated she was not aware of anything that goes in-between his toes.
During an interview on 2/23/16, at 12:47 p.m., LPN-B indicated a podiatrist had recommended the lamb's wool related to moisture and was not unsure if the lamb's wool was in place at that time r/t resident refusal for nurse to view toes. Of note; The record did not reflect a podiatry visit for R31 and the medical record did not reflect any concerns with moisture.
During an interview on 2/23/16, at 3:45 p.m. director of nursing (DON) reported documentation could not be found as to why the physician had ordered the lamb's wool. Indicated it was possibly related for comfort. During a subsequent interview on 2/25/16, at 9:12 a.m. DON stated physician rounds were performed by her, and a nurse had written a request for lamb's wool but did not indicate reason why. DON could not recall if there were open areas at the time of the request.
During an interview on 2/25/16, at 9:45 a.m. the resident's medical doctor (MD)-A stated, I remember ordering the lamb's wool, "but I haven't the slightest idea why." MD-A explained the nurses may have written down the indication on

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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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F 309	Continued From page 17 skin condition, and associated pain.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: 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 restore or prevent further loss of continence. R35's change of condition Minimum Data Set (MDS) dated 1/5/16 indicated R35 was frequently incontinent (this was a decline for R35) of urine, was not on a toileting program and required extensive assistance to toilet. The MDS assessment of 1/5/16 indicated that a toileting program was not being used to manage urinary incontinence. However, the admission MDS	F 315	F315 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: " R 35 a comprehensive assessment was completed. Care plan/NAR sheets revised to reflect current care needs. " All residents receive a continence evaluation upon admission, quarterly and with a significant change in condition.	3/21/16

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F 315	Continued From page 18 dated 12/7/15, indicated R35 was occasionally incontinent of urine, and was not on a toileting program. R35's Continence Evaluation dated 12/10/15 indicated, "Intermittently incontinent of urine, continent of stool. Wears depends through out [sic] day and night. Peri care assisted by staff." 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	F 315	" DNS/ Designee will complete a continence evaluation audit for 2 residents per week for 4 weeks then 1 resident per week for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. " DNS is responsible.	

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F 315	Continued From page 19	F 315		

trochanter, Parkinson's disease, Macular degeneration, HTN [high blood pressure], type II DM [diabetes]." Interventions directed staff to, "Provide for toileting upon arising, between meals, and per her request, Activities staff: notify nursing if incontinent during activities, Observe/document/report to medical practitioner PRN [as needed] possible medical causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects, Use disposable briefs and change as needed."

On 2/23/2016 at 1:57 p.m. R35 was interviewed while in her room. R35 stated she had been incontinent of urine prior to coming to the nursing home and stated staff have not talked to her about how she can improve her incontinence. R35 stated she put her light on when she had to go to the bathroom and stated staff also offer to take her to the bathroom. R35 stated she can tell when she needs to go to the bathroom and stated she dribbles a lot. R35 stated she needed help with going to the bathroom so she did not fall.

On 2/24/2016 at 12:22 p.m. registered nurse (RN)-A verified she had not identified R35 had a decline in bladder function according to the MDS assessments that were completed on 12/7/15 and 1/5/16. RN-A stated when a decline was identified in urinary incontinence you would look at why the resident had a change in continence, would complete a 3 day bowel and bladder assessment to see what times of the day a resident was incontinent to determine an appropriate toileting schedule to attempt to restore the bladder to the prior level of functioning. RN-A verified R35's care plan

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indicated R35 was occasionally incontinent and verified the facility had not put any interventions into place to help restore R35's bladder to the prior level of functioning.

On 02/24/2016 at 1:37 p.m., family member (FM)-A stated when R35 lived in assisted living she was scheduled to have assistance with toileting every two hours and stated there was not a problem with managing R35's incontinence when she lived in the assisted living. FM-A stated R35 has had problems with dribbling urine for years. FM-A stated at the care conference held February 11, 2016 she talked to the facility staff about setting a toileting schedule every two hours for R35 and she stated the facility thought that would be a good idea. FM-A stated she thought toileting R35 every two hours would help prevent urinary tract infections, as R35 dribbled urine and her incontinent product would be changed more frequently if she were toileting every two hours, and stated R35 was a creature of habit, had always been a pleaser and did not want to bother people for help.

Facility policy titled Practice Guideline and Procedure: Continence Evaluation dated 2014 instructed staff to, "...Each facility will ensure that each resident that is incontinent of bladder and/or bowel is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible. Appropriate treatment and services will be offered to restore as much function as possible ...each resident will be evaluate [evaluated] on admission, quarterly with a significant change in status or when there has been a change in the residents current continence status..."

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to justify the continued use of an antidepressant medication for 1 of 5 residents (R28) reviewed for unnecessary medication use. Findings include: R28 was observed on on 2/23/16 at 12:42 p.m.,	F 329	F 329 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	3/21/16

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F 329	Continued From page 22 R28 was in the dining hall eating with other residents. She was noted to appear calm. During an observation on 2/24/15 at 8:48 a.m., R28 was currently seated in the dining hall with other residents. She appeared calm. During an observation on 2/25/16 at 8:55 a.m., R28 was in the hallway speaking with a nurse. She was noted to be calm. R28's admission record, dated 6/6/13, indicated that the resident had diagnoses of Alzheimer's disease and dysthymic disorder (chronic depressed mood). R28's care plan, dated 9/17/2013, indicated that the resident used antidepressant medication (Zoloft) related to depression. The care plan's stated goal was that R28 was to be free from discomfort or adverse reactions related to antidepressant therapy. It recommended consultations with R28's pharmacist and medical 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.	F 329	solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: " R28 was reviewed for unnecessary medication. Zoloft dose was reduced from 150mg daily to 100mg PO daily per MD on 3/3/2016. " R28 a comprehensive mood and behavior assessment was completed on 3/18/16. " All residents receive a comprehensive mood and behavior assessment upon admission, quarterly and with a significant change in condition. " DNS/ Designee will audit 2 resident records for evidence of documentation to justify the continued use of an antidepressant per week for 4 weeks then 1 resident record for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. " DNS is responsible.	

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F 329	Continued From page 23 R28's consultant pharmacist review, dated 10/22/15, indicated that the resident's Zoloft had been increased on 10/1/15 to 150 mg. As an explanation, it stated that the increase had been due to a failed gradual dose reduction (GDR). However, there was no supporting documentation of how the failed GDR had been determined. R28's Drug History/Gradual Dose Reduction Flow Sheet (no date) stated that R28 had originally been prescribed Zoloft on 6/6/13 and received 150 mg per day. It stated that the resident had her dose lowered on 7/23/15 to 100 mg for a yearly gradual dose reduction attempt. It stated that on 10/1/15, the dose of Zoloft had been increased to 150 mg due to a failed gradual dose reduction attempt. Again there was not supporting evidence in the record as to why the GDR had failed. R28's Minimum Data Set (MDS), dated 9/5/15, indicated the resident had no symptoms of depression. R28's Mood and Behavior Evaluation, dated 9/2/15, indicated that the resident exhibited no moods or behaviors. R28's progress notes, reviewed for the month of September 2015, did not mention once that the resident had been suffering from any moods or behaviors. R28's family practice progress note, dated 10/1/15, indicated that the resident had been seen by a physician for a sixty day nursing home visit. It stated, "Nurses have noted her saying something to the effect of not wanting to go on	F 329		

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living much longer and feeling discouraged. A little over two months ago, we decreased her Zoloft from 150 mg back to 100 mg daily. About almost (sic) year and a half ago we had increase it from 100 to 150. We decreased it in July [2015] because of time to consider a gradual dosage reduction and she seemed to be doing okay then." The note stated that at the visit on 10/1/15 R28 stated that she felt okay and did not feel particularly depressed. At the end of the report, the physician ordered an increase in Zoloft to 150 mg daily. It stated, "Again, will get a progress check in 3 or 4 weeks to see how she is doing on that." Again there is no clear indication as to why the GDR failed nor why the medication was increased at this time.

R28's Progress Notes, reviewed from 10/1/15 through 2/21/16, indicated that the resident had no moods or behaviors noted once.

R28's family practice progress note, dated 12/3/15, indicated that the resident had been seen by a physician for a sixty day nursing home visit. It stated, "No depressive statements have been heard recently."

R28's Minimum Data Set (MDS), dated 12/5/15, indicated the resident had no symptoms of depression.

R28's Mood and Behavior Evaluation, dated 12/9/15, indicated that the resident had no moods or behaviors noted.

R28's Documentation Survey Report (a report that nursing assistants used to chart on residents), reviewed from September 2015 through January 2016, indicated that the resident

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had no moods or behaviors noted at all.

When interviewed on 2/24/16 at 12:42 p.m., Nursing Assistant (NA)-A stated that R28 did not have any moods or behaviors. She stated that the resident liked to read a lot.

When interviewed on 2/25/16 at 9:01 a.m., registered nurse (RN)-D stated that most of the time R28 was happy and liked to talk. She stated that she had never seen R28 in a sad mood. RN-D stated that if R28 was engaged in communication the resident was very pleasant.

When interviewed on 2/25/16 at 10:00 a.m., licensed practical nurse (LPN)-A stated that she had never seen R28 have a depressed mood or crying.

When interviewed on 2/25/16 at 10:09 a.m., Nursing Assistant (NA)-B stated that R28 never cried or seemed depressed. She stated that R28 had seemed happy. She stated that she had known R28 for as long as the resident had resided at the facility.

When interviewed on 2/25/16 at 10:40 a.m., the director of social services was asked about the justification to increase Zoloft on 10/1/15 when there had been no documentation to indicate that the resident had been having moods or behaviors prior to the increase. She stated that there should have been more to justify the increase in the dosage of the Zoloft medication.

Review of the document titled, Mood and Behavior Documentation Guidelines (November 2014), stated that the purpose was to communicate concerns in resident mood and/or

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F 329	Continued From page 26 behaviors and provide documentation of evidence for practice decisions and modifications to the resident plan of care. It stated that a mood and behavior evaluation would be completed for all residents on admission, quarterly, annually and prior to the use of and/or dose change of a psychoactive medication to evaluate the need for the medication and determine the target behavior related to the use of the medication. It stated that a behavior note was to be completed for documenting incidents of behaviors for residents. Documentation entries were to be completed with each episode which were to be charted by exception.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		3/21/16

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F 356	Continued From page 27 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required posting of the daily census on the daily nurse staff posting was current. This had the potential to affect 28 residents residing in the facility, staff, and visitors. Findings include: During the initial tour of the facility on 2/22/16, at 12:05 p.m., the facility staff posting dated 2/22/16, was posted on a bulletin board with the census listed as 31. However, the actual facility census for the current day, 2/22/16, was 28 upon surveyor entrance to the facility. On 02/22/16 at 12:20 p.m., social services director (SSD)-A verified the current number of residents in the building was 28 and stated there were three residents in the hospital. SSD-A verified the census sheet posted for 2/22/16 indicated there were 31 residents and should have indicated 28 residents, the actual number of resident currently in the building. On 02/25/2016 at 12:20 p.m., SSD-A stated the night staff was responsible to update the daily nursing hours. SSD-A stated the census was to	F 356	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 audit 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 monthly QA. The QA committee ill make	

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F 356	Continued From page 28 reflect residents currently in the building and residents that were in the hospital were not to be counted in the daily nursing hours. The facility policy, Nursing Hours Posting, revised 2015 did not direct the facility to include the daily census in the nurse hours posting.	F 356	decisions/ recommendations regarding any necessary follow up. " Executive Director is responsible.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		3/21/16

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F 431	Continued From page 29 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly label medications for 2 of 2 residents (R33, R9) reviewed during medication administration. In addition, the facility failed to prevent the administration of expired tuberculin testing solution for 2 residents (R54, R55) reviewed. Findings include: R33's Order Summary Report, dated 2/18/16, had handwritten orders by the physician: Tramadol (a pain medication) 50 mg by mouth three times, give at 8 a.m., 1 p.m. and 8 p.m. It stated to give with Tylenol. The indication was left hip pain. R33's Medication Administration Record (MAR), reviewed from 2/18/16 through 2/29/16 indicated that the resident had been receiving Tramadol 50 mg by mouth three times a day at 8 a.m., 1 p.m. and 8 p.m. During an observation of a medication administration on 2/22/16 at 6:59 p.m., Registered Nurse (RN)-C prepared to administer R33's medications. The medication package for Tramadol contained the label: 50 mg by mouth three times a day as needed. When asked about the accuracy of the label, RN-C stated that the label on the medication package was not correct	F 431	F 431 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: " R33 upon notification of medication label discrepancy a change label was implemented. Pharmacy was notified and order was changed in the pharmacy system on 3/18/16. " R9 upon notification of medication label discrepancy a change label was implemented. Pharmacy was notified and order was changed in the pharmacy system on 3/18/16. " R54 and R 55 upon notification of given expired tuberculin testing solution their mantoux series were restarted on 3/1/2016. " All medications will be reviewed for accuracy of label to include name, medication, dose route and time of administration by 3-23-16	

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F 431	Continued From page 30 as the order had recently changed. RN-C stated that a sticker should have been placed on the package which would have indicated there was an order change. R9's Order Summary Report, dated 11/11/11, had a physician order for Aspart insulin (a fast-acting insulin): 6 units at 8:00 a.m., 12:00 p.m. and 4:00 p.m. There was an additional order, dated 6/16/11, that R9 was to get additional units of Aspart insulin which depended on what her blood sugar was when she was to be administered 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	F 431	" All licensed staff will be provided re-education on proper verification of medication labels by 3-23-16 including medications with shortened expiration dates, information will be available to all nursing staff. " DNS/ Designee will audit 2 medication labels per week for 4 weeks then 1 medication labels for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. " DNS is responsible.	

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F 431	Continued From page 31	F 431		

solution and one unopened vial of tuberculin testing solution. The opened vial of solution had an opened date of 1/13/16. LPN-A stated that the tuberculin testing solution was only good for 30 days and should have been thrown away and not administered to any residents after it had expired on 2/13/16.

R54's order summary report, dated 2/16/16, indicated that the resident had an order to receive a 1st step tuberculin skin test (TST) (used to test for the presence of tuberculosis) on 2/16/16. R54 had received an outdated dose of tuberculin testing solution.

R55's order summary report, dated 2/18/16, indicated that the resident had an order to receive the 1st step Mantoux (sic) on 2/18/16. And also received an outdated tuberculin solution from the vial with open date of 1/13/16.

During an interview with the Director of Nursing (DON) on 2/25/16 at 1:21 p.m., she stated that she could not verify for certain that both residents had not received the tuberculin testing solution beyond the 30 day expiration once the vial had been opened. She stated that the tuberculin testing solution should have been thrown out after 30 days once the vial had been opened.

Review of the facility policy, titled Medication Labels (2006), it stated that improperly or inaccurately labeled medications were to be rejected and returned to the dispensing pharmacy. It stated that if the physician's directions for use change or the label was inaccurate, the nurse may place a 'directions changed- refer to chart' label on the container

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F 431	Continued From page 32 which would indicate there was a change in the directions for use. It stated that when such a label appeared on the container, the medication nurse was to check the resident's medication administration record (MAR) for current information. It then stated that the dispensing pharmacy was to be informed prior to the next refill of the prescription so the new container would show an accurate label.	F 431		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system was in place to identify ongoing physical environment repairs were completed for 8 of 23 resident rooms (1, 2, 7, 9, 11, 13, 14, and 17). Findings include: Environment tour with maintenance director on 2/24/16, at 1:00 a.m., revealed the following observations: Room 1-metal bathroom door frame missing metal near the floor, sharp edges exposed. Room 2-metal bathroom door frame missing metal near the floor, sharp edges exposed.	F 465	F 465 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: " Upon notification of needed repair in room(s) 7 and 14; maintenance director corrected the issues and repairs have been completed, effective 3/21/16. " Upon notification of needed repair in	3/21/16

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F 465	Continued From page 33 Room 7--large gouge in wall between closet door and bathroom. Room 9-two closet doors with lower edges missing wood. Room 11---two nightstands with areas of worn varnish and bare wood exposed, missing baseboard behind the room door. Room 13-one nightstand with areas of worn varnish and bare wood exposed, metal bathroom door frame missing metal near the floor, sharp edges exposed. Room 14-missing baseboard on wall by room door. Room 17-one nightstand with areas of worn varnish and bare wood exposed. During interview on 2/24/16, at 1:00 p.m., maintenance director verified these areas of 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 465	room 9; maintenance director has ordered material to resolve the observation and plan for repair will be completed by 3/23/16. " Upon notification of needed repair in room(s) 1, 2, and 13; maintenance director has received material quotes and labor estimates for repair of metal bathroom door frame(s). A plan for repair will be implemented by 3/23/16. " Upon notification of needed repair in room(s) 11, 13, and 17; maintenance director has received material quotes for additional nightstands. A plan for repair of nightstands or purchase of additional nightstands will be completed by 3/23/16. " All Staff will be re-educated on how to report areas needing repair by 3/23/16. " ED/Designee will monitor resident rooms weekly for 4 weeks and monthly there after for physical environment issues. Data will be shared at next QA committee by ED/Designee.	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		3/21/16

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F 520	Continued From page 34 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment and Assurance (QA&A) committee effectively sustained ongoing compliance related to repeat quality deficiencies in Minimum Data Set accuracy, monitoring non-pressure related skin issues, medication labeling, and infection control, which were identified during the recertification survey exited 4/2/15. This had the potential to affect all 28 residents who resided in the facility. Findings include:	F 520	F 520 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 35 During interview on 2/25/16, at 2:30 p.m., facility executive director, verified QA&A met quarterly. He stated the committee would be starting a new pain tracking program and psychoactive medication program beginning 3/1/16. During interview at that time, executive director stated he was not sure if the QA&A committee had developed and implemented plans of action to sustain compliance with repeat deficiencies in Minimum Data Set accuracy, monitoring non-pressure related skin issues, medication labeling, and infection control. These deficiencies were identified during the recertification survey exited 4/2/15. See F278: The facility failed to accurately code an admission Minimum Data Set (MDS) for 1 of 1 resident (R35) reviewed for urinary incontinence. In addition, the facility failed to accurately complete a comprehensive assessment for dental status for 1 of 1 residents (R31) reviewed for dental status. See F309: The facility failed to comprehensively asses and monitor impaired skin integrity for 1 of 1 residents (R31) who was diabetic. See F431: The facility failed to properly label medications for 2 of 2 residents (R33, R9) reviewed during medication administration. In 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,	F 520	that with respect to: " QA committee meetings are held monthly with involvement from facility designated physician at least quarterly; and at least 3 other members of the facility□s staff. " ED/Designee, is responsible for facilitating meeting, effective 3/17/16. " All department supervisors will be provided education on the Plan Do Study Act (PDSA) model; to address problematic areas and create a process of improvement for identified issues with respect to which quality assessment and assurance activities are necessary. Training to be completed on or before 3/23/16. ED/designee is responsible. " Regarding infection control; F441 was removed. " Regarding medication labeling; see POC for F431. " Regarding MDS accuracy; see POC for F278. " Regarding MDS accuracy; see POC for F309. " Planned QA committee agenda for April 2016 has included items e □ g, as referenced above. ED/designee is responsible for completion of QA committee agenda.	

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F 520	Continued From page 36 the facility failed to prevent the potential for infection for an inhaler with a spacer attached located in the medication cart (R31). Document review of facility Quality Assurance and Performance Improvement (QAPI) Implementation policy, undated, directed facility oversight responsibilities on page two, included quality measures and survey outcomes. QAPI data collection tools on page three included Centers for Medicare and Medicaid (CASPER) reports and Minnesota quality indicator reports. Page three directed "The community shall conduct PIPs (Performance Improvement Project) designed to achieve and sustain performance improvement over time.	F 520		

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	245367	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2016**

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MEADOW MANOR	**210 EAST GRAND AVENUE, PO BOX 365** **GRAND MEADOW, MN 55936**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC 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. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on February 23,2016. At the time of this survey, Meadow Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

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

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	245367	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2016**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion 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 sprinkled. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain one or more corridor doors in the means of egress in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.6.3. and Chapter 7, Section 7.2. In a fire emergency, this deficient practice could adversely affect any patients, staff or visitors within the affected smoke compartment. FINDINGS INCLUDE: During the facility tour between the hours of 9:30 AM and 12:30 PM on 2/23/2016, observation revealed: 1. Resident room #16 did not positively latch when tested. Door is warped and in disrepair. This deficiency was verified by the Maintenance	K 018	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: " Upon notification of needed repair in room 16; maintenance director sought out a quote for material needed for repair, and a new door was ordered, effective 3/14/16.	3/21/16

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K 018	Continued From page 3 Superior at the time of discovery.	K 018	" The maintenance director and/or his designee will visually inspect all facility doors to ensure doors positively latch, as not to affect a smoke compartment. " The maintenance director is responsible for this area of compliance.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all 27 residents within the smoke compartments. Findings include: On facility tour between 09:00 AM and 12:30 PM on 02/23/2016, it was observed that the aest and west wings had penetrations that the smoke barrier doors above ceiling tiles around wires. This deficiency was verified by Maintenance Superior at the time of discovery.	K 025	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: " Upon notification of needed repair in room 16; maintenance director sought out a quote for material needed for repair, and a new door was ordered, effective 3/14/16. " The maintenance director and/or his designee will visually inspect all facility doors to ensure doors positively latch, as not to affect a smoke compartment. " The maintenance director is responsible for this area of compliance.	3/21/16

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MDH
Minnesota
Department
of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	02/25/2016

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

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

Electronically Signed | 03/21/16

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 22, 23, 24 & 25, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.	2 302		3/21/16

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2 302	Continued From page 2 (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide a description of the facility's dementia program to consumers in either written or electronic form. During an interview on 2/25/16, at 9:43 a.m. licensed social worker (LSW) stated the facility does not currently have a method of communicating their dementia program to consumers. SUGGESTED METHOD OF CORRECTION: The facility could review the Minnesota statutes for dementia training and develop a written or electronic communication means of communicating their dementia training to the consumer. The facility could implement the communication into their admission process. The facility could then create and implement an	2 302	Corrected	

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2 302	Continued From page 3 auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify, monitor, and provide services to promote healing of non-pressure related impaired skin areas according to the care plan for 1 of 2 residents (R31) reviewed for non-pressure related skin issues. 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. R31's care plan acknowledged diagnoses of diabetes; the plan directed staff to observe/document/report to medical practitioner for dry skin and poor wound healing. The care 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	2 565	Corrected	3/21/16

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	00390	A. BUILDING: _____ B. WING _____	02/25/2016

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MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

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2 565	Continued From page 4 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." SCABBED AREAS TO LEFT FOREARM 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 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 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	2 565		

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2 565	Continued From page 5	2 565		

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. nursing assistant (NA)-B stated the scabs have been there for quite some time and not aware how long they have been there or what caused them.
During an interview on 2/23/16, at 12:47 p.m. licensed practical nurse (LPN)-B stated the TAR did not reflect monitoring of the scabs on the left arm.

SCABBED AREAS TO LEFT FOOT TOES
During an observation on 2/24/16, at 7:45 a.m. nursing assistant (NA)-B removed R31's socks and shoes. The left foot showed light brown scabs on the second and third digits (toes) and the right foot fourth digit showed a blanchable reddened area. There was not any type of dressing or protection noted to be in place at the time R31's socks and shoes had been removed. R31 stated he was aware of the scabs, indicated scabs had been there for awhile now, stated they were from his shoes and hammer toes, and indicated no treatments were being applied. R31

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2 565	Continued From page 6 stated "they put lamb's wool between my toes last night." Registered nurse (RN)-B entered the room, indicated she was not aware of the 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 2/11/16 simply stated the physician ordered resident to have lamb's wool between his toes. The progress note did not reflect the indication for use of the lamb's wool and a signed physician's order with indication for use was not evident. A 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	2 565		

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2 565	Continued From page 7 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. SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures for following the comprehensive care plans, develop and provide education pertaining to following the care plan, and review standards of nursing documentation and monitoring for for any impaired skin integrity issues. The facility could then develop and implement and auditing system as part as quality assurance to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised 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, with the	2 570		3/21/16

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2 570	Continued From page 8 participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise a comprehensive care plan to reflect new diagnoses of rib fractures, thoracic spine fractures, and pleural effusions after a fall for 1 of 2 residents (R45) reviewed for accidents. Findings include: R45 was admitted to the hospital on 1/28/16 after a fall from standing height. R45 sustained acute left sided rib fractures and closed thoracic fractures. In addition, R45 was diagnosed with left pleural effusions (condition in which excess fluid builds around the lung). R45 discharged back to the facility on 1/30/16 according to the hospital discharge summary dated 1/30/16. R45's care plan did not reference or give aftercare instructions/interventions for rib fractures and pleural effusions which may have had signs and symptoms of pain, shortness of breath, decreased movement, increased chance of skin integrity due to not moving, etc. The care plan indicated R45 had acute pain and decreased mobility related to recent right total hip surgery; the care plan was dated 7/17/15. However, this had not been reassessed for current pain after the fall and fractures. R45's hospital discharge summary included the following after care instructions for rib fractures: · Rib fractures usually heal on their own in 6-8 weeks. It is important you rest well while it heals. · Avoid strenuous activity. · When pain decreases, you may begin normal	2 570	Corrected	

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2 570	Continued From page 9 slow movements · Be careful to avoid bumping injured ribs, they may cause further pain. · To help prevent pneumonia take 10 deep breaths every hour while awake, take 6 short walks per day, brace ribs with hands or pillow while taking deep breaths or coughing can lessen the pain. · Take pain medications as instructed, use of heat can help lessen the pain or swelling. Use a heating pad turned on low or hot water bottle for 15-20 minutes every hour as long as you need it, but don't sleep on it. The summary also included additional suggestions for non-pharmacological interventions for pain control. · Contact primary care provider if fever greater than 101.5, cold symptoms or a cough, thick or bloody sputum. · Seek immediate attention for shortness of breath and/or chest pain, difficulty breathing, severe nausea, vomiting, or abdominal pain. The hospital discharge summary included the following after care instructions for the pleural effusions: · Will need to continue pulmonary hygiene measures upon dismissal including coughing (cough and take slow deep breaths at least once every hour), deep breathing, use of incentive spirometer (use a minimum of 10 times every one hour while awake) and mobilizing as tolerated. · Patient should continue with oral/transdermal pain control regimen to allow for participation in pulmonary hygiene. · Patient may utilize a rolled up blanket or pillow against the chest wall to assist with pain control during pulmonary hygiene. · Patient encouraged to be out of bed as much as possible (when allowed) to decrease debility and improve pulmonary hygiene. · Upon dismissal, patient encouraged to sleep	2 570		

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2 570	Continued From page 10 upright utilizing a wedge pillows, or to sleep upright to decrease pain and assist with pulmonary hygiene. · avoiding lifting > [more than] 10 pounds and avoiding overhead activities for approximately 6 weeks following dismissal to avoid chest wall pain/spasms. During an interview on 2/24/16, at 1:49 p.m. the director of nursing (DON) indicated there was not a care plan for rib fractures or pleural effusions. DON indicated care plan should have been revised to reflect locations of pain. The DON indicated the discharge instructions on the hospital summary were general care guidelines they give to everybody upon discharge and they are not physician's orders and do not have to go into the care plan. Facility policy Care Plan Completion last revised 8/2013 included, "All care plans should include individual and/or combined focus problems that address the following areas:" all current and chronic clinical conditions which they are receiving medications, treatment, and or care including pain-actual or potential. SUGGESTED METHOD OF CORRECTION: The facility could review procedures for revision of care plan and update if necessary. The facility could then education nurses on principles of care planning with acute condition changes and revise the resident's care plan to include acute condition goals and interventions for returning to the highest practical level of well-being. The facility could then develop and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 570		

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2 830	Continued From page 11	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed 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	2 830	Corrected	3/21/16

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2 830	Continued From page 12 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 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 care plan acknowledged diagnoses of diabetes; the plan directed staff to observe/document/report to medical practitioner for dry skin and poor wound healing. The care 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	2 830		

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2 830	Continued From page 13 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, lacked routine monitoring for healing, and did not reflect monitoring of the impaired skin for signs and symptoms of infection, as instructed by the care plan. During an interview on 2/23/16, at 12:39 p.m. nursing assistant (NA)-B stated the scabs have been there for quite some time and not aware how long they have been there or what caused them. During an interview on 2/23/16, at 12:47 p.m. licensed practical nurse (LPN)-B stated the TAR did not reflect monitoring of the scabs on the left arm. During an observation on 2/24/16, at 7:45 a.m. nursing assistant (NA)-B removed R31's socks and shoes. The left foot showed light brown scabs on the second and third digits (toes) and the right foot fourth digit showed a blanchable reddened area. Skin on both feet appeared dry. There was not any type of dressing or protection noted to be in place at the time R31's socks and	2 830		

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2 830	Continued From page 14 shoes had been removed. R31 stated he was aware of the scabs, indicated scabs had been there for awhile now, stated they were from his shoes and hammer toes, and indicated no treatments were being applied. R31 stated, "They put lamb's wool between my toes last night." R31 denied having discomfort. Registered nurse (RN)-B entered the room, indicated she was not aware of the 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 2/11/16 simply stated the physician ordered resident to have lamb's wool between his toes. The progress note did not reflect the indication for use of the lamb's wool and a signed physician's order with indication for use was not evident. A 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. The TAR reflected wool was placed everyday from 2/15/16 through 2/25/16 with the exception of 2 days (documentation lacked reason why treatment was not performed	2 830		

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2 830	Continued From page 15 for 2/19/16 and 2/20/16); the record lacked evaluation of the skin at the time of treatment and the effectiveness of the prescribed treatment. 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 instructed by the care plan. During an interview on 2/23/16, at 12:39 p.m. NA-B stated she was not aware of anything that goes in-between his toes. During an interview on 2/23/16, at 12:47 p.m., LPN-B indicated a podiatrist had recommended the lamb's wool related to moisture and was not unsure if the lamb's wool was in place at that time r/t resident refusal for nurse to view toes. Of note; The record did not reflect a podiatry visit for R31 and the medical record did not reflect any concerns with moisture. During an interview on 2/23/16, at 3:45 p.m. director of nursing (DON) reported documentation could not be found as to why the physician had ordered the lamb's wool. Indicated it was possibly related for comfort. During a subsequent interview on 2/25/16, at 9:12 a.m. DON stated physician rounds were performed by her, and a nurse had written a request for lamb's wool but did not indicate reason why. DON could not recall if there were open areas at the time of the request. During an interview on 2/25/16, at 9:45 a.m. the resident's medical doctor (MD)-A stated, I	2 830		

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2 830	Continued From page 16 remember ordering the lamb's wool, "but I haven't the slightest idea why." MD-A explained the nurses may have written down the indication on 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	2 830		

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2 830	Continued From page 17 dressing/description/color of drainage, amount of drainage, surrounding skin color, surrounding skin condition, and associated pain. SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures for skin care protocols. Review, develop, and present education pertaining to standards of nursing practice for identification, monitoring, and documentation of impaired skin integrity. The facility could then develop and implement and auditing system as part as quality assurance to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by:	2 910		3/21/16

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2 910	Continued From page 18 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 restore or prevent further loss of continence. R35's change of condition Minimum Data Set (MDS) dated 1/5/16 indicated R35 was frequently incontinent (this was a decline for R35) of urine, was not on a toileting program and required extensive assistance to toilet. The MDS assessment of 1/5/16 indicated that a toileting program was not being used to manage urinary incontinence. However, the admission MDS dated 12/7/15, indicated R35 was occasionally incontinent of urine, and was not on a toileting program. R35's Continence Evaluation dated 12/10/15 indicated, "Intermittently incontinent of urine, continent of stool. Wears depends through out [sic] day and night. Peri care assisted by staff." 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.	2 910	Corrected	

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2 910	Continued From page 19 [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 trochanter, Parkinson's disease, Macular degeneration, HTN [high blood pressure], type II DM [diabetes]." Interventions directed staff to, "Provide for toileting upon arising, between meals, and per her request, Activities staff: notify nursing if incontinent during activities, Observe/document/report to medical practitioner PRN [as needed] possible medical causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects, Use disposable briefs and change as needed." On 2/23/2016 at 1:57 p.m. R35 was interviewed while in her room. R35 stated she had been incontinent of urine prior to coming to the nursing home and stated staff have not talked to her about how she can improve her incontinence. R35 stated she put her light on when she had to go to the bathroom and stated staff also offer to	2 910		

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2 910	Continued From page 20	2 910		

take her to the bathroom. R35 stated she can tell when she needs to go to the bathroom and stated she dribbles a lot. R35 stated she needed help with going to the bathroom so she did not fall.

On 2/24/2016 at 12:22 p.m. registered nurse (RN)-A verified she had not identified R35 had a decline in bladder function according to the MDS assessments that were completed on 12/7/15 and 1/5/16. RN-A stated when a decline was identified in urinary incontinence you would look at why the resident had a change in continence, would complete a 3 day bowel and bladder assessment to see what times of the day a resident was incontinent to determine an appropriate toileting schedule to attempt to restore the bladder to the prior level of functioning. RN-A verified R35's care plan indicated R35 was occasionally incontinent and verified the facility had not put any interventions into place to help restore R35's bladder to the prior level of functioning.

On 02/24/2016 at 1:37 p.m., family member (FM)-A stated when R35 lived in assisted living she was scheduled to have assistance with toileting every two hours and stated there was not a problem with managing R35's incontinence when she lived in the assisted living. FM-A stated R35 has had problems with dribbling urine for years. FM-A stated at the care conference held February 11, 2016 she talked to the facility staff about setting a toileting schedule every two hours for R35 and she stated the facility thought that would be a good idea. FM-A stated she thought toileting R35 every two hours would help prevent urinary tract infections, as R35 dribbled urine and her incontinent product would be changed more frequently if she were toileting every two hours, and stated R35 was a creature of habit, had

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2 910	Continued From page 21 always been a pleaser and did not want to bother people for help. Facility policy titled Practice Guideline and Procedure: Continence Evaluation dated 2014 instructed staff to, "...Each facility will ensure that each resident that is incontinent of bladder and/or bowel is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible. Appropriate treatment and services will be offered to restore as much function as possible ...each resident will be evaluate [evaluated] on admission, quarterly with a significant change in status or when there has been a change in the residents current continence status..." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee would provide staff education/training and complete audits to ensure based on the comprehensive resident assessment, a nursing home must ensure that a resident who is incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of	21426		3/21/16

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21426	Continued From page 22 Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to most current tuberculosis guidelines for screening and education for 4 of 6 employees reviewed (E-C, E-D, E-E, E-F) and 5 of 6 residents (R35, R39, R31, R38, R51) who received tuberculosis screening and tuberculosis skin testing (TST) according to protocol; and failed to ensure 41 of 41 staff received tuberculosis training. This had the potential to affect all 28 residents in the facility, staff, and visitors. Findings include: LACK OF TB SCREENING AND/OR TWO STEP TST FOR EMPLOYEE: E-C had hire date of 11/23/15. E-C's personnel record lacked evidence of symptom screening for tuberculosis and lacked evidence of two-step tuberculosis skin test before working with residents. E-D had hire date of 1/29/16. E-D's tuberculin skin testing record lacked a negative TST within	21426	Corrected	

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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.
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 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 hours, results were 0 millimeters induration.
R31 lacked evidence of skin test read within

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21426	Continued From page 24 48-72 hours. R31 was admitted to the facility on 12/4/16, according to admission record. Document review of R31's tuberculin skin testing record revealed first step skin test was administered on 12/4/15, at 1:15 p.m. Results were read on 12/6/15, at 12:30 p.m., less than 48 hours, 0 millimeters induration. Second step skin test was administered on 12/18/15, at 7:00 p.m., time unknown. Results were read on 12/20/15, time unknown, 0 millimeters induration. R38 lacked evidence of skin test read within 48-72 hours. R38 was admitted to the facility on 5/3/15, according to admission record. Document review of R38's tuberculin skin testing record revealed the second TST was administered on 5/17/15, time unknown. Results were read on 5/19/15, time unknown, 0 millimeters induration. R51 lacked evidence of skin test read within 48-72 hours. R51 was admitted to the facility on 1/4/16, according to admission record. Document review of R51's tuberculin skin testing record revealed first step skin test administered on 1/4/16, at 2:30 p.m. There was no evidence of the skin test results following the TST on 1/4/16. Second TST was administered on 1/18/16, at 11:00 p.m. Results were read on 1/20/16, at 10:00 p.m., less than 48 hours, results 0 millimeters induration. During interview on 2/23/16, at 1:24 p.m., director of nursing stated she expected tuberculin skin tests to be read 48 hours to 72 hours after administered. TUBERCULOSIS EDUCATION: Although requested, the facility was unable to provide evidence of staff tuberculosis education. During interview on 2/24/16, at 8:15 a.m., director of nursing verified facility lacked evidence of staff tuberculosis education. Document review of facility Tuberculin Skin	21426		

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21426	Continued From page 25 Testing (TST) Protocol for Screening Health Care Workers policy, undated, revealed the following on page one: "Provide written reminder to employee to return for reading in 48 to 72 hours." "Confirm that TST was applied within 48 to 72 hours prior to reading. If under 48 hours, employee must return after 48 hours and before 72 hours." SUGGESTED METHOD FOR CORRECTION: The director of nursing could develop and implement policies and procedures related to the State tuberculosis guidelines. The director of nursing could provide tuberculosis education to all staff. The director of nursing could perform audits to ensure staff compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section	21535		3/21/16

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21535	Continued From page 26 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to justify the continued use of an antidepressant medication for 1 of 5 residents (R28) reviewed for unnecessary medication use. Findings include: R28 was observed on on 2/23/16 at 12:42 p.m., R28 was in the dining hall eating with other residents. She was noted to appear calm. During an observation on 2/24/15 at 8:48 a.m., R28 was currently seated in the dining hall with other residents. She appeared calm. During an observation on 2/25/16 at 8:55 a.m., R28 was in the hallway speaking with a nurse. She was noted to be calm. R28's admission record, dated 6/6/13, indicated that the resident had diagnoses of Alzheimer's disease and dysthymic disorder (chronic depressed mood). R28's care plan, dated 9/17/2013, indicated that the resident used antidepressant medication	21535	Corrected	

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(Zoloft) related to depression. The care plan's stated goal was that R28 was to be free from discomfort or adverse reactions related to antidepressant therapy. It recommended consultations with R28's pharmacist and medical 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.

R28's consultant pharmacist review, dated 10/22/15, indicated that the resident's Zoloft had been increased on 10/1/15 to 150 mg. As an explanation, it stated that the increase had been due to a failed gradual dose reduction (GDR). However, there was no supporting documentation of how the failed GDR had been determined.

R28's Drug History/Gradual Dose Reduction Flow Sheet (no date) stated that R28 had originally been prescribed Zoloft on 6/6/13 and received 150 mg per day. It stated that the resident had her dose lowered on 7/23/15 to 100 mg for a yearly gradual dose reduction attempt. It stated that on 10/1/15, the dose of Zoloft had been increased to 150 mg due to a failed gradual dose reduction attempt. Again there was not supporting evidence in the record as to why the GDR had

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21535	Continued From page 28 failed. R28's Minimum Data Set (MDS), dated 9/5/15, indicated the resident had no symptoms of depression. R28's Mood and Behavior Evaluation, dated 9/2/15, indicated that the resident exhibited no moods or behaviors. R28's progress notes, reviewed for the month of September 2015, did not mention once that the resident had been suffering from any moods or behaviors. R28's family practice progress note, dated 10/1/15, indicated that the resident had been seen by a physician for a sixty day nursing home visit. It stated, "Nurses have noted her saying something to the effect of not wanting to go on living much longer and feeling discouraged. A little over two months ago, we decreased her Zoloft from 150 mg back to 100 mg daily. About almost (sic) year and a half ago we had increase it from 100 to 150. We decreased it in July [2015] because of time to consider a gradual dosage reduction and she seemed to be doing okay then." The note stated that at the visit on 10/1/15 R28 stated that she felt okay and did not feel particularly depressed. At the end of the report, the physician ordered an increase in Zoloft to 150 mg daily. It stated, "Again, will get a progress check in 3 or 4 weeks to see how she is doing on that." Again there is no clear indication as to why the GDR failed nor why the medication was increased at this time. R28's Progress Notes, reviewed from 10/1/15 through 2/21/16, indicated that the resident had no moods or behaviors noted once.	21535		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 29 R28's family practice progress note, dated 12/3/15, indicated that the resident had been seen by a physician for a sixty day nursing home visit. It stated, "No depressive statements have been heard recently." R28's Minimum Data Set (MDS), dated 12/5/15, indicated the resident had no symptoms of depression. R28's Mood and Behavior Evaluation, dated 12/9/15, indicated that the resident had no moods or behaviors noted. R28's Documentation Survey Report (a report that nursing assistants used to chart on residents), reviewed from September 2015 through January 2016, indicated that the resident had no moods or behaviors noted at all. When interviewed on 2/24/16 at 12:42 p.m., Nursing Assistant (NA)-A stated that R28 did not have any moods or behaviors. She stated that the resident liked to read a lot. When interviewed on 2/25/16 at 9:01 a.m., registered nurse (RN)-D stated that most of the time R28 was happy and liked to talk. She stated that she had never seen R28 in a sad mood. RN-D stated that if R28 was engaged in communication the resident was very pleasant. When interviewed on 2/25/16 at 10:00 a.m., licensed practical nurse (LPN)-A stated that she had never seen R28 have a depressed mood or crying. When interviewed on 2/25/16 at 10:09 a.m., Nursing Assistant (NA)-B stated that R28 never	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	02/25/2016

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21535	Continued From page 30 cried or seemed depressed. She stated that R28 had seemed happy. She stated that she had known R28 for as long as the resident had resided at the facility. When interviewed on 2/25/16 at 10:40 a.m., the director of social services was asked about the justification to increase Zoloft on 10/1/15 when there had been no documentation to indicate that the resident had been having moods or behaviors prior to the increase. She stated that there should have been more to justify the increase in the dosage of the Zoloft medication. Review of the document titled, Mood and Behavior Documentation Guidelines (November 2014), stated that the purpose was to communicate concerns in resident mood and/or behaviors and provide documentation of evidence for practice decisions and modifications to the resident plan of care. It stated that a mood and behavior evaluation would be completed for all residents on admission, quarterly, annually and prior to the use of and/or dose change of a psychoactive medication to evaluate the need for the medication and determine the target behavior related to the use of the medication. It stated that a behavior note was to be completed for documenting incidents of behaviors for residents. Documentation entries were to be completed with each episode which were to be charted by exception. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service staff on monitoring medicaiton for justification as to why the medication was increased based on sound symptoms supporting the need for the medication.	21535		

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21535	Continued From page 31 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system was in place to identify ongoing physical environment repairs were completed for 8 of 23 resident rooms (1, 2, 7, 9, 11, 13, 14, and 17). Findings include: Environment tour with maintenance director on 2/24/16, at 1:00 a.m., revealed the following observations: Room 1-metal bathroom door frame missing metal near the floor, sharp edges exposed. Room 2-metal bathroom door frame missing metal near the floor, sharp edges exposed. Room 7--large gouge in wall between closet door and bathroom. Room 9-two closet doors with lower edges	21685	Corrected	3/21/16

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21685	Continued From page 32 missing wood. Room 11---two nightstands with areas of worn varnish and bare wood exposed, missing baseboard behind the room door. Room 13-one nightstand with areas of worn varnish and bare wood exposed, metal bathroom door frame missing metal near the floor, sharp edges exposed. Room 14-missing baseboard on wall by room door. Room 17-one nightstand with areas of worn varnish and bare wood exposed. During interview on 2/24/16, at 1:00 p.m., maintenance director verified these areas of 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. SUGGESTED METHOD OF CORRECTION: The administrator could work with the director of maintenance to develop a system to notify maintenance of needed repairs. The maintenance director could educate all staff to notify maintenance of needed repairs. The director of nursing could monitor staff compliance.	21685		

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21685	Continued From page 33 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

Huntington's Disease F21 **0** Ventilator/Respiratory Care F22 **0**
Other Spec Rehab. F23 **0**

Does the facility currently have an organized resident group? F24	**Yes**
Does the facility currently have an organized group of family members of residents? F25	**No**
Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

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 nurse aide training and competency program? F32	**No**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

		A	B	C	D
	Tag #	Services Provided 1 2 3	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	Yes Yes 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**					Date: **02/26/16**

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